Agenda – Children, Young People and Education Committee

Meeting Venue:
Committee Room 4 – Tŷ Hywel
Meeting date: 24 January 2018
Meeting time: 09.15

For further information contact:
Llinos Madeley
Committee Clerk
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Private Pre-meeting

(09:15 – 09:30)

1 Introductions, apologies, substitutions and declarations of interest

(09:15 – 09:30)

2 Inquiry into the Emotional and Mental Health of Children and Young People – Evidence session 16

(09:30 – 10:00) (Pages 1 – 12)

National Youth Advocacy Services Cymru
Sharon Lovell, Director
Gareth Jacobs, Operational Manger – Mental Health and Advocacy Provision
Derith Rhisiart, Service Manager – Advocacy in Mental Health Settings

Attached Documents:
Research Brief
CYPE(5)-03-18 – Paper 1 – National Youth Advocacy Service Cymru

3 Paper(s) to note

3.1 Letter to the Chair from Action for Children - Additional information following the meeting on 14 December

(Pages 13 - 14)

Attached Documents:

CYPE(5)-03-18 - Paper to note 1

3.2 Further information from the Samaritans following the meeting on 10 January

(Pages 15 - 24)

Attached Documents:

CYPE(5)-03-18 - Paper to note 2 - Report 1

CYPE(5)-03-18 - Paper to note 3 - Report 2

3.3 Letter to the Minister for Welsh Language and Lifelong Learning - Youth Work follow up

(Pages 25 - 31)

Attached Documents:

CYPE(5)-03-18 - Paper to note 4

Informal Roundtable Event: Inquiry into the Emotional and Mental Health of Children and Young People (invitees only)

Committee Room 5

10:00 – 12:00

The Committee will be meeting with frontline education staff to discuss the emotional and mental health support available for children and young people in schools in Wales. This roundtable event is not open to the public.

Agenda Item 2

Document is Restricted

Cynulliad Cenedlaethol Cymru | National Assembly for Wales
Y Pwyllgor Plant, Pobl Ifanc ac Addysg | Children, Young People and Education Committee
Ymchwiliad i Gwella Iechyd Emosiynol ac Iechyd Meddwl Plant a Phobl Ifanc | Inquiry into The Emotional and Mental Health of Children and Young People
EMH 35
Ymateb gan: Gwasanaeth Eiriolaeth Ieuenctid Cenedlaethol
Response from: National Youth Advocacy Service

NYAS welcomes the opportunity to respond to the inquiry consultation.

NYAS is the commissioned children and young people's independent advocacy and Independent Visitor services to over 63 LA's across England and Wales. We provide service to children, young people and adults in formal and informal patients in mental health setting across England and Wales.

We are a specialist Independent Mental Health Advocate (IMHA) provider of Independent advocacy services to young people detained in secure settings and hospitals.

Based on our current advocacy case work and consultation with young people, NYAS would like to propose the following recommendations for consideration:

Specialist CAMHS

1. **The extent to which new (and/or reconfigured) services are helping to reduce waiting times in specialist CAMHS. Whether the improvements in waiting times Welsh Government expected from CAMHS have been met.**

It is not clear from the data whether the reconfiguration of services are having a sustained impact on waiting times; whether children and young people are getting the services they need when they need them. Young people through our advocacy case work inform NYAS they are still waiting too long for therapies.

2. **What the data tells us about the variations in practice (equity of access) across Wales**.

The data presents a picture of work undertaken and the investment in specialist staff. However what we see across Wales is variations in practice in relation to:

- The promotion of social inclusion and how stigma is being tackled through awareness, prevention, signposting and advice. Children and young people with complex needs need to have their rights and entitlements explained to them in a format they understand. The principles and values of participation needs embedding within practice. This will mean changing the barriers and cultures across agencies. Independent Mental Health Advocacy Services (IMHA) needs greater investment. Not all LHB are commissioning IMHA for all age groups. This means not all children and young people are getting an active offer of IMHA service. Children and young people receiving any tier of mental health support services should have access to a generic independent advocacy services.

- Provision of information, advice and assistance; Families don't always understand diagnoses and their role in care and treatment planning. Further planning/training could be achieved around this. Primary and secondary care staff should undertake training in working and communicating with young people. Youth services and specialist youth workers could be integrated within health and social care services.

- The mechanisms for ensuring that children and young people who are assessed as having disorders are offered further assessment and intervention by services that can, together or separately meet their needs; This is confusing for young people and their families as they are not always clear on the what tier of service is being provided and the agencies/individuals putting this in place. Therefore, more could be done to make care and treatment plans simple and easy for both parents and children to understand. Also these plans need to be transportable to ensure 'stories are not retold; and there is a seamless provision/transfer of services and staff.

3. The extent to which changes have addressed the over-referral of children and young people to CAMHS.

Greater publicity and awareness of the tiers of services is filtering through health and social care sectors. Professionals are better aware of the thresholds. However, improved public awareness of CAMHS services and what can be offered needs improving. For example, clear free information for parents, young people and families about CAMHS and the support it offers. Importantly, young people waiting too long for primary care services should have access to specialist mental health advocates so their experiences of care and treatment, their views, wishes and feelings are take into account and our part of decision-making processes.

4. **Referrals and access to CAMHS by individual Health Board, including the restrictions and thresholds imposed by CAMHS**

The changes reflect an improved specialist CAMHS' service with ability to respond to out of hours and at times of crisis; whether out of hours care is working effectively, and is specifically looking at the needs of those children and young people who present and are assessed at hospital A&E departments would need greater independent scrutiny. However, within the triage model for assessing crisis care we should be actively engaging with the views of the patient, especially children and young people. In terms of reducing police involvement in s136 having advocacy and specialist youth workers as part of a crisis team could help reduce police time, enable crisis to be managed at home, work restoratively, to uphold rights and liberty. Young care experienced people often require specialist advocacy intervention to protect their rights and entitlements from their LAC status.

5. **The extent to which access to psychological therapies for young people has improved. Whether there has been a subsequent reduction in the use of medication for young people.**

See response at 1. Importantly, the NHS and Social care should build effective relationships within the voluntary sector; instead of LA's and LHBs running direct services. More could be achieved to harness the expertise we already have within the charitable and voluntary sectors, especially in delivering psycho- social education programmes which are underpinned by a cognitive behaviour approach.

The investment in psycho-social interventions should not just be left to education and schools. The local and national voluntary youth sectors also have a role to play in developing preventative mental health services and building resilience and emotional wellbeing.

The demise of the youth service in Wales has not helped. However, this is a prime opportunity for Welsh Government to promote and invest in youth services to promote wellbeing and for youth services to provide that all important out of hours support.

The commissioning of psychological therapies should be considered within a national framework approach to ensure consistency of provision across Wales. Professionals providing these therapies should be registered with a regulatory body and have an up-to-date Continual Professional, Education and Learning and are able to provided evidence of this. Would be helpful to know the view of HIW, CSSIW and Social Care Wales on maintaining standards and codes of professional practice in regards to these types of therapies and how they are audited and inspected.

6. **The extent to which the funding has been used to meet the needs of vulnerable children and young people, for example, children who are in care, children and young people with ADHD and autistic spectrum disorders, and those who are already in or at risk of entering the youth justice system, including those who are detained under section 136 of the Mental Health Act 1983.**

See 1. Despite an increase and welcome focus on improving outcomes for children and young people's mental health there remains a number of system-wide challenges. These include evaluating whether the increase public funds is making the impact which the data refers to.

The transition from CAMHS to adult mental health services especially for children placed in psychiatric/secure settings is improving but more could be achieved. The knock on effect of a delayed discharge because CAMHS and CMHTs have not prepared in time is detrimental to the process of recovery and the young person's reintegration to their community.

Although we have seen some improvements in integration between services and prevention, the barriers represent considerable challenges for the mental health sector. Improving the care delivered to children and young people will require more financial resources to sustain and safeguard their wellbeing across Wales. However, NYAS is still unclear on the points provided below.

1. The funding of £2.7m which was agreed to see the recruitment of over 40 wte specialist staff and associated administrative support. Did this make an impact on meeting the needs of young people? If so, how?
2. How many urgent referrals were dealt with (within 48 hours) across Wales per LHB area and how does this compare with other parts of the country?
3. Routine assessments were reduced to 28 days to easy waiting times. What has been achieved since the last update? What does this data look like across Wales broken down per LHB area?
4. As part of the introduction of the 28 day target and the additional investment in new neurodevelopmental services health boards were asked to stratify waiting lists. Has this happened and what were the results? Did this have any impact on reducing waiting lists? Which LHB areas have waiting lists and for what types of services are children and young people waiting for?
5. The number of existing placements outside NHS Wales at April 2015 was 20 As of January 2016 there were only 11. We have not identified a figure for 2017? Do previous and current figures include children placed in commercial and private mental health settings?
6. In order to better support children and young people during their treatment and to enable better planning for discharge from hospital

WG provided £56,000 to fund a dedicated social work post within the south Wales inpatient unit. What outcomes have been achieved? How many cases were referred and from which South Wales areas does this post cover?

7. Improving access to talking therapies as an alternative to medication is a key component of the additional CAMHS investment. Following WG approval of health board proposals £1.042m annual funding was agreed, creating 18.8 wte specialist posts. What impact has this made in improving access? How many referrals were achieved? Why do we still have waiting lists?
8. Specific support for neurodevelopmental conditions saw an additional £2m funding available to Health boards to plan and deliver or to provide a bespoke service or increase capacity in existing services to ensure children and young people receive tailored support. Where are these bespoke services? How many children and young people are receiving tailored support? What was the breakdown of funding and where has this been spent? What areas saw the greatest impact with these additional monies?

HOW ACTION FOR CHILDREN WORKS
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15th January 2018

Mrs Lynne Neagle
Chair of the Children, Young People and Education Committee
National Assembly for Wales,
Cardiff Bay,
Cardiff
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Dear Mrs Neagle,

I would like to thank you for giving Action for Children the opportunity to provide oral evidence to the Children, Young People and Education Committee's inquiry into the mental health and emotional wellbeing of children and young people. I am writing to clarify an issue that was raised during the oral evidence session held on 14th December 2017. In the letter that follows, I refer to points made during the meeting with reference to the numbered paragraphs specified in the Committee's draft transcript.

In paragraph 412, you asked for observations on the delays between a CAMHS assessment and the treatment subsequently offered to children and young people. Action for Children conducted a small survey to support our written response to this inquiry, based on the experiences of eighteen children and young people. Only five were offered treatment following a CAMHS assessment. Of the two that waited more than eight weeks for treatment to begin, both respondents felt the wait was 'too long'. They claimed their mental health worsened during this period. For example, one respondent stated that the lengthy wait intensified anxiety and self-harming behaviours.

In paragraph 414, Action for Children's Services Manager Sandra White stated that the waiting time for a CAMHS assessment is 26 weeks, and in paragraph 420, Action for Children was asked to give evidence to support this statement. Firstly, Action for Children would like to clarify that Sandra was referring to the maximum waiting time for referral to treatment. Secondly, we'd like to clarify that this comment specifically referred to the cases of children and young people with specialised neurological disorders. This information was reported in discussions with the service managers and practitioners working under the Health Boards listed in Action for Children's written statement. We hope that this clarifies the matter for the Committee.

In relation to the request for quantitative evidence, I'm afraid that it's not possible for us to gather quantitative evidence of the mental health experiences of all the young people and children we engage with at this time. Action for Children works with over 22,000 children, young people and families in Wales each year. Gathering these statistics would be a hugely complex task and would not be achievable in the timeframe given to respond to a consultation. However, we would be keen to show the Committee some of the work that Action for Children in undertaking to alleviate the mental health symptoms of the children and young people we support. By equipping young people with coping strategies, our aim is to reduce the likelihood that young people will experience mental health issues and in turn, we hope to reduce demand for CAMHS services.

We would like to invite Committee members to visit Action for Children's Blues programme; an evidence-based intervention delivered to 15-18 year olds in the school setting, with the aim of reducing the likelihood that children and young people will experience mental health issues. Through our corporate partnership with the Royal Mail, this programme is currently engaged with all secondary schools in Cardiff, along with some colleges and alternative education providers. Seven of these schools will deliver this programme over the next term and we've begun a recruitment drive to deliver in North Wales. All young people complete a questionnaire and the outcome score identifies whether the student would benefit from the therapeutic intervention offered by the Blues programme to support their mental health. This programme has evidenced positive outcomes on young people's depression scores in the United States, with a reduction of 48-83% after a six-month follow-up.

Action for Children would like to see a system for mental health support in Wales that offers children and young people support much sooner, with access to a wider variety of services. The Blues programme can only be a positive approach towards increasing children's' understanding and ability to deal with their own mental health. By equipping young people with coping strategies, our aim is to reduce the likelihood that young people will experience mental health issues and in turn, we hope to reduce demand for CAMHS services and alleviate the pressure they face.

We'd be delighted to show the Committee the work that we do to prevent mental health issues and look forward to hearing your response.

Kind regards,

Brigitte Gater
National Director Wales

School-based suicide prevention programmes: the SEYLE cluster-randomised, controlled trial

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Lancet 2015; 385: 1536–44

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See Comment page 1489

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Summary

Background Suicidal behaviours in adolescents are a major public health problem and evidence-based prevention programmes are greatly needed. We aimed to investigate the efficacy of school-based preventive interventions of suicidal behaviours.

Methods The Saving and Empowering Young Lives in Europe (SEYLE) study is a multicentre, cluster-randomised controlled trial. The SEYLE sample consisted of 11 110 adolescent pupils, median age 15 years (IQR 14–15), recruited from 168 schools in ten European Union countries. We randomly assigned the schools to one of three interventions or a control group. The interventions were: (1) Question, Persuade, and Refer (QPR), a gatekeeper training module targeting teachers and other school personnel, (2) the Youth Aware of Mental Health Programme (YAM) targeting pupils, and (3) screening by professionals (ProfScreen) with referral of at-risk pupils. Each school was randomly assigned by random number generator to participate in one intervention (or control) group only and was unaware of the interventions undertaken in the other three trial groups. The primary outcome measure was the number of suicide attempt(s) made by 3 month and 12 month follow-up. Analysis included all pupils with data available at each timepoint, excluding those who had ever attempted suicide or who had shown severe suicidal ideation during the 2 weeks before baseline. This study is registered with the German Clinical Trials Registry, number DRKS00000214.

Findings Between Nov 1, 2009, and Dec 14, 2010, 168 schools (11 110 pupils) were randomly assigned to interventions (40 schools [2692 pupils] to QPR, 45 [2721] YAM, 43 [2764] ProfScreen, and 40 [2933] control). No significant differences between intervention groups and the control group were recorded at the 3 month follow-up. At the 12 month follow-up, YAM was associated with a significant reduction of incident suicide attempts (odds ratios [OR] 0·45, 95% CI 0·24–0·85; p=0·014) and severe suicidal ideation (0·50, 0·27–0·92; p=0·025), compared with the control group. 14 pupils (0·70%) reported incident suicide attempts at the 12 month follow-up in the YAM versus 34 (1·51%) in the control group, and 15 pupils (0·75%) reported incident severe suicidal ideation in the YAM group versus 31 (1·37%) in the control group. No participants completed suicide during the study period.

Interpretation YAM was effective in reducing the number of suicide attempts and severe suicidal ideation in school-based adolescents. These findings underline the benefit of this universal suicide preventive intervention in schools.

Funding Coordination Theme 1 (Health) of the European Union Seventh Framework Programme.

Introduction

Worldwide, suicide is one of the three leading causes of death in young people.[1,2] Globally, in 2009, suicide accounted for 7·3% of all deaths in the age group 15–19 years, after road traffic accidents (11·6%), and preceding violence (6·2%), respiratory tract infections (5·4%), tuberculosis (4·8%), and HIV (2·3%).[3] According to the latest data from WHO, figures are similar in 2014.[4] The lifetime prevalence of suicide attempts in adolescents in the USA is 4·1%.[5] In Europe, the lifetime self-reported prevalence for similar age groups is 4·2%.[6]

Suicide attempts and severe suicidal ideation have potentially serious consequences, including substantial psychological effects, increased risk of subsequent suicide attempt, and death.[7,8] Importantly, suicidal behaviour also has profound negative effects on relatives and other people in the person's life.[9] The medical, financial, and emotional costs to communities affected by suicide are also substantial.[10] Consequently, the prevention of suicidal behaviour should be a national health priority, with the development of existing[11–13] and new evidence-based, suicide preventive interventions. Research lends support to the theory that the vast proportion of psychopathological changes has its onset in childhood and adolescence,[14] and therefore young people are an especially important target.[15,16] Most children and adolescents attend school, which makes these an appropriate setting for reaching young people.[17] The authors of two systematic reviews of school-based suicide preventive interventions[18,19] concluded that assessments of school-based intervention programmes tested in randomised controlled trials are needed. The theoretical framework of suicide prevention programmes generally acknowledges universal, selective, or indicated

approaches.[20–22] School-based universal programmes include all pupils, whereas selective and indicated efforts focus on those regarded at high risk or presenting suicidal behaviour. The few randomised trials based on a universal or a selective approach have focused almost exclusively on generating change in knowledge and attitudes.[19] Very few trials, all from the USA and none from Europe, have investigated changes in the reduction of severe suicidal ideation or suicide attempts.[23–26] In this Article, we report the results of the Saving and Empowering Young Lives in Europe (SEYLE) study, the first large-scale, multicountry, European randomised controlled trial of school-based prevention of suicidal behaviour in adolescents.[27] The main hypothesis is that preventive interventions are more effective than a control condition in reducing new cases of suicide attempt and severe suicidal ideation between baseline and follow-up assessments.

Methods

Trial design and participants

SEYLE was a multicentre, cluster-randomised trial designed to investigate the efficacy of school-based preventive interventions for suicidal behaviour. Pupils were recruited from 168 schools in ten European Union countries (Austria, Estonia, France, Germany, Hungary, Ireland, Italy, Romania, Slovenia, and Spain). Schools were deemed eligible if they were public, contained at least 40 pupils aged 15 years, had more than two teachers for pupils aged 15 years, and had no more than 60% of pupils of the same sex.[27] Within each country, the cluster design first led to randomisation of eligible schools to one of four trial groups. Within the schools, all classes with pupils aged mainly 15 years were approached for participant recruitment. To avoid discrimination, all pupils in the participating classrooms, including those aged 14 and 16 years, were also approached for recruitment.

Study site characteristics are described in the appendix. We assessed all behaviours at an individual level with a structured self-report questionnaire administered in one classroom session at baseline, 3 months, and 12 months. All pupils who reported suicide attempts ever, or severe suicidal ideation in the past 2 weeks before the baseline assessment, and those with missing data regarding these two variables were not included in the final analysis. Pupils with incident (new) suicide attempt(s) or severe suicidal ideation at 3 months and 12 months follow-up were identified to investigate the preventive effects of the interventions. A procedures manual covering all aspects of SEYLE was available to each site. Local teams were trained in the study methods before their implementation and a steering group monitored adherence to the procedures during the entire study period. Pupils in each group completed the same questionnaire, which assessed risk behaviours, symptoms of psychopathology and suicidal thoughts, plans, and suicide attempts, at baseline (before any intervention) and at a 3 month and 12 month follow-up. Ethics approval was obtained from each of the local research ethics committees. We obtained informed assent from each participant and written consent from at least one parent, which was a prerequisite for participation. SEYLE prescribed a specific procedure to assess and immediately assist every emergency case at each site. Emergency cases were pupils who reported either suicide attempts or severe suicidal ideation in the 2 weeks before baseline assessment. These pupils were immediately contacted for clinical assessment and referred to health-care services for treatment, if necessary. All referrals were done before implementation of the interventions. To avoid any stigma, all such emergency cases were allowed to continue in the study, but their results were excluded from the final analysis. SEYLE used an independent ethics adviser from Basel University, Basel, Switzerland.

Randomisation and masking

A list of all schools that met the study inclusion or exclusion criteria was generated at each site. Schools were then stratified into large (more than the site median) and small groups, to create a pool of potential participants that was homogeneous with respect to sociocultural factors, school environment, and school system structure. A random number generator was used to place schools at each site, first into one of the four trial groups, then schools within each group were placed in a random order within each of the two school size classifications (large or small). We identified schools (one large for every two small) for invitation into the SEYLE project according to a predefined order established by the randomised list. In the event that a selected school did not choose to participate or the trial group's target was not met, we approached the next same-size school from the randomised list. Each school was randomly assigned to participate in one intervention (or control) group only and was unaware of the interventions undertaken in the other three trial groups. During school recruitment, the same general information that SEYLE is a mental health promotion project was presented to all schools. We also presented a general, non-specific overview about the procedures of the intervention to which a particular school was randomly assigned, but did not disclose that alternative interventions were part of the project. On the basis of the information provided, each school could accept or refuse to join the study. Overall, 168 schools (72%) of 232 schools approached agreed to participate and no school dropped out of the study during the 12 month trial. All SEYLE randomisation procedures were developed by researchers from Columbia University (New York, NY, USA) and each site leader was responsible for implementing the plan.

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See **Online** for appendix

Procedures

Three intervention programmes were compared with a control group. All interventions were undertaken during a 4 week period, after a baseline assessment.

Question, Persuade, and Refer (QPR) is a manualised gatekeeper programme, developed in the USA.[28] In SEYLE, QPR was used to train teachers and other school personnel to recognise the risk of suicidal behaviour in pupils and to enhance their communication skills to motivate and help pupils at risk of suicide to seek professional care. QPR training materials included standard power point presentations and a 34-page booklet distributed to all trainees. Teachers were also given cards with local health-care contact information for distribution to pupils identified by them as being at risk. Although QPR targeted all school staff, it was, in effect, a selective approach, because only pupils recognised as being at suicidal risk were approached by the gatekeepers (trained school personnel).

The Youth Aware of Mental Health Programme (YAM) was developed for the SEYLE study[29] and is a manualised, universal intervention targeting all pupils, which includes 3 h of role-play sessions with interactive workshops combined with a 32-page booklet that pupils could take home, six educational posters displayed in each participating classroom and two 1 h interactive lectures about mental health at the beginning and end of the intervention. YAM aimed to raise mental health awareness about risk and protective factors associated with suicide, including knowledge about depression and anxiety, and to enhance the skills needed to deal with adverse life events, stress, and suicidal behaviours. This programme was implemented at each site by instructors trained in the methodology through a detailed 31 page instruction manual.

	Question, persuade, and refer (40 schools, 2692 pupils)	Youth aware of mental health programme (45 schools, 2721 pupils)	Screening by professionals (43 schools, 2764 pupils)	Controls (40 schools, 2933 pupils)
Age (years)	14·80 (0·82)	14·80 (0·85)	14·81 (0·80)	14·78 (0·89)
SDQ total score	10·47 (4·96)	10·83 (4·96)	10·70 (5·11)	10·14 (4·95)
Number of girls	1675 (63%)	1637 (60%)	1607 (58%)	1647 (56%)
Not living with both biological parents	592 (22%)	601 (22%)	605 (22%)	626 (21%)
Not born in the country of residence	158 (6%)	205 (8%)	142 (5%)	158 (5%)
Parent lost employment in previous year	273 (10%)	257 (10%)	247 (9%)	292 (10%)
Ever attempted suicide	83 (3%)	115 (4%)	102 (4%)	86 (3%)
Severe suicidal ideation during past 2 weeks	99 (4%)	106 (4%)	96 (4%)	103 (4%)

Data are mean (SD) or n (%). SDQ=Strengths and Difficulties Questionnaire. Counts of suicide attempts and suicide ideation might overlap.

Table 1: **Baseline characteristics**

The Screening by Professionals programme (ProfScreen), which was also developed for the SEYLE study, is a selective or indicated intervention based on responses to the SEYLE baseline questionnaire. When pupils had completed the baseline assessment, health professionals reviewed their answers and pupils who screened at or above pre-established cutoff points were invited to participate in a professional mental health clinical assessment and subsequently referred to clinical services, if needed.[30]

For ethical reasons, the control group was exposed to the same six educational posters displayed in their classrooms as those used in the YAM. Pupils in the control group who self-recognised the need for help could contact local health-care providers whose information was provided on a poster.

Process assessments and quality control were done in a standard manner at each site through a series of structured questionnaires to ensure that all preparatory procedures were executed correctly and that interventions were implemented in a standard way across sites and adhered to the SEYLE protocol. Analyses of these data suggest congruence between sites in both study implementation procedures and in undertaking of the interventions (data not shown).

Outcomes

The primary outcome was incident suicide attempt(s)—ie, all new cases of suicide attempt(s) identified at either the 3 month or 12 month follow-up. Another outcome was severe suicidal ideation in the 2 weeks preceding the follow-ups—ie, all new cases of suicidal ideation identified at either of the two follow-ups. All pupils reporting ever making a suicide attempt before the baseline date or having severe suicidal ideation in the 2 weeks before baseline were excluded from the analyses. Pupils were identified as having an incident suicide attempt if, at the 3 month and 12 month follow-up, they answered "yes" to the question: "have you ever made an attempt to take your own life?" Pupils were identified as having severe suicidal ideation, if they answered: "sometimes, often, very often or always" to the question: "during the past 2 weeks, have you reached the point where you seriously considered taking your life, or perhaps made plans how you would go about doing it?"

Suicide attempts and severe suicidal ideation were studied with the above mentioned questions from the five item Paykel Hierarchical Suicidal Ladder[31] that measures the intensity of suicidal behaviour, from feelings that life is not worth living, to death wishes, suicidal thoughts, severe suicidal ideation with plans, and suicide attempts.

Symptoms of psychopathology, assessed with the Strengths and Difficulties Questionnaire (SDQ),[32,33] and the sociodemographic variables presented in table 1 were used as covariates in all analyses.

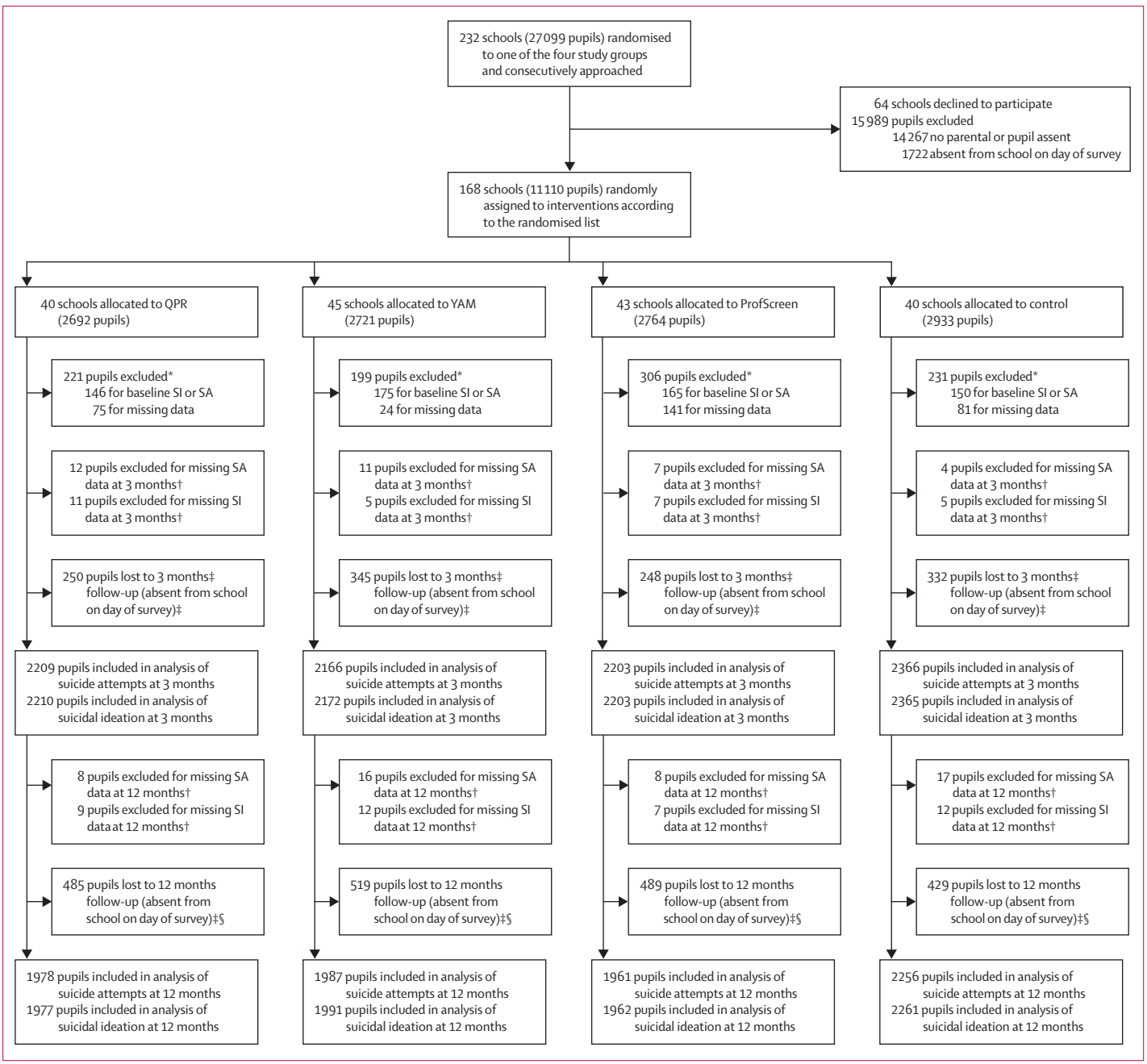

***Figure*: Study profile**

QPR=Question, Persuade, and Refer. YAM=Youth Aware of Mental Health Programme. ProfScreen=screening by professionals. SI=suicidal ideation. SA=suicide attempt. *Pupils who had ever attempted suicide or who reported severe suicidal ideation in the 2 weeks before baseline or who had missing data for the respective variable at baseline were excluded from analysis. †Pupils were excluded only in the analysis for the corresponding outcome. ‡Does not include lost-to-follow-up with other exclusion criteria. §Lost to follow-up between baseline and 12 months.

Statistical analysis

We established the sample size by incorporating a cluster-randomised design with assumptions about potential participants, based on previous school-based studies of suicidal behaviour such as that the intraclass correlation of outcomes within schools would be 0·01 or smaller and that the incident rate of the primary outcome, suicide attempt at 12 months, would be 3% or more in the control group. About 2500 pupils from 40 schools in each of the four groups (ie, 160 schools and 10 000 pupils), were judged to be a group of sufficient size to detect a 50% reduction in incidence of suicide attempt in any of the intervention groups, compared with the control group, with a power of 80%

	3 month follow-up				12 month follow-up			
	n	Cases (%)	OR (95% CI)	p value	n	Cases (%)	OR (95% CI)	p value
Question, persuade, and refer	2209	15 (0·68%)	0·62 (0·32–1·18)	0·147	1978	22 (1·11%)	0·70 (0·39–1·25)	0·229
Youth aware of mental health programme	2166	19 (0·88%)	0·78 (0·42–1·44)	0·422	1987	14 (0·70%)	0·45* (0·24–0·85)	0·014*
Screening by professionals	2203	27 (1·23%)	1·10 (0·61–1·97)	0·752	1961	20 (1·02%)	0·65 (0·36–1·18)	0·158
Controls	2366	27 (1·14%)	Reference	..	2256	34 (1·51%)	Reference	..

ORs and 95% CIs were generated from generalised linear mixed models with a logistic link, adjusted for age, sex, Strengths and Difficulties Questionnaire total score, not being born in the country of residence, parental job loss in the previous year, not living with both biological parents, and country of residence. Missing covariates were included through use of multiple imputation. OR=odds ratio. *Significant at p<0·05.

Table 2: **Incident suicide attempts at 3 and 12 month follow-up**

with a two-sided significance level of 0·05. The risk of severe suicidal ideation was assumed to be higher and thus this sample size would yield greater power to detect group differences. Despite the overall large sample size, because the risk of the primary outcome being investigated was expected to be very low, significance could only be achieved with adequate power if the intervention effects were very large (ie, about a two-fold decrease or more). Means and proportions of individual characteristics (age, sex, not being born in their country of residence, parental job loss in the previous year, not living with both biological parents, country of residence, and SDQ total score) and baseline reports of suicide attempts or severe suicidal ideation were calculated for each intervention group and tested with a model controlled for clustering of pupils within schools. To investigate the preventive effects of the interventions at 3 months and 12 months, all subsequent analyses of pupils with available questionnaire data at that timepoint excluding those who reported a lifetime suicide attempt at baseline or who reported severe suicidal ideation within the past 2 weeks at baseline. Raw counts and proportions of each outcome (suicide attempts and severe suicidal ideation) were tabulated within each intervention group at 3 months and 12 months. The intraclass correlation was calculated for each outcome to quantify variability across schools. Assessment of whether differential dropout (ie, missing both 3 month and 12 month outcomes) across intervention groups was dependent on outcomes was examined with logistic regression of dropout status and testing of an interaction between group and baseline attempt or ideation.

Generalised linear mixed models (GLMM)[34] with a logistic link, a random effect to account for clustering of pupils within schools, and a nested random effect to account for repeated (3 months and 12 months) measures within pupils, were used to test for intervention group differences. The GLMMs for each outcome included fixed effects for intervention group, categorical month, a group-by-month interaction, and controlled for individual characteristics. On the basis of the GLMMs, the adjusted odds ratios (OR) and 95% CIs for each of the three experimental intervention groups compared with the control group at 3 and 12 months, were used to test significance. Intervention groups were compared with the control group only; no mutual comparisons were made. The associated absolute risk difference and number needed to prevent were also calculated based on the adjusted risk of each outcome by intervention group estimated from the GLMM. A multiple imputation procedure[35] (50 imputations with full conditional specification for dichotomous variables)[36] was used to manage missing values of individual characteristics (<1% missing for each individual characteristic), so that all pupils with an outcome at 3 months or 12 months were included in the GLMMs. Additional models, including sex-by-intervention group interactions, and age-by-intervention group interactions were tested for differential intervention effects by sex and age. To assess the robustness of the findings, tests for intervention group differences were redone including only the subset of pupils with complete outcome data at both 3 months and 12 months. All analyses were done with SAS version 9.3. The trial is registered at the German Clinical Trials Registry, number DRKS00000214.

Role of the funding source

The funder of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report. The corresponding author (DW) had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Results

Of 232 schools that were approached and randomly assigned to one of four study groups, 168 schools (72%) accepted to participate. 27 099 pupils were approached: 14 267 were not enrolled because parental consent or pupils' assent were not given, and 1722 pupils were absent from school on the day of baseline assessment. We recruited 11 110 pupils (median age 15 years [IQR 14–15], mean age 14·8 years [SD 0·8]; 59% girls). Of the 11 110 pupils with baseline assessment, 9798 (88%) were available at 3 months and 8972 (81%) at 12 months (figure), with only 622 (5·6%) pupils not participating at either follow-up. Our recruitment procedures generated about an equal number of pupils in each group (figure): 2692 pupils were assigned to QPR; 2721 were assigned to the YAM; 2764 were assigned to ProfScreen, and 2933 were assigned to the control group. 221 pupils in the QPR group, 199 in YAM, 306 in the ProfScreen group, and 231 in the control group were excluded from the analysis because they reported a previous suicide attempt or severe suicidal ideation in the 2 weeks before baseline, or were missing data for the respective variables (figure, table 1). Pupils referred at baseline for psychiatric treatment and

thus excluded from analysis were 23 (0·8%) in the QPR group, 22 (0·8%) in the YAM group, 28 (1·0%) in the ProfScreen group, and 24 (0·8%) in the control group. There was no significant interaction between any intervention group and baseline suicide attempt (p=0·533) or severe suicidal ideation (p=0·456) for dropout status.

Table 1 shows baseline characteristics of the sample for each intervention group. Differences in mean SDQ total score between groups were less than 1 point and are not considered clinically significant, because the scale ranges from 0 to 40 points and has a borderline region of 3 points.[32]

At 3 months, of 9724 pupils who answered both outcome questions, 333 (3·4%) reported either an attempt or ideation and 85 (0·9%) reported both. At 12 months, of 8885 pupils who answered both questions, 261 (2·9%) reported either and 55 (0·6%) reported both. Intraclass correlations across schools at 12 months were 0·003 for suicide attempt and 0·007 for severe suicidal ideation.

Analyses of the interaction between intervention groups and time (3 months and 12 months) showed no significant effect on incident suicide attempts in the three intervention groups, compared with the control group at the 3 month follow-up. However, at the 12 month follow-up, we noted a significant effect (OR 0·45, 95%CI 0·24–0·85; p=0·014) of the YAM on incident suicide attempts, compared with the control group (table 2).

After analyses of the interaction between intervention groups and time (3 months and 12 months), we noted the following results for severe suicidal ideation: at the 3 month follow-up, there were no significant effects of QPR, YAM, or ProfScreen compared with the control group. However, at the 12 month follow-up, we noted a significant effect of the YAM (OR 0·50, 0·27–0·92; p=0·025), compared with the control group (table 3).

Neither sex nor age significantly modified the intervention effect for either outcome (interaction p=0·2658 for sex and 0·8933 for age for suicide attempts, and 0·1315 for sex and 0·9324 for age for severe suicidal ideation). YAM showed stronger effects for incident suicide attempts (OR 0·36, 95% 0·18–0·72; p=0·004) and severe suicidal ideation (0·46, 0·24–0·88; p=0·018) when the analysed sample included pupils who participated in all waves of data collection (n=8282).

Overall, in terms of suicide attempts, at 12 months in the YAM group absolute risk fell by 0·60 % (ie, 6·0 of 1000 pupils) and relative risk (RR) was reduced by 54·6% (ie, of 1000 pupils, 11 attempted suicide in the control group *vs* five attempts in YAM). Therefore, the number needed to have an intervention with YAM to prevent one suicide attempt per year was 167. In terms of severe suicidal ideation, in the YAM group absolute risk fell by 0·50% and RR fell by 49·6%. The number needed to have an intervention with YAM to prevent one case of severe suicidal ideation per year was 200.

Site leaders in each country had contact with SEYLE school principals throughout the whole investigation period and were instructed to obtain information about any completed suicides. No completed suicides were reported for any study participants.

	3 month follow-up				12 month follow-up			
	n	Cases (%)	OR (95% CI)	p value	n	Cases (%)	OR (95% CI)	p value
Question, persuade, and refer	2210	25 (1·13%)	0·69 (0·40–1·19)	0·182	1977	29 (1·47%)	0·95 (0·55–1·63)	0·856
Youth aware of mental health programme	2172	32 (1·47%)	0·88 (0·52–1·48)	0·629	1991	15 (0·75%)	0·50* (0·27–0·92)	0·025*
Screening by professionals	2203	27 (1·23%)	0·72 (0·42–1·23)	0·229	1962	22 (1·12%)	0·71 (0·40–1·25)	0·234
Controls	2365	35 (1·48%)	Reference	..	2261	31 (1·37%)	Reference	..

ORs and 95% CI were generated from generalised linear mixed models with a logistic link, adjusted for age, sex, baseline Strengths and Difficulties Questionnaire total score, not being born in the country of residence, parental job loss in the previous year, not living with both biological parents, and country of residence. Missing covariates were included through use of multiple imputation. OR=odds ratio. *Significant at p<0·05.

Table 3: **Incident severe suicidal ideation at 3 and 12 month follow-up**

Discussion

This study represents the first European, multicountry, randomised controlled trial of the prevention of suicidal behaviour in adolescents (panel). The results show that the YAM, a universal, school-based intervention of short duration (5 h in 4 weeks),[29] was significantly more effective in preventing new cases of suicide attempts and severe suicidal ideation, including planning, than no intervention (the control group). The reported reduction in incident suicide attempts was more than 50% with YAM than for the control group. This effect is higher than those noted in other successful public health interventions—eg, for bullying and bully victimisation (17–23%),[37] or specific types of school-based interventions addressing smoking cessation (14%).[38]

So far, trials of only two other interventions undertaken in the USA have shown a significant decrease in suicide attempts. Results from a classroom-based intervention, Signs of Suicide (SOS), with 2100 pupils in five North American high schools, showed a reduced risk of suicide attempts at a 3 month follow-up, although there were no differences in suicidal ideation.[23] Similar results were reported on the basis of an extension of this programme undertaken with 4133 pupils in nine US high schools, for which again, the incidence of suicide attempts at a 3 month follow-up was significantly lower, but no improvement in suicidal ideation compared with controls was noted.[24] Neither study, however, followed up beyond 3 months. Only one other trial, a classroom-based behavioural intervention called the Good Behaviour Game with two cohorts of about 1000 and 2000 North American first-grade pupils, showed a reduced incidence of suicidal ideation and suicide attempts when followed up at ages 21–22 years.[26]

In SEYLE, the YAM not only prevented suicide attempts, an important predictor of completed suicides,[39,40] but it

Panel: **Research in context**

Systematic review

We searched PubMed, PsycINFO, Cochrane Library, and Google Scholar with no date restrictions for English-language, peer-reviewed articles of the outcomes of school-based suicide preventive interventions in April, 2014. The search terms included "suicide", "attempted suicide", "prevention", "intervention", "adolescent", "school", "gatekeeper", "screening", "mental health promotion", "mental health education", and "randomised controlled trial". References included in searched articles were also screened for relevant publications. The articles identified by the searches were read by two researchers. Articles that reported randomised controlled trials of suicide preventive interventions undertaken in a school setting, with suicide attempt or suicidal ideation as outcome measures, and systematic reviews, were analysed. Three trials undertaken in a school setting in the USA were identified. They showed significant reductions in suicide attempts, and one of them also in suicidal ideation. Systematic reviews underlined the need for more randomised controlled trials.

Interpretation

Suicide attempt and suicidal behaviours in adolescents are known predictors of mental health problems and future suicidal behaviours throughout their lifecourse, which calls for early preventive measures. The results of our SEYLE trial in ten European Union countries with 11 110 school-based adolescents show that the Youth Aware of Mental Health Programme (YAM) is effective in significantly reducing incident severe suicidal ideation and suicide attempts, which are the negative results of adverse life events, stress, and mental health problems. This is the first multicentre, European study of a large sample of adolescents, and is a step forward in view of the shortage of studies of the effectiveness of school-based suicide prevention programmes. The SEYLE results provide evidence for the effectiveness of a universal suicide prevention programme (YAM) and, in addition to previous studies, the validity of a universal approach to adolescent suicide-prevention in a school setting.

also reduced new cases of severe suicidal ideation, including suicide planning—all important markers of poor psychological wellbeing. The design of the YAM, aimed at changing pupils' negative perceptions and improving their coping skills in the management of adverse life events and stressors, which often are triggers of suicidal behaviour, could account for its significant effects. The YAM, through active participation might also have provided the pupils, most probably for the first time, with an opportunity to think, verbalise, and discuss among themselves a range of issues related to mental health. Such opportunities are especially important, because people showing suicidal behaviour tend to suppress their emotions and have difficulties in identifying their feelings.[41] These potentially sustained interactive processes and integration of new knowledge[29] need time, and the associated cognitive processes were further helped by the adolescents becoming 1 year older and thus more mature at the 12 month follow-up. Additionally, effects of the YAM could not have been detected before the 12 month follow-up because no additional intermediate measurements between 3 months and 12 months were available.

The QPR and ProfScreen interventions did not have significant effects. Changes in suicidal behaviour are perhaps more likely to occur if pupils are personally engaged in the intervention, than with adult-driven interventions, which adolescents might be reluctant to accept. Importantly, QPR is designed to empower teachers to recognise pupils at risk of suicide. However, previous SEYLE findings have shown that teachers' readiness to help pupils with mental health disorders is dependent on the teachers' subjective psychological wellbeing, which could possibly affect the effectiveness of the QPR interventions in this study.[42] Moreover, for QPR, teachers need to be able to identify signs of suicide risk; but because suicidality is mainly an internal process, many warning signs might be scarcely visible or very well hidden in adolescents, even if teachers are well trained to recognise them. ProfScreen had the objective of identifying pupils at risk of mental health problems, and early detection and treatment of adolescents with psychopathology. This is an important approach to diminishing the burden of mental disorders in adulthood.[43] However, as previous investigations have shown, the acceptability of screening is difficult and this intervention approach would most probably benefit from concurrent activities designed to reduce the stigma of mental health issues among pupils and parents, and thus to help society to be more open about mental health problems.[30,44]

Limitations of this study include reliance on self-report, as with other, similar studies.[23,24] However, we regard it as unlikely that training in mental health awareness, as was done in the YAM, would negatively affect self-report of suicide attempts and severe suicidal ideation. Rather, with deeper knowledge and language skills reporting is more likely to increase and therefore diminish the significance of the results found in this study. For ethical reasons the control group was exposed to the same mental-health information as the YAM group, displayed on posters in the classrooms. Therefore, we assume that the effect sizes for the YAM are probably underestimated. A reported difference at baseline between groups for SDQ Total Score is less than one point and therefore not clinically significant.[32]

The strengths of SEYLE, in addition to being a randomised controlled trial, include having the largest number of adolescent participants of any school-based suicide preventive study up to now, good follow-up participation rates, and the inclusion of new suicide attempts and severe suicidal ideation as outcome measures.

This study provides much-needed empirical evidence of the effectiveness of a universal school-based public health

intervention by showing that the YAM can prevent suicide attempts and severe suicidal ideation, including the planning of suicide, in adolescents. According to these data, YAM can prevent one suicide attempt by targeting 167 pupils. These findings are important in view of research showing that young people who attempt suicide are more likely to have persistent mental health disorders in adulthood[45] and complete suicide, than those who do not attempt suicide in childhood.[40] The results underline the necessity for action[46,47] regarding large-scale implementation of universal, school-based suicide prevention programmes. Further studies are needed to replicate these results, and to assess the cost-effectiveness of the YAM intervention, and the potential added benefit of booster activities and combinations of different kinds of interventions. Further research is also needed to study the effect of a larger-scale implementation of the YAM intervention, including alternative methods of delivery.[48]

Contributors

DW led the development of the study design and methodology, and supervised all phases of the study and analyses. DW and VC wrote several sections of the manuscript and critically revised the final version of the manuscript. VC advised on research methodology, and supervised the quality control of data collection and data analyses. CWH advised on research methodology and provided consultation for epidemiological issues. CW participated in the design of the study and advised on implementation of the methods for the RCT interventions. MW was responsible for the statistical analyses and wrote the sections of the manuscript about data analysis. RE did the statistical analyses and designed the tables. GH performed quality control of the statistical analyses. IK participated in conducting exploratory statistical analyses and critically revised the manuscript. MS participated in the study design. PV performed quality control and management of the SEYLE databases. GM participated in the randomisation process and along with AA, in the quality control of the implementation of RCT interventions. FG provided input to the statistical analysis. SR-T provided ethical consultation for the ongoing interventions. All authors critically revised and approved the manuscript before submission.

Declaration of interests

We declare no competing interests.

Acknowledgments

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Additional information from the Samaritans following the meeting on 10 January –they agreed to share the following report:

World Health Organisation report (*Growing up unequal: gender and socioeconomic differences in young people's health and well-being. Health Behaviour in School-aged Children (HBSC) Study: International Report from the 2013/14 Survey (WHO))*

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Plant, Pobl Ifanc ac Addysg

National Assembly for Wales
Children, Young People and Education Committee

Eluned Morgan AM
Minister for Welsh Language and Lifelong Learning

18 January 2018

Dear Eluned

What type of youth service does Wales want? Committee Follow up into its Youth Work Inquiry

I am writing to keep you informed of the proposed approach that the Children, Young People and Education Committee (the Committee) will be taking in following up on its inquiry into Youth Work. It was good to meet with you in November, and have some early dialogue with you regarding this.

The Committee is grateful to the previous Minister for Lifelong Learning and Welsh Language for providing a six month update on progress against the Committee's recommendations. However, the Committee is committed to undertaking on-going scrutiny of this inquiry, to help ensure that work is undertaken against all of the recommendations made in its report.

The Committee is also keen to establish whether work undertaken since publication of our report has made, or is making, a difference to those involved with delivering youth work/youth services on the ground. With that in mind, the Committee will be launching a targeted consultation in the coming weeks, seeking feedback from key stakeholders on the Committee's recommendations and how these are being taken forward.

However, in advance of the consultation, the Committee would welcome a further update from Welsh Government on progress made against the Committee's recommendations. A full list of the recommendations, together with the relevant information provided by Welsh Government to date, is at Annex 1. It would be very much appreciated if you could provide an update on the recommendations where appropriate, but in particular on:

- 'Extending Entitlement' and the National Youth Work Strategy, and establishing the National Youth Support Service Board;

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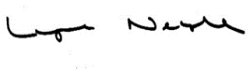
- Youth work sufficiency assessments;
- The development of an accountability framework for local authorities' use of funds for youth work via the revenue support grant;
- Securing access to Erasmus+.

The Committee will use your update on the points above to help inform its consultation with stakeholders, so we would be grateful if you could provide this information by February half term.

Yours sincerely,



Lynne Neagle AC / AM
Cadeirydd / Chair

Annex 1

CYPE Committee Recommendation	WG Response
Recommendation 1. The Minister should review the National Strategy and refresh the statutory guidance in consultation with stakeholders and young people. A detailed action plan for implementation, including timescales, must be developed alongside a new strategy.	**Accepted** I have already committed to refresh Extending Entitlement - the statutory guidance which underpins the provision and delivery of youth support services in Wales. Reviewing the National Youth Work Strategy will, by necessity, need to form part of this work. A detailed action plan for implementation will be developed and published by the end of March 2017.
Recommendation 2. The Minister should hold urgent discussions with the Ministerial Youth Work Reference Group to address the concerns from within the sector about a lack of engagement from Welsh Government.	**Accepted** I met with the Youth Work Reference Group on 8 December 2016. I have asked the group to work with my officials on the refresh of Extending Entitlement. My officials will maintain regular engagement with the group and the wider sector as we develop our thinking around future plans for youth work delivery in Wales. When considering the Committee's report and recommendations, my officials engaged with the reference group to ensure their views were taken into account.
Recommendation 3. There should be a clear and meaningful route for young people to be equal partners in developing youth services in Wales. This should be developed by the Minister, stakeholders and young people.	**Accepted** The Welsh Government remains committed to enabling the voice of young people to be heard in decisions which affect them. We will continue to engage with young people and utilise the expertise of stakeholders including Children in Wales and Young Wales to engage with a broad range of young people around developing youth services in Wales.
Recommendation 4. The Minister should introduce a national model for youth work, encompassing statutory and voluntary provision. The Minister should report to this Committee on progress within 6 months of the publication of this report.	**Accepted** Any consideration of a national model for youth work needs to be informed by the refresh of Extending Entitlement and the review of the National Youth Work Strategy. I am happy to report back to the Committee as this work progresses. **6 Month update (21.6.17):** Any consideration of a national model for youth work needs to be informed by the review of Extending Entitlement and the review of the National Youth Work Strategy. The formal consultation for Extending Entitlement will take place in

	the autumn. Feedback from this consultation will inform the new Extending Entitlement direction and guidance which will be formally launched summer 2018. A review of the existing National Youth Work Strategy is currently being carried out by Glyndwr University, this review will inform the Extending Entitlement consultation paper. A formal consultation process for a new National Youth Work Strategy will be carried out following the publication of Extending Entitlement. The Youth Work Reference Group will play a key role in the development of a new youth work strategy. We have begun the process to establish an independently chaired, National Youth Support Service Board. The Board will be able to provide constructive challenge and scrutiny of the Welsh Government's policies and proposals for Youth Support Services, including youth work. The Chair and Board members will be subject to the Public Appointment process. I expect the Chair to be in place by the autumn. The Chair will then support me to appoint all other board members, who we will have in place by spring 2018.
Recommendation 5. The Minister should report back to the Committee within 6 months of the publication of this report on how he intends to assess the extent to which his commitment to universal, open access provision, in English and Welsh, is being delivered.	**Accepted in Principle** It is clear from the evidence provided to the Committee that the youth work landscape in Wales is changing. Local authorities have had to adapt to a challenging financial climate and the changing needs of young people in their area. This has often meant adopting different approaches to engaging with young people that go beyond traditional youth work provision. In order to get a better understanding of the situation I have asked my officials to work with key representatives from the sector to explore if sufficiency assessments might be a suitable vehicle to assist local authorities to assess the needs of their local populations. Sufficiency assessments may be able to provide a better understanding, at a local level, of what youth work support looks like on the ground. This is because any sufficiency assessment undertaken by a local authority would need to take account the current provision available to young people (both open access and targeted) which is provided through the statutory and voluntary sectors. Sufficiency assessments also provide a useful source of evidence for Public Services Boards to take account of in preparing their assessments of local well-being. I expect this work to inform the refresh of Extending Entitlement and any national model of youth work delivery. I am happy to report back to the Committee as this work progresses. **6 Month update:** (Recommendations 5, 6 & 7). My officials have begun to explore if sufficiency assessments might be a suitable vehicle and the best way

	forward to assist local authorities in mapping out and developing their local youth work offer. We plan to include the consideration of sufficiency assessments within the formal consultation of Extending Entitlement. This will ensure stakeholders have an opportunity to have their views heard. I believe that sufficiency assessments may be able to provide a better understanding, at a local level, of what youth work provision within the statutory and voluntary sector looks like on the ground. I do not believe a national mapping approach is the best way forward. I am happy to report back to the Committee as this work continues to progress.
Recommendation 6. Within 6 months of the publication of this report, the Minister should commission an exercise to map voluntary youth work provision across Wales. The exercise should be refreshed periodically.	As above.
Recommendation 7. The Minister should ensure that youth work sufficiency assessments are undertaken by local authorities as part of their population needs assessments and report back to the Committee on progress within 6 months of the publication of this report.	As above.
Recommendation 8. The Minister should develop an accountability framework for local authorities' use of funds for youth work via the revenue support grant. The framework should include sanctions if outcomes are not delivered.	**Accepted in Principle** The RSG is an un-hypothecated funding stream, and it is therefore a decision of local authorities as to how this funding is utilised to best meet local needs and priorities. It is not possible to identify how much RSG is spent on youth work or to prescribe this amount – the Standard Spending Assessments are notional amounts that are used for calculation purposes only and are not targets for spending. However, historically the Welsh Government has provided direct support to a number of grant schemes intended to support the outcomes of youth work. We have begun the process to undertake a review of all these youth work funding streams to identify the true impact and to support future thinking for supporting youth work in Wales. I want to ensure we have better transparency and value for money. **6 month update:** We are currently in the process of externally reviewing our additional youth work grants, including the National Voluntary Youth Organisation (NVYO) grant, all evaluations are due to be completed

	this summer. It will be at this point I will consider our options and then announce my decision, which will include any changes to the NVYO grant. I am fully aware of timescales for current NVYO recipients, including the need to know of any future funding decisions by 31 December. My officials have recently met with the Principal Youth Officers Group (PYOG) and the Council for Wales of Voluntary Youth Services (CWVYS), where they shared information relating to all current reviews taking place and how they all link. In July I will be meeting representatives from the Boys and Girls Clubs and Youth Cymru to hear about the benefits of the NVYO grant and the extra resources that it has enabled them to bring into in Wales, I will also be meeting with the PYOG. I'm sure you will agree that we are at a crucial point for youth work where we have the opportunity to take a step back and consider all our options relating to: funding, statutory guidance, sufficiency, the role of a new national board, a new youth work strategy and, how we support the youth work sector to work together. I can assure you that the Welsh Government is taking a strategic approach.
Recommendation 9. The Minister should explore the potential continuation of Erasmus+ funding, should the UK Government decide not to do so.	**Accepted in principle** We have published a White Paper, "Securing Wales' Future: Transition from the European Union to a new relationship with Europe", which can be found online at: www.gov.wales/brexit. The White Paper provides a comprehensive and credible plan for the negotiations with our partners in Europe on the UK's exit from the European Union – based on solid evidence that places Wales' priorities center stage but which is designed to work for the UK as a whole. It balances the message which the Welsh people gave us that we should leave the European Union with the economic reality that makes participation in the single market so important for the future prosperity of Wales, and indeed the UK as a whole. The decision is made that the UK will leave the European Union. The challenge we all face now is ensuring that we secure the best possible deal for Wales and the UK.
Recommendation 10. The Minister should ensure that the statutory and voluntary youth work sector play a central role in the process of curriculum reform.	**Accepted** The statutory and voluntary youth work sectors are both represented on the Education Reform Strategic Stakeholder Group (SSG). The group was established to ensure that key stakeholders, especially those who are not represented elsewhere in the governance structure or on working groups, are: -informed of and involved in developing the approach to implementing *Successful Futures: Independent Review of Curriculum and Assessment*

	Arrangements in Wales, and *Teaching for Tomorrow's Teachers: Options for the future of initial teacher education in Wales* -informed of and involved in developing the approach to implementing the Additional Learning Needs Transformation Programme (ALN-TP), and are -aware of alignment with Professional Learning for the workforce.

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