ORIGINAL ARTICLE

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Mainstream and special schools' use of well-being programmes: A regional survey

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Abstract

The incorporation of mental well-being provision into school curricula is increasingly the focus of government policy in the UK and internationally. However, it is not clear what well-being programmes schools provide to pupils, and how these programmes are delivered. The current study was an online survey to assess the use of whole-school well-being programmes in primary schools in North Wales. Normalisation Process Theory was utilised as a framework to assess normalisation of the well-being programmes. One-hundred and fifty-one schools in North Wales responded to the survey. The mean number of whole-school well-being programmes utilised by schools was 4.59, and nine of the 10 most frequently used programmes had little or no associated evidence base. The well-being programmes were generally perceived as normalised (i.e. everyday practice) by respondents. Implications for future practice are discussed, including the need to support schools to identify and implement evidence-based mental well-being provision.

KEYWORDS
evidence-based practice, interventions, mental well-being, schools

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Key insights

What is the main issue that the paper addresses?

It is not yet fully understood what whole-school well-being provision schools provide to pupils. The paper reports the findings of a survey of the whole-school well-being provision in North Wales primary schools, the delivery of these programmes and the extent to which they are normalised within schools.

What are the main insights that the paper provides?

The paper provides preliminary understanding of the current whole-school well-being provision in North Wales primary schools. On average, a high number of well-being programmes are in use, and many programmes used by schools lack evidence of their effectiveness in improving outcomes.

INTRODUCTION

The key role schools can play in the promotion of pupils' mental well-being has received increased attention (Fazel et al., 2014; Goldberg et al., 2019; Weare & Nind, 2011). This recognition has resulted in shifts in educational policy to incorporate mental well-being. In the USA, the National School Mental Health Projects, from the Substance Abuse and Mental Health Services Administration (SAMHSA), has developed planning and implementation guidance for a national school mental health curriculum (Mental Health Technology Transfer Center Network and the National Center for School Mental Health, 2019). Additionally, US government funding has recently been awarded to Project Advancing Wellness and Resilience in Education, the aim of which is to develop an infrastructure for school-based promotion of social and emotional development in schools across the country (SAMHSA, 2022).

Mental well-being provision is also part of national school curricula across the UK. In 2019, the Department for Education issued statutory guidance for compulsory Relationships, Health and Sex Education lessons to be integrated into primary and secondary schools' curricula in England (Department for Education, 2019). These lessons are required to cover two key areas: 'relationships' and 'physical health and mental well-being'. The national curriculum in Scotland, known as the Curriculum for Excellence, features Health and Well-Being as one of eight core curriculum areas. One of the 'organisers' in this Curriculum for Excellence Health and Well-being area is mental, emotional, social and physical wellbeing (Education Scotland, 2022). In Northern Ireland, well-being is taught as part of curriculum area 'Personal Development and Mutual Understanding' in primary schools and 'Learning for Life and Work' in secondary schools (Council for the Curriculum, Examinations, & Assessment, 2019). The Welsh curriculum is currently undergoing reform and Health and Well-being is one of the six Areas of Learning and Experience (AoLE) forming the new Curriculum for Wales (CfW) being implemented in 2022 (Welsh Government, 2020). Additionally, in England, the Transforming Children and Young People's Mental Health Green Paper released by the Department of Health and Social Care and the Department for Education in (2017) had a substantial focus on the role educational institutions should play in offering mental

health provision. Proposals for reform included all schools being incentivised to appoint a designated mental health lead.

There has also been significant investment from UK national governments to support well-being provision in schools. Supports and investments include the establishment of Mental Health Support Teams in England (Department for Education, 2022), and funding for the CAMHS In-Reach to Schools pilot programme in Wales (Welsh Government, 2021a). The promotion of school-based mental-wellbeing at a government level is also exemplified by the introduction of the statutory guidance for the Whole-School Approach to Emotional and Mental Well-Being in Wales (Welsh Government, 2021b). This framework sets out how schools can review their existing whole-school provision to identify and address areas of weakness, as well as continuing to build on good practice. The guidance can be utilised by schools when planning their well-being provision as part of the Health and Well-being AoLE in the CfW 2022.

In this context of the increasing recognition of the role of schools in supporting and promoting mental health and well-being of young people internationally and in the UK, it is vital to ensure that the interventions schools use to address mental health and wellbeing are effective. In general, there is a growing emphasis on the use of evidence-based practice across education by policy-makers (Coldwell et al., 2017; Nelson & Campbell, 2017; Pellegrini & Vivanet, 2021). There has also been a concerted effort to make evidence more accessible for schools. For example, the Education Endowment Foundation (EEF) and the Early Intervention Foundation (EIF) were established in the UK in 2011 and 2013 respectively to provide evidence-based resources for educators. These resources, such as the EIF's Guidebook (Early Intervention Foundation, 2022) provide summaries of key information around intervention programmes, including how they impact outcomes, the strength of evidence, and the cost of implementation. There is also a range of international evidence repositories available to education professionals, including the What Work Clearinghouse, the Best Evidence Encyclopaedia and Evidence for Every Student Succeeds Act established in the USA, and Evidence for Learning Toolkits from Australia. These efforts to increase the accessibility of information about the effectiveness of intervention approaches have also been reflected in the use of evidence by schools (Gorard et al., 2020). For example, a survey of 1587 school leaders in England by Ager and Pyle (2013) found that the majority referred to these evidence repositories when making decisions regarding where to allocate 'Pupil Premium' funding (additional funding to improve the learning of disadvantaged pupils). Other research, however, indicates that teachers are more inclined to draw on their own experiences, alongside the views and experiences and expertise of colleagues and staff in other schools, when making decisions about which programmes and practices to adopt (Nelson & Campbell, 2017; Nelson & O'Beirne, 2014; Walker et al., 2019).

School-based mental well-being programmes

In the broader context of the use of evidence-based practices in schools and given the increased use of mental well-being provision in schools, it is important that the programmes and interventions schools use improve pupil well-being. The evidence for school-based mental well-being provision improving well-being outcomes is variable. Systematic reviews of school-based interventions to improve a range of pupil well-being outcomes have established that they can result in reductions in anxiety and depression symptoms (Fazel et al., 2014), increased social and emotional skills (Clarke et al., 2021), and improvements in mental health literacy and reductions in mental health stigma (Ma et al., 2022). However, not all well-being programmes used in schools are supported by an evidence base. For many programmes, there is either insufficient or no high-quality research to determine

their effectiveness; or evaluation of the programmes has found no positive outcomes on pupil well-being. For example, a systematic review and meta-analysis by Caldwell et al. (2019) found little to no evidence for the effectiveness of school-based interventions for the prevention of anxiety and depression. Owing to the mixed evidence base for these programmes, schools need to ensure the well-being provision is based on more evidence-informed approaches rather than those lacking robust evidence of causal impact on learner outcomes.

Although there has been evaluation of the effectiveness of well-being programmes and approaches, there is currently a lack of research to evaluate what schools' typical practice looks like. Some insight comes from a recent survey into Social and Emotional Learning (SEL) practices in 621 primary schools in England, conducted by Wigelsworth et al. (2021). They found that nearly 90% of schools reported using scheduled SEL programming and the most frequently implemented SEL programme was the Social and Emotional Aspects of Learning (SEAL) (Department for Education and Skills, 2007), followed by Targeted Mental Health in Schools (Department for Children, School and Families, 2008), and FRIENDS Resilience (Barrett et al., 2000). Further insight comes from a scoping survey in English schools by Vostanis et al. (2013). They surveyed 599 primary and 137 secondary schools on the nature of their mental health strategies and provision and found that programmes in use were primarily reactive (i.e. in response to pupils' existing mental health difficulties) and not preventative of future mental health issues. Another important finding was that the majority of interventions used by the surveyed schools were not evidence based. This suggests that despite the shift towards evidence-based practice that increasingly frames educational policy, this is not necessarily reflected in well-being practice in schools.

This general conclusion is supported by a recent study by Pegram et al. (2022), which evaluated the use of interventions in a cluster of schools in North Wales. The term school 'cluster' refers to the grouping of schools in the same geographical region for pedagogic, economic and administrative purposes (Chikoko, 2007). A questionnaire design was used to collate the interventions used by schools, and a supporting systematic review was conducted to evaluate the evidence for the interventions schools reported using. The focus of this study was interventions delivered to pupils in small groups or on a one-to-one basis. Interventions were categorised into four 'areas of need', one of which was Social, Emotional and Mental Health (SEMH) and is relevant to this study. It was found that most programmes used by schools lacked empirical support. Specifically, for SEMH interventions, 77% of the programmes had no available evidence, and only 6% had moderate to high-quality evidence considered to be 'promising'. Additionally, the authors reported that when schools were informed of the evidence base for the interventions they were using via summary reports, many schools continued to use these programmes including those that lacked any evidence of causal impact. These findings demonstrate that despite the push towards evidence-informed practice in educational policy, and the increased availability of accessible information, there is still significant work to be done in relation to schools implementing evidence-based well-being programmes.

This area of research has gained even greater significance following the Covid-19 pandemic and resulting restrictions, given the subsequent impact on pupils' well-being and schools' efforts to respond to this. Estyn (the education and training inspectorate in Wales) conducted school visits across North Wales in 2021 to assess the impact of the pandemic on pupils and staff—a summary report highlighted that the majority of schools had provided more well-being support and interventions in response to the pandemic (Estyn, 2021). While this is a positive response from schools, it also highlights the importance of ensuring they offer effective, empirically supported programmes to improve pupil well-being.

Whole-school well-being provision in schools

For school-based well-being provision, there is currently a significant focus on whole-school well-being provision. This stems from an acknowledgement that all pupils, and not just those at risk, can benefit from this whole-class and/or whole-school promotion of positive well-being (Fazel et al., 2014). A potential benefit of this approach can be that it is preventative, rather than reactive. The predominant approach to mental health provision in schools has been on targeted support, where the focus is the delivery of interventions such as counselling services or cognitive-behaviour therapy to pupils experiencing or at risk of mental health difficulties individually or in small groups (Patalay et al., 2017). With the increased emphasis on the integration of well-being provision into school curricula, there has been a move towards a whole-school approach for all pupils. A range of national initiatives for whole-school approaches have been introduced globally, such as Be You in Australia, which provides an end-to-end approach for mental health promotion and support in schools (Australian Government—Department of Health, 2021). Whole-school approaches to improve well-being have diverse theoretical underpinnings. Globally, SEL is one of the most commonly used whole-school approaches in schools (Patalay et al., 2017). Social and Emotional Learning refers to how individuals gain and utilise skills and knowledge which enable them to regulate emotions, build healthy self-identities, set and achieve goals, empathise with others, engage in responsible and caring decision-making, and have supportive relationships (CASEL, 2022). Goldberg et al. (2019) conducted a meta-analysis of 45 studies to establish the effects of whole-school SEL approaches and found small but significant improvements in pupils' social and emotional adjustment, behavioural adjustment, and internalising symptoms. Other common whole-school well-being approaches include cognitive-behavioural therapy interventions (which seek to improve well-being through cognitive restructuring eliciting change in behaviours; Rotheram-Fuller & MacMullen, 2011), positive psychology, mental health education, such as the Youth Aware of Mental Health programme (Wasserman et al., 2015) and the Mental Health and High Schools Curriculum Guide (Kutcher & Wei, 2017), and mindfulness (Mackenzie & Williams, 2018; O'Reilly et al., 2018). Several systematic reviews and meta-analyses have evaluated the effectiveness of whole-school well-being approaches for a range of well-being outcomes—positive impacts have been found for outcomes including reductions in pupils' depressive and anxiety symptoms (Dray et al., 2017), and improvements in their resilience and coping skills (Fenwick-Smith et al., 2018).

Some whole-school programmes have been more robustly evaluated than others, such as FRIENDS Resilience, which is a suite of play-based, experiential programmes, rooted in cognitive-behaviour therapy principles (Barrett et al., 2000). There are four developmentally sensitive FRIENDS programmes, for pupils aged 4 years and older, which can be delivered flexibly through weekly sessions over one or two school terms. There is preliminary evidence for FRIENDS programmes improving well-being outcomes. Ruttledge et al. (2016) conducted a randomised controlled trial (RCT) evaluation of FRIENDS in 27 Irish primary schools and found that the intervention group showed improvements in emotional well-being and increased coping skills over the control group. Another RCT evaluation of FRIENDS by Rodgers and Donsmuir (2015), with 62 pupils in three Irish primary schools, reported reductions in anxiety in the treatment group post-intervention, with continued reductions at 4 month follow-up.

Another commonly used programme which has been evaluated empirically is Promoting Alternative Thinking Strategies (PATHS). PATHS is a multi-year manualised well-being programme, which utilises the affective-behavioural-cognitive-dynamic model of development (Kusché & Greenberg, 1994). It is designed to be delivered twice weekly, in 20–30 min sessions, over the course of one academic year. Improvements in pupils' behavioural and

well-being outcomes have been found following use of PATHS. Domitrovich et al. (2007) conducted an RCT evaluation of PATHS in 20 classrooms in Pennsylvania, USA, and found that pupils who received PATHS had higher emotional knowledge and were rated as being less socially withdrawn and more socially competent. More modest effects of PATHS were found in a mixed-methods cluster RCT by Humphrey et al. (2018), conducted in primary schools in seven local authorities across Manchester, UK. There were very small but significant improvements in pupils' social skills and psychological well-being following the intervention. It is important to note that the frequency of delivery of PATHS lessons by schools in this study was sub-optimal, with competing priorities cited as the reason by school staff—this may have contributed to the limited impact of the programme on pupils' well-being.

Implementation

A strong evidence base should be a key consideration for schools when selecting well-being provision, but this alone is not sufficient to improve outcomes for pupils. It is equally important that the programme is implemented effectively—if a programme is not delivered as intended by the programme developers, it may fail to have the intended impact, regardless of whether it is empirically supported. Implementation has been established as a key factor in the success of well-being programmes in effectively improving pupil well-being: improved implementation of programmes is associated with enhanced well-being outcomes (Dowling & Barry, 2020; Humphrey et al., 2018). However, schools often implement well-being interventions with low levels of implementation fidelity (Durlak & DuPre, 2008) and failures of well-evidenced programmes to produce expected outcomes owing to poor quality implementation have been identified in the research literature. A systematic review and meta-analysis by Durlak et al. (2011) of over 200 school-based whole-school SEL interventions established that the presence of implementation problems negatively affected well-being outcomes. Additionally, a controlled trial by Kam et al. (2003) found that poorer well-being outcomes following the PATHS programme were found when implemented with low fidelity and without strong support from the school leader. This highlights the importance of schools not only identifying and using evidence-based practices, but also ensuring they are implemented effectively to achieve improvements in well-being.

Therefore, when assessing how schools' well-being provision is used and delivered in practice, implementation quality is a key consideration for schools as they plan for the efficient use of scarce resources to improve learner well-being outcomes. Assessing implementation of whole-school approaches in schools is particularly important, as they are arguably more difficult to implement than targeted programmes owing to the need to integrate well-being provision across different curriculum subjects. Also, whole-school programmes are primarily delivered by school staff and not mental health professionals. This may influence the quality of implementation as most teachers do not receive formal training on well-being and, consequently, this can negatively affect their self-efficacy beliefs when providing well-being support (Graham et al., 2011; Mazzer & Rickwood, 2015).

There are various frameworks within implementation science which seek to describe, understand and evaluate implementation. Normalisation process theory (NPT) is a theoretical framework used to assess the implementation of complex interventions, and how they become a part of everyday practice (May & Finch, 2009). School-based interventions can be conceptualised as complex owing to the interplay of factors involved in their adoption and delivery (e.g. school staff as intervention facilitators, time constraints to deliver interventions). There are four constructs in NPT, which each reflect an aspect of the work people do in terms of implementing, embedding and sustaining an intervention. These constructs are Coherence (making sense of the intervention), Cognitive Participation (working

out participation), Collective Action (doing the work) and Reflexive Monitoring (reflecting on the practice). The focus of this theory is not only on people's attitudes towards interventions, but also on their actions (i.e. do people interact and engage with programmes in a manner that is indicative of normalisation?).

A qualitative systematic review of 29 papers using NPT reported that the majority of study authors found it to be beneficial as a conceptual framework to analyse implementation processes (McEvoy et al., 2014). This suggests that NPT may be a useful tool to contribute to our understanding of how school-based interventions become embedded within the school environment and ethos. This is an important consideration in the context of the shift in educational policy to incorporate well-being provision. If school-based well-being provision is to become everyday practice, it requires school leadership and staff involved in the programmes to be fully invested in the programmes they utilise. Although there has been little use of NPT previously as a framework to assess school-based interventions, Meiksin et al. (2020) conducted an NPT-informed process evaluation of a whole-school relationships and sex education intervention. They found the barriers and facilitators to implementation identified in the process evaluation aligned well with the key constructs described by the theory. For example, greater staff understanding of the intervention was associated with better implementation, which links with the NPT construct of 'coherence', as this describes the work people do to make sense of an intervention. Also, insufficient buy-in from staff was cited as a barrier to delivery, which links with the NPT constructs of 'cognitive participation', as this describes how people engage with interventions. The use of NPT in this study demonstrates its potential as a framework for assessing implementation processes in school-based interventions.

Normalisation process theory can also be used to contribute to our understanding of why, despite the widespread availability of evidence for well-being programmes (e.g. EIF's Guidebook), there are still considerable difficulties in getting schools to use more strongly evidenced-informed programmes. A potential explanation may be that the use of programmes with little or no evidence base is normalised within schools (e.g. Pegram et al., 2022). If so, schools may choose to continue to utilise these programmes, as they are seen as everyday practice, rather than introduce new programmes, despite their stronger evidence base. NPT can enable us to explore whether this is the case, by establishing if programmes with little or no evidence based are normalised within schools.

The current study

The school curriculum in Wales is currently undergoing a comprehensive overhaul to help improve education standards and reduce the attainment gap between pupils (Donaldson, 2015). Implementation of the new curriculum will begin in September 2022 and, as part of this reform, schools are required to design and implement their own curriculum, based around six AoLEs. Health and Well-being has been designated as one of these AoLEs. When schools are designing their new curriculum, they will be required to incorporate provision for the promotion of pupils' well-being. The Regional School Effectiveness and Improvement Service for North Wales (GwE) works with schools in six local authorities to improve the quality of school provision and outcomes for learners. As part of its work to help schools realise the Health and Well-being AoLE, the current study was part of wider evaluation of provision in schools. Evaluating well-being provision provides valuable information regarding what is being done well, what requires improvement, and any gaps in the provision. For example, the scoping survey of mental health provision in English schools conducted by Vostanis et al. (2013) highlighted key areas for improvement, such as the lack of evidence-based practice and limited training and support for teachers to deliver the

provision. Additionally, the survey of schools' SEL practices by Wigelsworth et al. (2021) reported staff training issues were frequently mentioned as a barrier to implementation. As both of these surveys were conducted solely in English schools, similar mapping should be undertaken in other contexts. Availability of interventions can vary across contexts, owing to factors such as the availability of translations and/or culturally appropriate adaptations. Future mapping studies would also benefit from the inclusion of a heuristic device to assess implementation, such as NPT.

The aim of the current study was to conduct a survey to explore the current whole-school well-being provision for pupils in North Wales schools and to assess the delivery, training, staff involvement and implementation of the identified programmes. At present, there has been no comprehensive assessment of the whole-school well-being provision in schools in Wales. The focus of the survey was to evaluate the whole-school well-being provision as this is a national policy initiative linked to the realisation of the CfW. The aim of this study was to answer the following questions:

1. What whole-school mental well-being provision is currently offered by primary schools in North Wales?
2. How is the whole-school mental well-being provision delivered by schools to pupils?
3. To what extent do schools access training and support in relation to the whole-school well-being provision?
4. Which staff members are involved in delivering and leading the whole-school well-being provision?
5. To what extent are the whole-school well-being programmes utilised by schools perceived as normalised (i.e. incorporated as everyday practice)?

MATERIALS AND METHODS

Participants and schools

The sampling unit was maintained primary schools in North Wales and the target population was staff members in these schools responsible for the co-ordination of whole-school well-being provision for pupils. We aimed to recruit a total sample of maintained primary schools in North Wales.

Measures

To address the research questions, a bespoke survey was developed by the research team to capture what whole-school well-being provision is used in North Wales primary schools, and factors relating to the usage of the programmes. The survey featured close-ended questions (with single and multiple-choice options, Likert scales and dichotomous yes/no responses) and open-ended questions. A copy of the survey is available upon request from the first author.

The first section of the survey asked demographic information questions relating to the respondent's school, professional role and the school's mental health plans/policies. This included the language categories of schools—there are six language categories in schools in Wales: Welsh-medium, English medium, Dual Stream, Bilingual Type A, Bilingual Type B, and English with significant Welsh (see Supporting Information—Section A for descriptions of each language category). The language category of the majority of the mainstream

schools was English-medium (60.5%) followed by Welsh-medium (33.3%) (see Table 1). The language category of all special schools was English-medium.

Demographic questions were followed by questions regarding the current whole-school well-being provision in the schools. Definitions of well-being and whole school interventions were provided as follows:

1. 'Mental well-being can be defined as feeling good, feeling that life is going well, and feeling able to get on with daily life' (Anna Freud Centre for Children and Families, 2020).
2. 'Whole-school well-being interventions provide mental well-being support for all pupils and are embedded across all aspects of school life. This includes:

  (i) A curriculum which integrates mental well-being promotion across all subject areas.
 (ii) A school environment, culture and ethos which promotes positive mental well-being.
(iii) Engagement with partnerships outside the school (e.g. the family and the wider community) to support pupil's mental well-being.' This definition was developed for the survey by the research team, and it was derived from wider reading around whole school well-being interventions.

TABLE 1 Mainstream school demographic data.

	n	%
School language		
Welsh-medium	49	33.3
English medium	89	60.5
Dual stream	3	2
Bilingual Type A	2	1.4
Bilingual Type B	2	1.4
English with significant Welsh	2	1.4
Does your school have plans/policies related to mental health/well-being?		
Yes	110	74.8
No	37	25.2
Does your school have a designated lead for mental health/well-being?		
Yes	104	70.7
No	43	29.3
Role of designated lead		
Headteacher	40	38.5
Deputy headteacher	12	11.5
Head of year	1	1
Head of department	3	2.9
SENCo or ALNCo	17	16.3
Teaching staff	22	21.2
Support staff	14	13.5
Other	11	10.6

Abbreviations: ALNCo, Additional Learning Needs Co-ordinator; SENCo, Special Educational Needs Co-ordinator.

A list of 25 whole-school well-being programmes was compiled and included in the survey. The programmes were identified through evidence repositories for school-based interventions, i.e. the EEF Teaching and Learning Toolkit (Education Endowment Foundation, 2018) and the EIF Guidebook (Early Intervention Foundation, 2022). The list was also refined through consultation with GwE well-being officers to ensure the list included programmes were established as having been used as whole-school well-being programmes in North Wales and other areas of the UK. Respondents were asked to use this list to identify programmes in current use in their school. A brief description outlining the key features of each programme was provided (e.g. 'Quality Circle Time—developed by Jenny Mosley, this programme seeks to promote better relationships and positive behaviour through regular Quality Circle Time meetings between pupils and staff. These meetings involve creative circle time activities, games and the practice of speaking and listening skills'). The full list of programmes and descriptions can be found in Supporting Information—Section B. Respondents were also provided with the option to enter the names and descriptions of other well-being programmes not mentioned in the survey, or bespoke programmes developed by their school.

Respondents were asked a series of questions designed to gather information on the implementation and delivery of well-being programmes. For each selected programme they were asked about: the language of delivery (Welsh, English, or both languages); how many hours per week each year group received the programme; alignment of the programme with school policy (on a scale of 1 to 4, with 1 being 'not at all aligned' and 4 being 'strongly aligned'); the extent to which the programme was delivered as intended (on a scale of 1–4, with 1 being 'not at all' and 4 being 'fully'); and whether the school accessed on-going training and support for the programme. Finally, respondents were also asked about staff involvement in the programmes, including which staff members received training, which staff members delivered the programme, and which staff members led the programme.

The survey also included items from the Normalisation MeAsure Development questionnaire (NoMAD) instrument (Rapley et al., 2018), which is designed to assess implementation processes from the perspectives of staff involved in the delivery of complex interventions. The instrument was developed to reflect the four constructs of NPT. Seventeen items from the NoMAD survey instrument were included in the current survey—some examples of the NoMAD items are: 'I can see how the intervention differs from usual ways of working', 'I can easily integrate the intervention into my existing work in the school' and 'Sufficient training has been provided to enable school staff to implement the intervention'.

Six items from the instrument were excluded from the current survey owing to them being less suitable for the school context delivering multiple well-being interventions. The NoMAD instrument has been validated and established as having high levels of internal consistency and reliability (Finch et al., 2018). Internal consistency of a NoMAD total score drawing on all items was tested for the current sample and the scale had high internal consistency (Cronbach's $\alpha = 0.990$). Respondents were asked to complete the NoMAD items for each well-being programme they selected as being used in their schools, to establish the extent to which the programme is embedded in the school. Responses were on a five-point Likert scale ranging from strongly agree (5) to strongly disagree (1). More positive ratings on NoMAD items represent higher potential for the programme to be normalised (Finch et al., 2018). We used total NoMAD scores, as this allowed for comparison of the extent to which different well-being programmes are normalised in schools.

Procedure

Ethical approval for this study was granted by the Humanities and Social Science Research Ethics Committee at the University of Warwick (reference 205/19-20). Participants were

recruited by GwE, who advertised the survey to schools via a school bulletin. The survey was first advertised in the bulletin during January 2021, and on a fortnightly basis thereafter. In May 2021, schools who had not responded were contacted individually by GwE officers with a reminder to complete the survey. The survey remained live until July 2021.

All participant facing materials (participant information leaflets, consent forms and the survey) were translated into Welsh by translators from GwE and back-translated into English to ensure the accuracy of the translation. The survey was hosted online on the University of Warwick Qualtrics™ platform. Respondents accessed the survey through an anonymous Qualtrics link, provided in the recruitment advert. On opening the survey link, respondents were presented with the study information leaflet and were required to answer consent questions, confirming if they had read and understood the information and consented to participating in the study. They were able to leave the survey and return to it at a later time if they needed to consider their participation or responses. Upon completion of the survey, all respondents were assigned with a randomly generated unique identifier in case they later wished to withdraw their data from the study.

Data analysis

Data were imported from Qualtrics™ into SPSS. Owing to the anonymous nature of the survey, there was a possibility of duplicate responses from schools. To address this, school names provided by respondents were examined for more than one response from the same school. Where duplicates were identified, the responses were compared to assess the level of agreement. Any discrepancies between responses were discussed by the research team to establish a consensus regarding appropriate actions to be taken and a composite response was created. Actions involved averaging of responses for questions using a Likert scale to get a mean response, and if two respondents identified different well-being programmes as being used in their school, all programmes were included in the composite response. For a small number of responses, the respondent provided a joint response for two schools in the same federation. For analysis purposes, this was counted as a single response. Responses to open-ended questions were categorised into existing response categories where applicable, or new response categories were created. Two additional variables were computed: total number of programmes used by schools, and total scores across all NoMAD instrument items (separately for each programme used by schools). To ensure a sufficient number of responses were included in the analysis for meaningful comparisons to be made between programmes, total NoMAD scores were computed only for programmes identified as being used by a minimum of 10 schools. Descriptive statistics were calculated, with frequencies and percentages for the categorical data and means, standard deviation, range and 95% confidence intervals for the continuous data.

RESULTS

We aimed to recruit a total sample of the maintained 337 primary schools in North Wales. Staff from 151 schools in North Wales responded to the online survey. Of these, 147 were mainstream schools and four were special schools. The main results are reported below are for the mainstream schools, given the small number of special schools in the sample.

Table 1 presents the school demographic data. Most schools reported having plans/policies in place for mental health/well-being (74.8%) and a designated well-being lead (70.7%). The professional role of this designated lead was most frequently held by the headteacher (38.5%), the Special Educational Needs Co-ordinator/Additional Learning

Needs Co-ordinator (21.2%) or teaching staff (21.2%). The mean number of well-being programmes schools reported using was 4.59 (standard deviation, SD = 2.477, range = 11). The most commonly used programmes were Growth Mindset ($n = 119$, 80.9%), Healthy Schools Scheme (HSS) ($n = 102$, 69.3%) and Quality Circle Time (QCT) ($n = 72$, 48.9%). The results reported here are for the 10 well-being programmes used most by schools ($n = 24–119$ schools).

Table 2 displays the language of delivery and duration of delivery per week for the well-being programmes. Each of the well-being programmes was most frequently delivered in English (47.8%–100%). The average hours per week that schools delivered for each programme varied between programmes and across year groups. The average duration of delivery for ranged from 45 min to 4 h a week.

Factors relating to training for the well-being programmes are displayed in Table 3. Access to training was generally reported to be high across schools (84.6–100%) for all programmes, with the notable exception of the SEAL programme, for which only 50% of respondents reported that training for the programme was accessed. The length of the training accessed by schools varied between programmes, with the most common duration being '1 day' or '3 or more days'. There was also substantial variation between schools regarding the length of training accessed for each programme—for example, the responses for the HeadStart programme ranged from 'half a day or less' to '3 or more days'. They were also asked if on-going support and consultation is accessed for the well-being programmes. The number of schools who reported accessing this ranged substantially from 0% (for SEAL) to 100% (for CAMHS In-Reach), with an average of 49.9% across all the programmes.

School staff involvement in the well-being programmes is displayed in Table 4. Staff involvement in the programmes varied considerably between both schools and programmes, with the designated lead for well-being, teaching staff, support staff and senior leadership staff all being highlighted as having varying degrees of involvement. Teaching and support staff were most frequently reported as receiving training to deliver, and being involved in the delivery of, the well-being programmes to pupils. For six of the 10 programmes, teaching staff were most frequently responsible for leading the well-being programme.

Respondents were asked to rate how well the programmes align with their mental health/well-being plans and policies (on a scale of 1–4, with 1 being 'not at all aligned' and 4 being 'strongly aligned'). The well-being programmes were reported to be well aligned with policies, with the median score ranging from 3.00 to 4.00 (see Table 5). The interquartile range (IQR) was 1.00 for most programmes, except for FRIENDS Resilience (IQR = 2) and SEAL (IQR = 0). Respondents were also asked to rate extent to which the programmes were delivered in accordance with the programme instructions and training (on a scale of 1–4, with 1 being 'not at all' and 4 being 'fully'). The median score for this question was 3.00 across programmes—this suggests they were delivered moderately, but not fully, in accordance with programme and training instructions. The IQR was 1.00 for most programmes, with the exception of HSS, National Nurturing Schools Programme and Trauma Informed Schools (IQR = 2) and QCT (IQR = 0). The NoMAD instrument was used to assess normalisation of programmes, and the highest possible total NoMAD score in the current study was 85. Table 6 displays the mean NoMAD total scores for each well-being programme. Mean NoMAD scores ranged from 63.92 to 72.70, suggesting that the well-being programmes were perceived to be fairly well normalised in their schools. There was substantial overlap between 95% confidence intervals for the total NoMAD scores for almost all of the programmes, suggesting there was generally no difference in the extent to which these programmes were normalised in schools. An exception to this was the total NoMAD score for the SEAL programme, for which the 95% confidence intervals did not overlap with one of the other programmes (Growth Mindset) and only minimally overlapped with several other

TABLE 2 Delivery of well-being programmes.

Well-being programme (n[a])	Quality Circle Time (n=72)	FRIENDS Resilience (n=51)	Healthy Schools (n=102)	HeadStart (n=24)	Growth Mindset (n=119)	CAMHS In-Reach (n=35)	National Nurturing Schools Programme (n=35)	SEAL (n=32)	Trauma Informed Schools (n=66)	Seasons for Growth (n=49)
Language of delivery (n, %)										
Welsh	17 (28.3%)	2 (8.7%)	10 (19.2%)	11 (84.6%)	25 (35.7%)	–	3 (27.3%)	–	4 (17.4%)	8 (36.4%)
English	36 (60%)	20 (87%)	35 (67.3%)	–	35 (50%)	10 (100%)	8 (72.7%)	11 (91.7%)	11 (47.8%)	10 (45.5%)
Both	7 (4.7%)	1 (4.3%)	7 (13.5%)	2 (15.4%)	10 (14.3%)	–	–	1 (8.3%)	8 (34.8%)	4 (18.2%)
Hours per week (M, SD)										
Nursery	1.31 (1.17)	–	0.98 (0.53)	0.94 (0.17)	1.03 (0.51)	1.00 (0.00)	1.00 (0.00)	0.75 (0.27)	1.50 (0.56)	–
Reception	1.24 (1.10)	0.88 (0.25)	1.00 (0.54)	1.30 (0.68)	1.26 (0.93)	1.00 (0.00)	3.33 (4.04)	0.79 (0.27)	2.25 (1.89)	0.75 (0.35)
Year 1	1.37 (1.45)	0.83 (0.26)	1.00 (0.54)	1.50 (1.27)	1.37 (0.94)	1.00 (0.00)	2.75 (3.50)	0.79 (0.27)	2.60 (1.92)	0.75 (0.35)
Year 2	1.35 (1.45)	0.75 (0.27)	1.00 (0.54)	1.60 (1.36)	1.44 (0.96)	1.00 (0.00)	2.92 (2.94)	0.79 (0.27)	2.00 (1.55)	0.83 (0.29)
Year 3	1.19 (1.00)	1.08 (0.52)	1.02 (0.59)	1.44 (0.73)	1.44 (0.92)	1.00 (0.00)	2.88 (3.42)	0.92 (0.20)	2.20 (1.64)	1.20 (0.57)
Year 4	1.25 (1.11)	0.98 (0.41)	1.17 (0.93)	1.44 (0.73)	1.43 (0.93)	1.00 (0.00)	2.50 (3.08)	0.93 (0.19)	2.00 (1.53)	1.50 (0.81)
Year 5	1.17 (1.01)	0.98 (0.41)	1.03 (0.60)	1.44 (0.73)	1.51 (1.00)	1.00 (0.00)	2.50 (3.08)	0.92 (0.20)	2.17 (1.60)	1.29 (0.80)
Year 6	1.21 (1.12)	0.90 (0.30)	1.10 (0.90)	1.44 (0.73)	1.51 (1.00)	1.00 (0.00)	2.92 (2.94)	0.92 (0.20)	1.83 (1.60)	1.29 (0.29)

[a] The n refers to the total number of respondents to the questions regarding language and duration of delivery for each well-being programme.

Abbreviations: M, mean; SD, standard deviation.

TABLE 3 Training and support for well-being programmes.

Well-being programme (n)[a]	Quality Circle Time (n=33)	FRIENDS Resilience (n=20)	Healthy Schools Scheme (n=28)	HeadStart (n=6)	Growth Mindset (n=42)	CAMHS In-Reach (n=6)	National Nurturing Schools Programme (n=6)	SEAL (n=6)	Trauma Informed Schools (n=17)	Seasons for Growth (n=17)
Is training for the programme accessed? (% yes)	85%	100%	90%	84.6%	86.8%	87.5%	90%	50%	95.7%	90.9%
Duration of training (n, %)										
Half a day or less	5 (15.2%)	–	1 (3.6%)	–	3 (7.2%)	–	–	1 (20%)	–	–
1 day	18 (54.5%)	2 (10%)	9 (32.1%)	4 (66.7%)	10 (23.8%)	4 (66.7%)	–	4 (80%)	10 (58.8%)	2 (11.8%)
2 days	3 (9.1%)	11 (55%)	8 (28.6%)	1 (16.7%)	8 (19.0%)	1 (16.7%)	2 (28.6%)	–	2 (11.8%)	8 (47.1%)
3 or more days	7 (21.2%)	7 (35%)	10 (35.7%)	1 (16.7%)	21 (50%)	1 (16.7%)	5 (71.4%)	–	5 (29.4%)	7 (41.2%)
Is on-going support/ consultation for the programme accessed? (% yes)	38.3%	47.8%	62.0%	15.4%	43.5%	100%	90%	0%	47.8%	54.5%

[a] The *n* refers to the total number of respondents to the questions relating to training and support for each well-being programme.

TABLE 4 Staff involvement with well-being programmes.

Well-being programme	Quality Circle Time	FRIENDS Resilience	Healthy Schools	HeadStart	Growth Mindset	CAMHS In-Reach	National Nurturing Schools Programme	SEAL	Trauma Informed Schools	Seasons for Growth
Staff trained to deliver the programme (n[a], %)										
Designated lead	23 (41.8%)	9 (39.1%)	15 (30.6%)	3 (25.0%)	21 (31.3%)	3 (37.5%)	6 (60.0%)	1 (12.5%)	11 (50.0%)	1 (4.5%)
Teaching staff	46 (83.6%)	3 (13.0%)	39 (79.6%)	11 (91.7%)	58 (86.6%)	4 (50.0%)	7 (70.0%)	7 (87.5%)	14 (63.6%)	6 (27.3%)
Support staff	31 (56.4%)	14 (60.9%)	14 (28.6%)	6 (50.0%)	42 (62.7%)	2 (25.0%)	7 (70.0%)	4 (50.0%)	14 (63.6%)	17 (77.3%)
Senior leadership	16 (29.1%)	4 (17.4%)	15 (30.6%)	3 (25.0)	28 (41.8%)	3 (37.5%)	7 (70.0%)	2 (25.0%)	9 (40.9%)	2 (9.1%)
Other	3 (5.5%)	1 (4.3%)	3 (6.1%)	–	1 (1.5%)	2 (25.0)	–	1 (12.5%)	2 (9.1%)	1 (4.5%)
Staff involved in programme delivery (n[a], %)										
Designated lead	21 (35.6%)	6 (26.1%)	13 (26.0%)	2 (15.4%)	25 (36.2%)	3 (37.5%)	5 (50.0%)	2 (16.7%)	11 (47.8%)	2 (8.7%)
Teaching staff	52 (88.1%)	7 (30.4%)	47 (94.0%)	13 (100.0%)	65 (94.2%)	6 (75.0%)	9 (90.0%)	11 (45.8%)	16 (69.8%)	6 (26.1%)
Support staff	42 (71.2%)	16 (69.6%)	31 (62.0%)	9 (69.2%)	49 (71.0%)	4 (50.0%)	8 (80.0%)	5 (41.7%)	14 (60.9%)	16 (69.6%)
Senior leadership staff	10 (16.9%)	2 (8.7%)	19 (38.0%)	1 (7.7%)	24 (34.8%)	3 (37.5%)	5 (50.0%)	5 (41.7%)	7 (30.4%)	3 (13.0%)
Other	1 (1.7%)	1 (4.3%)	5 (10.0%)	–	3 (4.3%)	1 (12.5%)	1 (10.0%)	1 (8.3%)	2 (8.7%)	1 (4.3%)
Staff responsible for leading programme (n[a], %)										
Designated lead	23 (39.7%)	8 (43.8%)	17 (34.0%)	4 (30.8%)	19 (27.5%)	–	6 (60.0%)	2 (16.7%)	9 (39.1%)	3 (13.0%)
Teaching staff	43 (74.1%)	5 (21.7%)	39 (78.0%)	12 (92.3%)	52 (75.4%)	4 (50.0%)	2 (20.0%)	10 (83.3%)	11 (47.8%)	5 (21.7%)
Support staff	19 (32.8%)	14 (60.9%)	12 (24.0%)	3 (23.1%)	24 (34.8%)	2 (25.0%)	4 (40.0%)	3 (25.0%)	6 (26.1%)	13 (56.5%)
Senior leadership	13 (22.4%)	5 (21.7%)	16 (32.0%)	–	23 (33.3%)	4 (50.0%)	6 (60.0%)	4 (33.3%)	7 (30.4%)	5 (21.7%)
Other	1 (1.7%)	–	2 (4.0%)	–	–	–	–	1 (8.3%)	–	1 (4.3%)

[a] The n refers to the total number of respondents to the questions regarding staff involvement for each well-being programme.

TABLE 5 Respondent's views on alignment with school policy and programme fidelity.

Well-being programme (n[a])	Quality Circle Time (n=60)	FRIENDS Resilience (n=23)	Healthy Schools Scheme (n=51)	HeadStart (n=13)	Growth Mindset (n=70)	CAMHS In-Reach (n=10)	National Nurturing Schools Programme (n=11)	SEAL (n=12)	Trauma Informed Schools (n=23)	Seasons for Growth (n=12)
Alignment of programme with school policy median (IQR)	4.00 (1)	4.00 (2)	4.00 (1)	4.00 (1)	4.00 (1)	3.00 (1)	4.00 (1)	3.00 (0)	3.50 (1)	3.00 (1)
To what extent is the programme delivered according to training and/or instructions? Median (IQR)	3.00 (0)	3.00 (1)	3.00 (2)	3.00 (1)	3.00 (1)	3.00 (1)	4.00 (2)	3.00 (1)	3.00 (2)	3.00 (1)

[a] The n refers to the total number of respondents to the questions regarding alignment with school policy and programme fidelity for each well-being programme.

Abbreviations: IQR, interquartile range.

TABLE 6 Total NoMAD scores for well-being programmes.

Well-being programme	Quality Circle Time (n=59)	FRIENDS Resilience (n=23)	Healthy Schools Scheme (n=51)	HeadStart (n=13)	Growth Mindset (n=69)	CAMHS In-Reach (n=8)	National Nurturing Schools Programme (n=11)	SEAL (n=12)	Trauma Informed Schools (n=22)	Seasons for Growth (n=23)
NoMAD total score *M* (SD, 95% confidence interval)	69.12 (8.37, 66.94–71.30)	68.00 (7.11, 64.93–71.07)	67.38 (7.18, 63.04–71.73)	68.80 (6.94, 66.85–70.76)	71.66 (8.01, 69.72–73.93)	—[a,b]	72.70 (9.93, 65.59–79.81)	63.92 (6.17, 60.00–67.84)	68.45 (8.87, 64.53–72.38)	66.17 (7.67, 62.86–69.49)

[a] The *n* refers to the total number of respondents to the NoMAD questions for each well-being programme.
[b] Fewer than 10 responses.

well-being programmes (QCT, FRIENDS, HeadStart). These suggest that SEAL may be less normalised in schools than these other programmes.

DISCUSSION

The aim of this study was to map and assess the whole-school well-being provision in North Wales primary schools. An online survey design was utilised to establish what well-being programmes are provided by schools, and to explore factors relating to delivery, staff involvement and implementation of programmes.

A key finding is the high number of whole-school well-being programmes that schools reported using, with an average of four programmes in use and as many as 11 being reported by one school. Whole-school programmes are intensive in nature, as programmes are delivered to all pupils and well-being is integrated across all subject areas. Given the substantial time commitment involved, it may be difficult for schools to deliver multiple programmes with a high level of fidelity. Therefore, if the developers of these programmes intend them to be used as the main whole-school well-being provision, the delivery of multiple programmes at the whole-school level could be counter-productive and may hinder improvements in pupils' well-being. Utilising multiple programmes to improve well-being outcomes is also likely to be an inefficient use of school resources. Therefore, schools might benefit from streamlining their provision to focus on consistent, high-quality implementation of one or two well-established, strongly evidenced-based programmes. Given the time required to source and set up whole-school programmes, it seems unlikely that the timing of the survey during the ongoing Covid-19 pandemic (and potentially increasing focus on well-being provision; Estyn, 2021) explains the finding of a high number of programmes being used in schools. Future research may seek to explore why some schools opt to use a relatively high number of programmes, as this could inform how to best disseminate to schools the potential value of focussing their provision.

In terms of empirical support, the programmes schools reported using in this survey had limited or no evidence base. Growth Mindset (Dweck, 2006), which most of the surveyed schools reported using, is a motivational learning strategy that focuses on building a positive and resilient mindset in classrooms. Growth Mindset has also gained international popularity despite that fact that there is conflicting evidence that it is an effective strategy. Studies evaluating the use of Growth Mindset in schools have focused on how it can impact academic attainment (Li & Bates, 2019). Two meta-analyses by Sisk et al. (2018) identified weak effects of Growth Mindset on academic outcomes. Growth Mindset has not been evaluated as a whole-school intervention to improve pupil well-being. Two other programmes widely used by the surveyed schools are the HSS (Public Health Wales, 2016) and QCT (Mosley, 2005). Both were reported to be used in half or more of the schools in the sample. There are also currently no evaluations to show that either of these two programmes has a positive causal impact on pupil well-being outcomes. Of the 10 programmes schools most frequently reported using, only FRIENDS Resilience has been robustly evaluated and has preliminary evidence for improving pupils' well-being outcomes. This supports the findings of previous research by Vostanis et al. (2013) and Pegram et al. (2022), who reported a lack of a robust evidence base for well-being programmes used by schools.

To our knowledge, this study is the first to utilise NPT as a framework to assess implementation of school-based well-being provision. Items from the NoMAD survey instrument, derived from NPT, were used to assess implementation processes. The findings suggest that the use of the well-being interventions was normalised for participating schools, and perceived as everyday practice. This is a positive finding in that it highlights how well-being provision can become embedded within the school curriculum, as is increasingly mandated

by national education policies. However, this finding must be considered in relation to the fact that the programmes in use are not typically evidence-based practice. Therefore, even if well implemented, it cannot be assumed that there will be improvements in pupil well-being as a result of the provision. Embedded (normalised) practice may also be more resistant to change. This emphasises the need for schools to prioritise engagement with, and use of, evidence-based practice. In particular, we found that programmes without an established evidence-base are perceived by school staff as everyday practice, and this may impede the introduction of more strongly evidenced-based programmes. School staff's awareness of the importance of evidence-based practice may be improved in part through inclusion of guidance on the selection and implementation of well-being programmes as part of both teachers' initial training and their continuing professional development.

The use of NPT in this study highlights some interesting points for consideration regarding schools' selection and delivery of well-being programmes. First, it raises the question of if and how the conceptualisation of 'success' of programmes potentially differs between research and practice. Researchers may consider statistically significant improvements on validated measures of well-being, established through well-designed evaluations, to be requisite for a programme to be considered successful, and these criteria are also used in guidance as to what is considered 'evidence-based'. However, the widespread use and normalisation of programmes that do not match this conceptualisation of evidence by schools suggest they may have different criteria for success. If this difference exists, it is then important to establish how success is defined by schools. Second, it is noteworthy that most schools did not deliver the programmes fully in accordance with programme and training instructions—this suggests the possibility that some schools may have given less attention to processes that could promote later normalisation of programmes. Schools may benefit from dedicating more time and training to processes that support implementing and embedding an intervention. These could include sense-making work (Coherence—perhaps by identifying the active ingredients of the intervention) and working out participation (Cognitive Participation—perhaps by identifying staff to lead intervention delivery). This may enable school staff to develop a more comprehensive understanding of programmes, which in turn would allow them to be delivered with greater fidelity.

Whilst there was variation across all well-being programmes in terms of how they were delivered, the SEAL programme (Department for Education and Skills, 2007) was most markedly different. Only 50% of schools using SEAL accessed training, and none of the schools accessed on-going support or consultation for the programme. Also, SEAL had the lowest mean scores for alignment with school mental health/well-being policy, delivery in accordance with programme instructions and total NoMAD score. There are several contextual factors which may explain why schools' delivery and perception of SEAL differed considerably from the other programmes. First, as SEAL was initially introduced into schools in Wales and England as a government well-being initiative in 2005, it may have outlived its utility in schools as more current well-being programmes, with greater alignment to the modern school settings and curricula, have been developed. In addition, there may have been a longer period for implementation styles and perceptions of normalisation to have drifted, compared with other interventions schools may have accessed more recently. Second, SEAL is not a manualised programme, but a collection of guidance and resources which teachers can select from and deliver as they see fit, depending on the need in their class. Whilst this provides them with flexibility in their teaching, it also increases their workload, which can serve as a barrier to effective implementation. This has been found previously in a national evaluation of SEAL by Humphrey et al. (2016) in English secondary schools, who reported staff resistance to the programme, with high workload cited as a contributing factor. The findings in relation to SEAL in this survey provide a good example of well-being provision not currently being in line with everyday practice.

The questions regarding staff involvement with well-being programmes highlighted some interesting patterns across the schools. Teaching staff were reported as being responsible for receiving initial training, and then delivering and leading the well-being programmes (although only 21% held the role of designated well-being lead). This raises the question as to why work relating to well-being provision, such as experiencing training for the programmes, is not focused on the designated well-being lead within the school. Schools may benefit from clear delineation of the remit of the designated well-being lead, to ensure responsibilities pertaining to well-being provision, such as co-ordinating a whole-school approach within the school, are undertaken by the appropriate staff member. This could also facilitate reductions in the workload of teaching staff, which is a key consideration for senior leadership and education authorities considering the high levels of stress teachers report in comparison with other professions (Scheuch et al., 2015) and the high rates of attrition in teaching (Sims & Jerrim, 2020).

Another important finding from this study is the lack of well-being provision delivered in the Welsh language. Most provision was reported to be delivered in English, despite one-third of schools in the sample being in the Welsh-medium language category. If this is due to a lack of availability of Welsh translations for some programmes, pupils in Welsh-medium schools may not receive the same level of well-being support as their peers in English-medium schools. This is an important issue of equity for pupils from schools in all language categories.

It is also interesting to note that all of the 10 most frequently utilised programmes, with the exception of Seasons for Growth, are preventative in nature. While this is a good fit with a whole school approach (e.g. promotion of mental well-being for all pupils), it is not clear how pupils with more significant mental health needs might respond to a preventative approach. Further research on multiple levels of mental health support in schools is needed. In addition, there is a related challenge about how best to measure what has been 'prevented', which is a different construct to improvements or otherwise in well-being. To evaluate the impact of preventative interventions in practice, schools may need to consider ways of assessing changes in skills and coping strategies that are promoted through these approaches, perhaps in addition to changes in mental health and well-being.

Special schools

As only four special schools responded to this survey, there were insufficient data to draw reliable conclusions about the whole-school well-being practice in these settings. However, these four responses provide some useful insight (see Table 7). Three of the four schools reported having plans and/or policies in place for mental health/well-being and two reported having a designated well-being lead. The designated lead role was held by the head of department in one school and teaching staff in another school. The number of well-being programmes used by the special schools was variable: one school used two programmes, one school used three programmes, one school used eight programmes and one school reported using no well-being programmes. Nine well-being programmes were reported as being used in special schools: CAMHS In-Reach, the HSS, Trauma Informed Schools (Trauma Informed Schools UK, n.d.), and Seasons for Growth (Graham, 1996) were each used in two of the four schools; I Can Problem Solve (Shure, 2000), the National Nurturing Schools Programme (The Nurture Group Network, n.d.), Growth Mindset, Restorative Approaches in Schools (Hopkins, 2002), and SEAL were each used in one of the four schools.

There is a need for targeted assessment of what is being provided to pupils with Additional Learning Needs/Special Educational Needs and Disabilities (SEND) in terms of well-being—particularly as they comprise a population at greater risk of mental health issues

TABLE 7   Special school demographic data.

	N	%
School language		
Welsh-medium	0	0
English medium	4	100
Dual Stream	0	0
Bilingual Type A	0	0
Bilingual Type B	0	0
English with significant Welsh	0	0
Does your school have plans/policies related to mental health/well-being?		
Yes	3	75
No	1	25
Does your school have a designated lead for mental health/well-being?		
Yes	2	50
No	2	50
Role of designated lead		
Headteacher	0	0
Deputy headteacher	0	0
Head of year	0	0
Head of department	1	50
SENCo or ALNCo	0	0
Teaching staff	1	50
Support staff	0	0
Other	0	0

Abbreviations: ALNCo, Additional Learning Needs Co-ordinator; SENCo, Special Educational Needs Co-ordinator.

(Barnes & Harrison, 2017; Dix et al., 2010). Currently, there is limited research in this area—a systematic review by Daley and McCarthy (2020) found that only one in five studies of whole-school well-being programmes included students with SEND. It is also important to consider that well-being programmes used specifically with this population can be distinct from those offered to pupils without SEND. This can include developmentally appropriate adaptations made to existing well-being programmes, or bespoke programmes developed for pupils with SEND (and sub-groups within this population). Therefore, robust evaluation of this provision is required to establish the impact of these programmes on well-being outcomes.

Limitations

There are several limitations of the current study. As a volunteer sample was used, schools with a greater focus on well-being may have been more inclined to complete the survey and, therefore, may be overrepresented in the sample. Additionally, the overall response rate was under 50% of the mainstream primary schools in North Wales. This may be partially attributable to the time period in which the survey was live (January ro July 2021). As this was immediately after schools were able to re-open following Covid-19 lockdown restrictions, there were heightened demands on school staff's time and high rates of staff absence. These factors may have detrimentally impacted both school staff's capacity to complete the

survey and the quality of their responses (e.g. reduced quality of responses following initial reporting of which programmes schools were using). Consequently, the survey findings may not depict a full picture of the well-being provision in North Wales primary schools. Also, the findings from this study are specific to the context of North Wales primary schools and cannot be generalised beyond this sample. It is important for similar mapping to be undertaken in other contexts, to provide a broader understanding of how schools provide whole-school well-being programmes. Finally, as only one staff member from each school responded to the survey, there is a reliance on one person's knowledge and perceptions of well-being practice. Future research could seek to gather data from multiple respondents. There would also be significant benefit to collecting NoMAD data from all staff involved in delivering and leading the provision, to assess if there is variation in their perceptions of normalisation and perhaps to gain a clearer understanding of normalisation of well-being programmes at the school level.

CONCLUSION

The findings of this regional school survey provide insight into the current whole-school well-being provision in North Wales primary schools, and highlight several key areas for improvement for practice and research. Most programmes used by the surveyed schools lack underlying research support. Therefore, despite concerted efforts to promote schools' use of evidence through international initiatives such as the What Works Clearinghouse and the EEF, there is evidently more work to do to engage schools with research findings to promote the use of more strongly evidence-based approaches. When educational policy reform is introduced (e.g. the CfW 2022), this needs to be accompanied by appropriate support and guidance for schools to help them identify and implement more promising programmes. Continued mapping of schools' practice, as has been conducted in this study, is also vital to progress understanding of how provision can be improved. For example, this survey highlighted the disproportionately high number of whole-school programmes schools use. This finding can be disseminated to schools, and school improvement professionals, to reinforce the need for higher quality implementation of fewer programmes in individual schools. Another key finding is the need for Welsh language translations of well-being provision to be available, so that all pupils receive the same level of well-being support regardless of the language of instruction. Additionally, assessment of well-being provision in settings such as special schools is needed, to ensure sufficient support is available for this important population of pupils at high risk of mental health difficulties.

CONFLICT OF INTEREST STATEMENT
There authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT
Data supporting the findings of this study can be provided by the corresponding author on request.

ETHICS STATEMENT

Ethical approval was granted by Humanities and Social Sciences Research Ethics Committee at the University of Warwick and consent was obtained from all participants.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Nisar, A., Hastings, R. P., Watkins, R. C. & Williams, S. (2023). Mainstream and special schools' use of well-being programmes: A regional survey. *British Educational Research Journal*, *00*, 1–26. https://doi.org/10.1002/berj.3903