FIXING A FAILING SYSTEM

RETHINKING MENTAL HEALTH SUPPORT IN SCHOOLS FOR THE POST-COVID GENERATION

THE COALITION FOR YOUTH MENTAL HEALTH IN SCHOOLS

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PUBLICFIRST

Public First is a global strategic consultancy that works to help organisations better understand public opinion, analyse economic trends and craft new policy proposals. While The Coalition commissioned this report from Public First, all estimates are derived from official, third-party and proprietary information.

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About the Coalition

The Coalition was created by a range of representatives from independent and state schools who were interested in understanding more about the current state of mental health in young people, particularly in the context of Covid, and how schools could best support their students' mental health. The Coalition were especially interested in sharing best practices and insights from across both sectors. The Coalition includes:

Jane Lunnon, Headteacher, *Alleyns School*

Rachel Hart, Head of PSHE, *Lady Eleanor Holles School*

Lisa Crausby, Executive Director of Education, *Star Academies*

Alice Vicary-Stott, Director of Safeguarding, *Eton College*

Jon Needham, Director of Safeguarding, *Oasis Academies*

Sam Madden, Deputy Head (Wellbeing and Mental Health), *St Paul's School*

Susie Gilham, Deputy Head (Pastoral), *City of London School for Girls*

Lesley Devine, Executive Director of SEND, *Outwood Grange Academies Trust*

Dave Walker, Deputy Head (Pastoral & Wellbeing), *Wellington College*

Juliet Jaggs, Regional Director (Secondary), *David Ross Educational Trust*

Georgia Strong, Assistant Headteacher and DSL, *Reach Academy*

Gabrielle Ward-Smith, Housemaster and Deputy DSL, & Emma Blakemore, Head of Wellbeing, *Westminster School*

Sophie Blunt, Head of Wellbeing, *Wycombe Abbey*

On behalf of the Coalition, Public First ran a detailed research project using a mix of qualitative and quantitative research methods. Between June and August 2021, Public First ran 7 focus groups with parents, teachers and young people, including:

- 2 focus groups with parents with secondary school aged children
- 1 focus group with parents with primary school aged children
- 1 focus group with primary school teachers
- 2 focus group with secondary school teachers
- 2 focus groups with sixth formers

Over the same period, Public First facilitated 3 evidence sessions for Coalition members to speak with experts in mental health, schools, and teacher training. The witnesses present at the evidence sessions were:

Evidence Session 1:

- Professor Jess Deighton, Director of Applied Research and Evaluation Division, *Anna Freud Centre and Director of the Evidence Based Practice* Unit and Professor in Child Mental Health and Wellbeing, UCL
- Catherine Roche, Chief Executive, *Place2Be*
- Hannah Kinsey, Head of Training and Development, *Young Minds*

Evidence Session 2:

- Dame Rachel de Souza, *The Children's Commissioner*
- Professor Sam Twiselton OBE Director, *Sheffield Institute of Education*
- Jonathan Baggaley, Chief Executive, *the PSHE Association*

Evidence Session 3:

- Gregor Henderson, Former Director of Mental Health, *Public Health England*; Chair of the Research Advisory Group, *Place2Be*
- Tom Bennett, Independent Behaviour Advisor, *Department for Education*; Founder and Director, *researchED*

Lastly, Public First ran a national representative poll of 1,080 teachers across England and a nationally representative poll of 1,010 young people (16-18-year-olds) across England. Quantitative and qualitative research complement one another - quantitative research provides insight into what teachers and young people think and qualitative research allows us to probe why they think it.

“Happiness can be found even in the darkest of times, if one only remembers to turn on the light.”

— Albus Dumbledore

Foreword from the Chair

No-one who works in education can be in any doubt about the impact of the Covid pandemic on schools over the last two years. The (heroic) effort to keep the lights on and maintain some kind of learning, the digitalisation of the classroom, the redesigning of assessment and the efforts to continue the delivery of the curriculum, through all the Covid privations, has been, for educators everywhere, surely one of the deepest of challenges.

Alongside the much-publicised recognition of the academic deprivations of Covid, has come the (alarming and ever increasing) awareness of its shadowy impact on the mental health and emotional wellbeing of so many of our children and young people, which is clearly reflected in this report.

The scale of this impact will come as no surprise to any who work in schools. Whilst some kind of curriculum delivery continued in some shape or form in most places, there is no doubt that the effect on wider school life; the abrupt end of so much of the richness and fun of being at school, had a detrimental impact on the wellbeing of so many students. And this was not just due to the temporary suspension of co-curricular activity, the sport, music, drama, from which so many of our children derive their sense of self. It was also about the more incidental routines: the chat at registration, the laughter over lunch, the giggling during assembly, the catching up with friends on the bus home, the planning of campaigns or parties, the sharing of concerns or worries, the sheer physical proximity of friends and peers. This is so much more than ephemera for children and teenagers; this is the petri dish for the development of their identity, wholeness and sense of place in the world. The light receded from all of this overnight during Covid and is returning only gradually as the pandemic recedes.

With all that communal collegiality and everyday connection compromised for so long, it was sadly perhaps inevitable that the mental health of many children, particularly those who were most vulnerable, suffered. Certainly, many schools across the country, are now experiencing unprecedented demand for mental health support and therapeutic services – a demand which mostly can't be satisfied by the current provision, either in schools or beyond them.

It was partly in anticipation of this, that the Coalition for Youth Mental Health in Schools was established, although it had its roots just before the start of the second lockdown, in the publication of yet another depressing report [1] citing the declining mental health of our young. What struck a number of us, on reading that report, was not just the reference to growing levels of anxiety and depression but more the tone of resignation and the lack of surprise in the coverage. It seemed as though serious levels of unhappiness in our young people had become commonplace and we were, as a nation, increasingly inured to that fact. That is a darkness indeed.

Time to turn on the light perhaps. This coalition, made up of school leaders and Head teachers from the independent and maintained sectors, arose out of a spontaneous, shared and fierce desire to do something positive in the face of this situation. Our unique collaboration, between a number of extraordinary and highly engaged pastoral leaders and Public First, has led to illuminating research into the mental health need in schools and to a number of important and exciting recommendations about what we might do next to address the issue.

In addition to the staff on the coalition, we've been grateful for the input of a number of dedicated and highly experienced professionals from across the wider educational sphere, who have helped shape these recommendations – as have the moving testimonies and comments of the significant numbers of students, parents and staff, surveyed during the research phase. Yes, there is a growing need – indeed there is a desperate hunger in some places, for solutions and answers, but there is also a powerful, palpable determination to come up with positive, clear and actionable steps, which could quickly make a real difference in this space. These have been presented in the report's recommendations.

Some of these focus on the need for more therapeutic, reactive support in schools: fund more counselling, diversify our counselling offer and ensure that mental health training for all staff working with students is in place and is appropriate. Some of the recommendations focus on education and on proactive , positive intervention; set a universal, timetabled minimum for PSCHE provision in all schools, train up expert and dedicated PSCHE staff through the ITT programmes.

Whether reactive or proactive, all of the recommendations reflect something exciting; the drive and energy which can be generated by teachers and school leaders when they come together, with a shared purpose and a strong mutual aim, to make a real difference. I am so grateful to all of them and to our friends at Public First, who have contributed so powerfully to the report and to the discussion. (A discussion of course made so much easier, because, since Covid, all schools are online and immediately contactable. There is an education network waiting to be switched on and this feels like just the start of it.)

So, perhaps, out of the darkness of Covid, has come an important and energising opportunity, not only to turn on the light around teenage mental health – but to shine it brightly across the educational sector in this country. In doing that, we will help our young find ways to avoid, combat and defeat mental illness, to bolster and nurture their mental health and to emerge from these challenging times, all the stronger, full of self-belief, determination and agency and ready to switch on their own lights in the years ahead.

Jane Lunnon
Headteacher, Alleyns School

Introduction from Place2Be

Place2Be has been providing mental health support within school communities for over 27 years. We've seen first-hand that children's mental health and wellbeing has been an area of significant concern since well before the pandemic. However, the challenges of the past 18 months have exacerbated that for many, and we have seen the number of children and young people struggling with their mental health, particularly in areas of disadvantage, increasing.

Schools are on the frontline faced with this challenge, and although school leaders want the best for their students, it can be difficult to know where to start. Our experience shows us that establishing a 'mentally healthy school community' can have a positive impact on all students and staff. Our vision is for every school to have an embedded mental health service, accessible, without stigma, enabling a child or young person to access the right type and level of support when they need it. This service would work hand-in-hand with school leaders and staff to promote and nurture good mental health and wellbeing, with everyone equipped and skilled to play their part – students staff and parents.

We know that 50% of mental health problems are established by the age of 14, and 75% by the age of 24. That's why early intervention really matters. Evidence, research and practice in this field has advanced and we know that we can stop issues escalating and developing into adolescence and adulthood when we intervene early. And by doing so, we have the potential to reduce long term costs to society. An independent analysis of Place2Be's work conservatively predicted that every £1 invested in the service results in a £6.20 benefit in terms of improved long-term outcomes.

The establishment of local Integrated Care Systems in England offers a real opportunity to unite the worlds of education, health and social care. I want to see these systems seizing the opportunity to strategically commission high quality school and community-based mental health support for children and young people. We need to see local leaders jointly championing early intervention mental health support services in schools.

Considering the increased demand on children's mental health services, ensuring the availability of a skilled mental health workforce, attuned to the specifics of working in the education sector, needs to be a priority. This report's recommendation of a new apprenticeship standard focused on school-based counselling resonates with me as a real innovation and opportunity. This could also help to make the profession more accessible for people from diverse backgrounds that have been historically underrepresented in the workforce.

It is truly fantastic to see this coalition of school representatives uniting together to champion children and young people's mental health. I look forward to continuing to be involved with the Coalition and I will follow with interest and enthusiasm the best practice and insights that are being shared. No single organisation or person can solve this crisis on their own. We need to continue to work together to ensure that every child receives the mental health support they need and deserve.

Catherine Roche
Chief Executive, Place2Be

SCHOOLS DON'T NEED A LIFEBOAT, WE NEED TO BUILD A NEW SHIP

Children can't concentrate on catching up, if they can't concentrate

Children in England have lost an average of 115 school days over the past eighteen months with disruption likely to continue for at least another year.* The scale of the catch up challenge facing schools is therefore immense.

However, less spoken about is the mental health crisis enveloping young people and schools, ready to blockade progress being made to support academic catch up. We spoke with teachers, parents and young people across England as part of our work for this report and the large majority said the same thing: the pandemic has had a significant impact on children and young people's mental health, and fixing it should be a key priority for schools and government.

This extraordinary coalition came together because we believed that something needed to be done from within the sector, both independent and state. We believe that we have more in common than divides us, especially in the area of mental health and pastoral education. We also believe that if the whole sector speaks with one voice in this incredibly pressing area of our work - sharing our knowledge and our lived experience as educators - we can make a major contribution as the country and its young people try to get back on their feet after Covid. Further, we recognise that the sector's recent Covid-induced digitalisation has meant we can connect and collaborate easier than ever before.

* Lost learning: Up to 95% of teaching days missed during Covid crisis | Tes

But we don't know enough about what works best

The truth is that is not quite as easy as putting in more funding or more teachers. As a society, we don't really understand mental health as well as we do physical health, so understanding why the prevalence of mental health conditions is increasing is difficult. We also don't know enough about what works in principle or practice, partly due to little investment in research and partly due to a lack of collection and transparency in data for NHS commissioned mental health services.

There is a tendency within education to put more and more responsibilities on teachers, support staff and Heads, and within health to focus on the treatment as opposed to prevention. We think it is time to take a step back, reflect on what we do know and be clear about what schools can and should do. The key question is: how can schools use their expertise in *education* to support their students' mental health?

That's why we are setting out a minimum entitlement.

A minimum entitlement

Weekly timetabled PSHE lessons taught by specialist teachers

PSHE education can improve a student's physical and psychosocial well-being, in turn improving academic outcomes. However, historically, PSHE has not been taught consistently well in all schools. A 2013 Ofsted review found that PSHE was inadequate in 40% of English schools - a finding that was reaffirmed by our focus groups with teachers and young people. Our research suggests there are two major barriers to delivering PSHE education well: 1. Many schools do not allocate sufficient, regular time dedicated to PSHE, and 2. Teachers delivering PSHE education often lack training and feel unprepared to deliver it. We heard that, all too often, PSHE is taught by teachers who are trained and qualified to teach another subject, filling up their timetable with a period of two of PSHE lessons.

To ensure our students feel the full benefits of PSHE education, we recommend implementing a commitment of at least one PSHE lesson every week for every student, through a properly timetabled lesson. Further, we recommend the development of a specialist PSHE route in Initial Teacher Training, ensuring lessons are taught by enthusiastic and specialist teachers who can deliver the subject safely and well. Schools should have a PSHE department staffed by highly engaged and well-trained practitioners to address this need.

A Designated Mental Health Senior Lead in every school properly trained and resourced

The government commitment to ensure there is a Designated Senior Lead for Mental Health in every school and college by 2025 is a welcome one. This is because key to the successful implementation of a 'whole school approach' is the introduction of a designated lead within the school who can really understand how all the pieces fit together, who can champion its importance in the school, and who has the time and training to be able to do this effectively.

Our recommendation to accelerate the implementation of a Designated Senior Lead for Mental Health lead by two years will go some way to show the government is serious about paying more than lip service to the importance of mental health and wellbeing in schools. However, long lasting sustainable change will only occur if these designated leads - who are rightly still not mental health professionals - have a clearly defined toolkit and measurable outcomes to facilitate their endeavour at their disposal, akin to a safeguarding lead.

Annual mental health training for all school staff akin to safeguarding training

School staff are not and never should be expected to be mental health experts, but just as they are all trained annually and statutorily to spot signs of safeguarding risks and know clearly what to do and what to say if a child discloses something to them, it is important they are also able to identify mental health difficulties in their students and know who they should tell when they do. Further, teachers should feel confident talking about strategies that will promote good mental health - such as resilience and mindfulness - in the same way they can discuss the promotion of physical fitness to promote physical health. And just as appropriate safeguarding training is given to all school staff who have some contact with children and young people, this should be extended to mental health training in the same way.

Classrooms are phone-free sanctuaries

The classroom should be a sanctuary, where the nudges and prods of competing apps and messages are left at the door. This gives children and young people the space to build high quality peer relationships and the ability to focus on learning free from distraction.

However, schools cannot hide from the fact that phones and social media are an increasingly influential part of students' lives. Therefore, an important part of any whole-school strategy is to continue to teach children how to navigate the challenges that they may face in using social media and mobile phones and to build up this increasingly critical part of the PSHE curriculum.

A counsellor in every secondary school

The evidence suggests counselling* is effective at reducing students' psychological distress and improving self-esteem. However, for school counsellors to have the biggest possible impact on a students' mental health and wellbeing, they must be embedded in a school with a trained Designated Senior Lead for Mental Health who can facilitate referrals and guard their independence. Further, recruiting more school counsellors from the surrounding areas who reflect the diversity and culture of the local community would help overcome some of the stigma around accessing mental health services.

Given the likely increase in demand for school counsellors if the government 'Counsellor Guarantee' is put in place and the desire for more diversity, we believe that a pragmatic solution would be to create a new apprenticeship standard focused on school counselling. This would reduce the burden on individuals for whom the upfront training cost is a barrier and crucially not require additional funding from government but rather better utilise the apprenticeship levy already available to schools.

THE STATE WE ARE IN

The pandemic has exacerbated issues for schools

"People became a lot quieter in my friendship circle, and as a year group as a whole. A really important thing that crept up was eating disorders. In my year, before any lockdown happened, I think maybe 5% of the year had them, but coming into the end of last year, I think over 50% did."

- Female Sixth Former at an Independent School, London

"[lockdown] just got incredibly boring … and I just became quite isolated and just not really speaking with anyone apart from my immediate family. So that definitely made me quite anxious"

- Male, Sixth Former at a Comprehensive School, Cheshire

"Definitely loneliness. Before we were so reliant on our friends and could meet up with them every day at school, which wasn't possible anymore, so definitely [loneliness]. "

- Female Sixth Former at a State School, Lancashire

The pandemic has exacerbated mental health concerns for children and young people. According to YoungMinds, over 80% of young people with a history of mental health problems agreed that the coronavirus pandemic made their mental health worse, often related to increased feelings of anxiety, isolation, loss of coping mechanisms or a loss of motivation. Further, almost 1 in 3 young people who were accessing mental health support before the pandemic were unable to access support during the pandemic despite still needing it.[2]

Our poll confirms that young people experienced poorer mental health during the pandemic:

71%

reported feeling like they had **no motivation** more frequently than pre-pandemic.

62%

reported feeling **anxious or worried** more frequently than pre-pandemic.

46%

reported feeling a **continuous low mood or sadness** more frequently than pre-pandemic.

42%

reported **not getting any enjoyment out of life** more frequently than pre-pandemic.

38%

reported feeling **hopeless or tearful** more frequently than pre-pandemic.

18%

reported having **suicidal thoughts** more frequently than pre-pandemic.

Many sixth formers in our focus groups confirmed these findings, reporting that they had felt their own mental health worsen throughout the pandemic and struggled with feelings of isolation, boredom, and stress, often exacerbated by home learning.

Mental health issues in children and young people are not only increasing but becoming more acute and occurring earlier in childhood

Mental Health *(noun)*
/ˌmen.təl ˈhelθ/

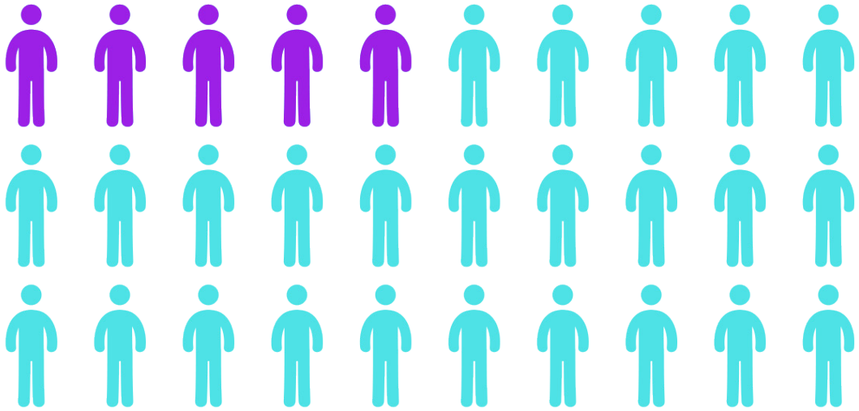
The World Health Organisation (WHO) defines mental health as "a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community."[3]

"What we're also seeing is some of the issues that traditionally might have come through in secondary school aged students, we're seeing come in earlier at the top end of primary school. So issues such as eating disorders, self-harm and suicidal ideation, which are the ones that really concern us and are highlighted again and again as areas of increase."

- Catherine Roche, Chief Executive, Place to Be.

The prevalence of mental health problems amongst children and young people is increasing at an alarming rate up 60% from **one in ten** in 2004, to **one in nine** in 2017, to **one in six** in 2021.[4]

On average, 3 students in a class of 30 had a probable mental health disorder in 2004.[5]



On average, 5 students in a class of 30 had a probable mental health disorder in 2021.[6]

In our poll, just 45% of young people rated their mental health as good vs. 72% who rated their physical health as good.*

* See Appendix 1 for full tables from our poll of young people

Anxiety

1 in 14 children and young people have a diagnosed anxiety disorder.[7]

69% of girls and 45% of boys report being worried about their own mental health, including stress and anxiety, in the last year.*

Depression

Although rates of diagnosed depression amongst children and young people are low,[8] our polling found that 8% of young people felt depressed all the time (between 5-7 days) over the past week, and a further 18% felt depressed a moderate amount of time (between 3-4 days).**

Eating disorders

Eating disorders are most prevalent in girls aged 17-19 (1.6%), 4x the rate for all 5-19 year olds (0.4%).[9] Although diagnosed eating disorders are rare, eating problems are very common and are increasing in prevalence – especially amongst teenage girls. According to the NHS, in 2021, 76% of girls aged 17-19 had a possible eating problem, compared to 61% in 2017.[10] Eating problems can become extremely dangerous as they increase in severity - anorexia nervosa has a higher mortality rate than any other mental disorder, resulting from malnutrition, physical complications, and suicide.[11]

* See Appendix 1 for full tables from our poll of young people

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Self-harm

15.5% of 13-18 year olds in England report having ever self-harmed, with the highest rate found in females aged 16-18 with nearly 1 in 3 (29.0%) reporting ever self-harming.[12]

Rates of hospital admission as a result of self-harm are considerably higher for girls compared to boys. Between 2012/13 and 2019/20 hospitalisations as a result of self-harm rose by 37%.[13]

Self-harm rates amongst girls have increased by 37% from 2012/13 to 2019/20. Further, the rate of hospitalisation as a result of self harm for 9-12 year olds has doubled over the last six years.[14]

Individuals admitted to hospital due to self-harm have a 49 times greater risk of suicide than the general population.[15]

Suicide

Suicide amongst young children is extremely rare and rates get higher with age. For the age group 15-19, the suicide rate for boys is 9 per 100,000, which is double the girls' rate of 4.4.[16]

Among all 10-24 year olds, suicide rates are three times higher in boys compared to girls.[17]

Risk Factors

There are several risk factors which increase the likelihood of children and young people experiencing mental health problems, including: socioeconomic disadvantage, being Lesbian, Gay, Bisexual, Transgender (LGBT), gender, having poor physical health, experiencing adverse childhood events or having special educational needs or disabilities (SEND).*

Socioeconomic disadvantage

Children from the poorest 20% of households are **four times** more likely to have a mental health disorder compared to those from the wealthiest 20%.[18]

LGBTQ+

Over half (52%) of LGBTQ+ young people report having ever self-harmed and **44%** report ever having suicidal thoughts. Only **36%** of trans young people agree with the statement "*in most ways my life is close to ideal*", compared to 47% of LGB and 51% of heterosexual non-trans young people.[19]

* For a longer discussion on risk factors see Annex 1

Gender Dynamics

By 17, nearly one quarter of young women have an emotional mental health disorder, **three times** the rate of young men.[20]

Although self-harm rates are **three times** higher amongst girls,[21] suicide rates are **three times** higher amongst boys.[22]

SEND

In the UK, children with SEND are **more than five times** more likely to have a diagnosed mental health disorder than those without.[23]

Race

Across ethnic groups, Black women are the most likely to have a common mental health problem (29.3%), compared to white British women (20.9%) and non-British white women (15.6%) – however, these differences were not found across ethnic groups for men.[24]

Amongst all women, those of mixed ethnicity have the highest rate of suicide (7.1 deaths per 100,000 females in the mixed ethnic group compared to 4.9 suicides per 100,000 in the white group). For men, those of mixed ethnicity and white have the highest rates of suicide across different ethnicities (14.7 and 14.9 suicides per 100,000 respectively).[25]

Our language must evolve as we get better at spotting and talking about mental health

"In terms of mental health awareness, looking back when I was at school, I can also identify a couple of children in my class that definitely had [mental health] difficulties. I can particularly remember one that seemed depressed … and another girl who was always called naughty, but I think she just couldn't cope with a classroom type of situation."

- Mother of two, Manchester

"There isn't enough differentiation between those feelings of being low or being anxious - just natural, everyday feelings - and something that would be worrying in relation to the longevity and the severity of that feeling. And whilst we've obviously as a society increased awareness about mental health issues, we haven't increased with it the differentiation and understanding between normal mental health reactions … we are still conflating momentary mental distress with mental illness."

- Gregor Henderson

It is undeniably a good thing that more young people, teachers and parents are feeling able to speak about mental health and wellbeing. And thus, when we ask questions to people they are likely to feel more comfortable than they did in the past to say, "yes, I'm feeling anxious or a bit sad today."

However, we heard concerns from parents and teachers in our focus groups that some of the rise in mental health disorders amongst children may be due to over-pathologizing - with normal fluctuations of human emotion being deemed mental health disorders. Much of this stems from a lack of clarity around the language we use within the broad umbrella of "mental health" - worsened by ubiquitous and often uninformed messaging across social media.

Clearly feelings of sadness are different from diagnosed depression and, similarly, feelings of anxiety around exams are different from diagnosed anxiety disorders. However, what we heard from schools is that the terms used to describe these feelings are often used interchangeably. Terms such as 'mental health issues' are often used to refer to a range of emotions and experiences - from normal fluctuations in emotion to very serious diagnosable disorders. Further, other terms such as 'mental health' and 'mental wellbeing' are often combined or used interchangeably, obscuring the difference between them and causing confusion for many. As a result, there is a need to improve our language around mental health to coincide with the increase in discussion around it.

Although beyond the scope and remit of this report, we think this is an area that warrants further research.

So what role can and should schools play in supporting the mental health of their students?

"We're inundated. We don't have the capacity to deal with the demand for it. We have a counsellor on site, and she's just fully booked. So it's down to teachers and their goodwill. Our teachers aren't going to turn away a child who's clearly upset or anxious. But we're inundated."

- Assistant Head Teacher, Secondary School, London

"There tends to be a real backlog with the counsellors at my school anyway, like six month waiting lists. If you need help, you want to get it right then and there."

- Female Sixth Former at an Independent School, London

There is clearly an upward trend in both the prevalence and severity of mental health conditions, and schools are bearing the brunt of this. Access to Child Adolescent Mental Health Services (CAHMS) is woeful, with only a fifth of children able to access support within 4 weeks. Even worse, nearly half (49%) of young people referred get no access at all (either because their referral was closed before treatment or they have yet to be contacted).

This means that school staff are increasingly being expected to deal with more and more children and young people who need specialist help and support in school, making it difficult to be proactive around prevention and early intervention as they are so busy firefighting with challenges that they do not and nor should be expected to have the expertise to deal with.

We can't expect school staff to be mental health professionals, they're not, but there's nowhere else to go. Even when children are accessing mental health services, they don't disappear from the school, they're still in school and they still need some kind of support in place.

With regards to the mental health of their students, government guidance states schools are responsible for the following:

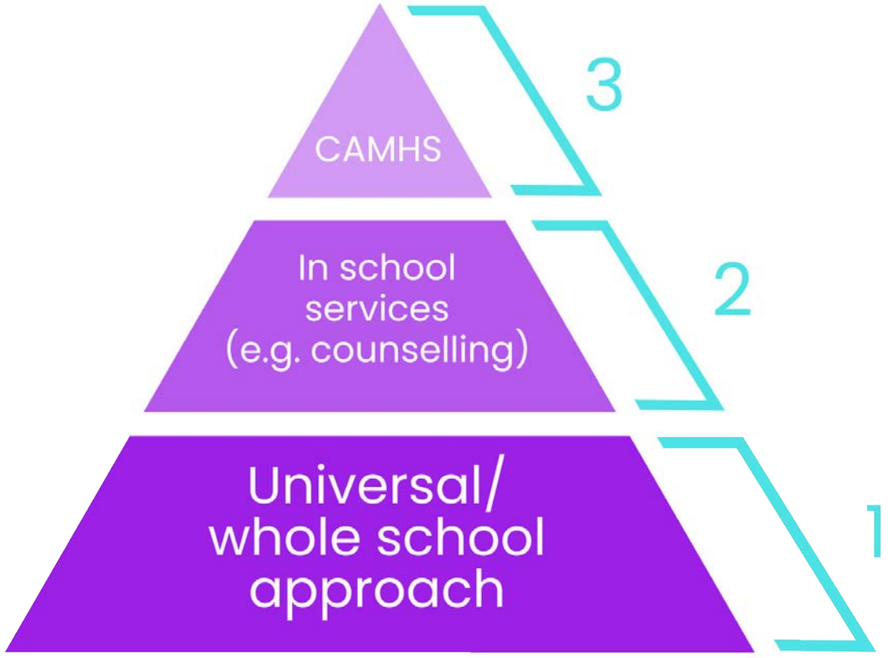
Universal Prevention. Broadly it is schools' responsibility to run a universal preventative approach around self-esteem and resilience and being healthy and active. Schools do this through their pastoral system, PSHE lessons, embedding a positive whole school culture, promoting exercise and healthy living.

Identification of those with mental health concerns. It is schools' responsibility to have in place good processes to identify early any mental health concerns through their pastoral system and data such as attainment, attendance and behaviour.

Targeted intervention. Some schools will also engage directly with interventions or programmes, such as in-school counselling.

Specialist referral. Schools are responsible for referring and working with external partners and agencies to provide access to support and treatment for students where necessary.

Broadly, the tools that schools have at their disposal can be illustrated through a three-level pyramid. At each layer - if done correctly - mental health problems can be identified and treated (or prevented in the first place) which can reduce the number of students who move up to the higher levels with more acute issues.

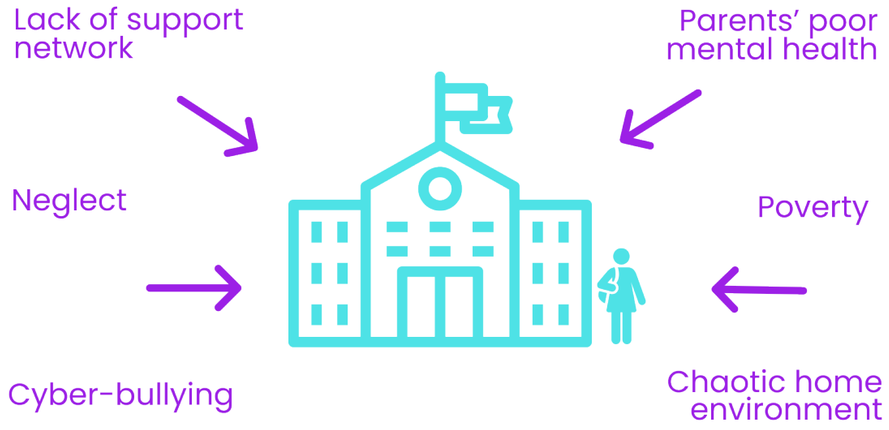


Level 1 is the most fundamental layer: the universal/whole school approach to mental health. A whole school approach is one which embeds the social and emotional wellbeing of children and young people through all aspects of the life of a school. It also promotes engagement across the entire school, including leadership, staff and students, as well as with parents and external services, to ensure a joined-up, community-wide strategy for improving mental health and wellbeing.

Level 2 is the provision of targeted in-school services, including counselling. If level 1 is implemented effectively, it should reduce the number of students who need to use these services. However, there will still be some students who will need these services and therefore it is important that they are both available and effective.

Level 3 is referrals to external services, namely Children and Adolescents Mental Health Services (CAMHS). If a school can firstly build an environment that focuses on preventing, as much as possible, mental health problems from arising in the first place, and secondly identify and treat mental health problems arising in students early through services such as counselling, then the number of students who reach a crisis point and need referral to CAMHS should be reduced. Regardless, some students will still need to be referred for external specialist help and therefore schools must have strong systems in place to ensure students can be referred quickly and efficiently.

Given the levels are interconnected, all three must be strengthened in tandem. Schools must implement a whole school approach to mental health, which is driven by the school's leadership and which embeds a mentally healthy environment and ethos. Simultaneously, they must also improve the availability of in-school services such as counselling and strengthen links with external services to make the referral process as efficient as possible.



Although strengthening the three levels should help improve children's mental health in schools, it is worth noting that, in reality, much of the drivers of students' mental health are outside of a schools' control. Therefore, (although beyond the scope of this report) there is a need for wider action and joined-up thinking across the entire community, including a clear need to identify, train and recruit more counsellors and therapists across the nation to meet the growing need.

Case Study: Integrated, Community-led Strategies for Children's Mental Health in The Netherlands

Since 2015, the Dutch provision of mental health support for young people (and in fact all youth related policy) has been decentralised, with complete responsibility for prevention and treatment given to municipalities.[26] The Dutch model for youth mental health policy has reoriented services away from institutions and towards community-based prevention and treatment.[27] Earmarked funding for youth mental health services is provided by the federal government to the municipalities.[28]

Schools in the Netherlands have very good links with external services compared to other countries.[29] Every school is obliged to have a Care and Advice team, made up of teachers, youth care professionals, social workers, police and others, which are a teacher's first point of contact if a child is suspected of needing professional mental health help.[30] Care and Advice teams are tasked with preventing, detecting and treating mental health problems in students. Over 98% of secondary schools and 67% of primary schools in the Netherlands have access to Care and Advice teams.[31]

Further, the Netherlands mental health strategy focuses on a "whole-school approach", and a study of 10 European countries found that schools in the Netherlands have the most mental health support for staff.[32]

Overall, the landscape of youth mental health in the Netherlands is characterised by:

1. A whole-school, holistic approach;
2. Decentralised youth mental health responsibilities;
3. Strong external links with other services.

RECOMMENDATION:

The introduction of a nationally standardised framework for measuring and tracking outcomes for CAMHS across the country alongside increased funding.

Schools can and should improve their mental health offer internally, but external services must be reformed simultaneously to fully address children's mental health issues

"I hear so often - almost daily – 'they haven't met the threshold for CAHMs.' And the fact that I'm on the phone trying means in my opinion, they absolutely have."

- Female, Assistant Head Teacher, Secondary School, London

"It's really difficult until they're at crisis point, and it's too late then. We've got quite a few kids who, until they've actually made an attempt at their own life, we had struggled to get access. So as soon as they had they'd been fast tracked straight away, which is great, but if they've got the support a lot earlier, they wouldn't have got to that point."

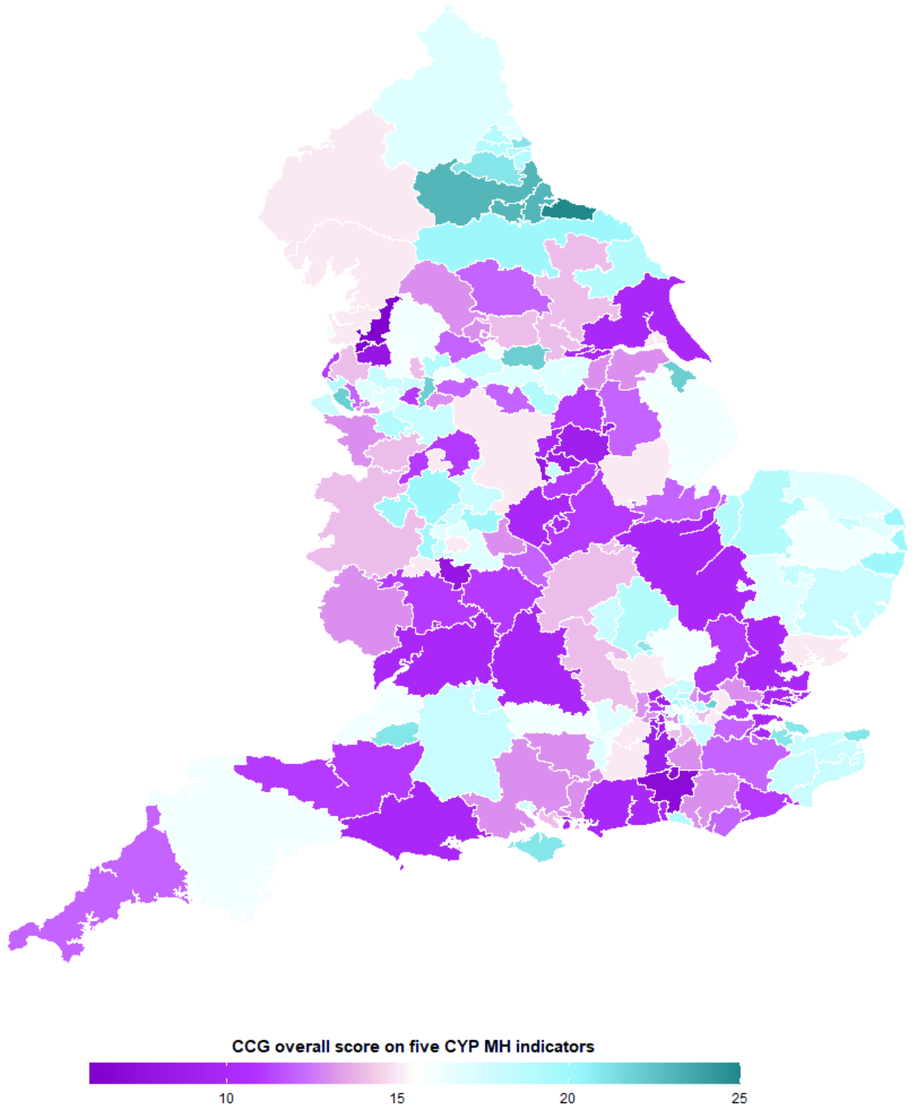
- Female, Secondary School Teacher, Manchester

Currently, the Children's Commissioner compares clinical commissioning groups (CCGs) around the country based on their budget for children's mental health and metrics around how well children can access services in their area.[33] Comparing these measures show there is a "postcode lottery" in CCG spending on children's mental health and a significant disparity in wait times.[34]

In 2019/20, the highest CCG spending per child on mental health services was Islington CCG at £202 per child vs. the lowest, Halton CCG, who spent £25 per child.

There is a massive difference in wait times across the country - in 2019/20, in the Barking and Dagenham CCG children only waited on average 8 days to access services. In comparison, children in the Fylde and Wyre CCG waited on average 87 days.

The different 2019/20 CCG rankings from the Children's Commissioner report are illustrated in the map below:



What these figures do not assess, however, is the actual effectiveness of CAMHS interventions as they are currently implemented. The most common way that CAMHS across the country evaluate the effectiveness of their interventions is through questionnaires filled out by young people, and/or their parents, and/or the therapist, known as Routine Outcome Monitoring (ROM). However, there is no standard ROM to be used across all CAMHS, which makes it difficult to compare trends in outcomes across different areas. A 2018 review of ROMs in CAMHS found that the most frequently measured outcome was symptoms of anxiety and depression through the Revised Children's Anxiety and Depression Scale (used by 70% of participants in their sample). Other common measurements were goal-based outcome measurements (measuring how a young person is progressing towards goals set at the start of services, used by 55%) and a session rating scale (measuring how the service user experienced the session, used by 55%).[35] If the system is to be reformed, gathering standardised evidence on the outcomes of CAMHS interventions across the country will be a crucial starting point.

"There is no nationally collected data to tell us about children and young people's experience of using services for their mental health needs, as there is for children with physical health conditions, nor data to tell us about the outcomes of their mental health care"

- Care Quality Commission, 2018, Are We Listening? Review of Children and Young People's Mental Health Services

A RISING TIDE THAT LIFTS ALL BOATS

RECOMMENDATION:

The government should accelerate its ambition to ensure every school has a designated mental health leader by 2023 by bringing forward the funds allocated for training by two years.

Getting the 'whole school approach' to mental health right is key

"So, we have to put that front on in front of our students to say, 'you know, we're there for you to support you.' But deep down, I didn't feel confident in providing the support they might need. I was hoping that nobody would come and knock on my door and say, 'can you help me out' because I wouldn't know where to turn and who to turn to."

- Male, Secondary School Teacher, London

The best evidence we have available on how schools can most effectively support mental health and wellbeing is to implement a 'whole school approach'.[36] Research suggests that a whole school approach can positively impact a range of social (e.g. good relationships with others; social skills; bullying), emotional (e.g. levels of happiness/depression, confidence, resilience) and educational outcomes (e.g. rates of absenteeism, exam scores).[37] This stems from the understanding that promoting positive mental health, supporting wellbeing, and building resilience across schools will help children and young people not only to thrive both emotionally and academically but also to cope better when adverse situations occur. Given half of adult mental ill health starts before someone is 15, there is a clear public health benefit to getting this right as early as possible and investing in it properly.[38]

Case study: A whole school approach at Oasis Community Learning

"At Oasis Community Learning we have a vision to deliver 'Exceptional education at the heart of the Community,' at our 52 primary and secondary schools. Addressing the emotional and mental health needs of our students is not a 'quick fix' and it cannot happen in isolation – we can only meet this challenge by working alongside the young people and their families.

As part of the wider Oasis group of charities, we deliver hubs where we support our families in meeting whatever challenges they are facing where they are – be that hunger, lack of employment, or mental health. This work is complemented by our approaches within school.

Our Mental Health Strategy, designed to increase understanding around mental health across the community, has encouraged resilience building. Further, the promotion of good emotional and mental health is codified in Oasis's Safeguarding and Child Protection Policy and a programme to develop mentally healthy schools is in place, which looks at leadership, policy, support for students and staff and the development of peer mentors across our secondary provision.

We have appointed a National Mental Health Lead, who leads on the development of emotional well-being and mental health intervention across our schools and provides clinical expertise to our staff. We also have a Mental Health Lead at each academy who, in collaboration with the Safeguarding Lead, works to identify early any students who might have any mental health concerns.

The final part of our approach is ensuring our staff are equipped. Training, bespoke guidance for school leadership teams, and wider supervision mean we have a "Whole School Approach" that means colleagues can respond in the best possible way when a student is struggling with their mental health. In addition, our staff induction process includes training on adverse childhood experiences (ACEs) and its impact on learning and aspiration, we provide coaching sessions around Trauma Informed Practice, and through our partners at Place2Be every staff member is offered foundation mental health training."

Giving mental health a prominent role in schools has been accelerated by the impacts of the pandemic on everyone. And, by and large, school staff are looking to rise to the challenge. Staff understand the increasingly important pastoral role they have to play in their students' lives, but they need more clarity about what is and crucially is not their responsibility, along with better training and support to follow through on this.

Transforming Children and Young People's Mental Health Provision: a Green Paper (2017)[39]

The Government has committed to a Designated Senior Lead for Mental Health in every school and college:

Their core role is seen as:

- Overseeing the whole school approach to mental health and wellbeing, including how it is reflected in the design of behaviour policies, curriculum and pastoral support, how staff are supported with their own mental wellbeing and how students and parents are engaged.
- Overseeing the help the school gives to students with mental health problems.
- Helping staff to spot students who show signs of mental health problems.
- Offering advice to staff about mental health.
- Referring children to specialist services.

Funding is being made available from September 2021 to offer training to one individual in every school by 2025.

The government commitment to ensure there is a Designated Senior Lead for Mental Health in every school and college by 2025 is a welcome one. This is because the introduction of a designated lead within the school who can understand how the pieces of the puzzle fit together, who can champion its importance in the school, and who has the time and training to be able to do this effectively is key to the successful implementation of a 'whole school approach'.

The issue is that the funding for this training promised by the government is only about to come to fruition, due to the procurement for it being paused due to the 2019 election and a lack of capacity for it to be restarted during the pandemic.[40] Even then, it won't reach all schools until 2025. Given the increase in need for schools this is not good enough.

Our recommendation to accelerate the implementation of a Designated Senior Lead for Mental Health lead by two years would go some way to show the government is serious about paying more than lip service to the importance of mental health and wellbeing in schools. However, it is also crucial that the training and guidance provided to schools is effective. Research suggests that the most effective 'whole school approaches' have the following characteristics: "specific, well-defined goals and rationale, a direct and explicit focus on desired outcomes, explicit guidelines, possibly manualised, thorough training and quality control and complete and accurate implementation."[41] A box-ticking 'wellbeing PowerPoint presentation' of the sort frequently referred to by teachers in our focus groups is simply not going to cut it."

There is of course a balance that can be reached between adhering to manuals that ensure minimum standards are met and being flexible enough to create empowered leaders, but the research is clear: long lasting sustainable change will only occur if these designated leads - who are rightly still not mental health professionals – have a clearly defined toolkit and measurable outcomes to facilitate their endeavour at their disposal, akin to a safeguarding lead..

72% of teachers think schools in the UK tend to focus more on academic performance than the mental health and wellbeing of students*

*See Appendix 2 for full tables from our poll of teachers

RECOMMENDATION:

The government should introduce a statutory requirement for every school staff member to receive appropriate mental health and wellbeing awareness training as part of annual safeguarding training.

Let’s not set schools up to fail

“I’ve never seen so many teachers cry”

- A teacher reflecting on Summer term 2021

“Certainly when I trained there was nothing in the teacher training that prepared you for anything like [serious mental health issues]. And things do seem - even before COVID - mental health-wise, to have got worse over the last five or so years. And I don’t think there’s been any training that’s matched that increase in mental health issues”

- Female, Secondary School Teacher, Manchester

Thinking about mental health in a similar way to safeguarding could be a successful approach going forward, not only for the designated leads but for all staff. A true whole school approach to positive mental health and wellbeing requires all staff to be invested and properly trained in this.

*76% of teachers did not receive any training on how to support their students' mental health during their Initial Teacher Training**

Whilst again, teachers and wider school support staff are not and never should be expected to be mental health experts, just as they are all trained annually and statutorily to spot signs of safeguarding risks and know clearly what to do and what to say if a child discloses something to them, it is important that they can identify mental health difficulties in their students and know who they should tell when they do. Further, it is important that teachers and, where appropriate, other support staff are able to educate on strategies to strengthen and support mental health as a way of helping to prevent the emergence of serious issues.

One of the worries for teachers and pastoral staff is that they think there is an expectation that they wear lots of hats - they need to be a social worker, a housing officer, a counsellor and so on. This training recommendation is not meant to equip them to wear all of these hats. In fact, it is crucial that it strikes the right balance in ensuring that staff know what they need to know about how to spot issues, where to signpost, and how to talk about mental health positively, without distorting professional boundaries

This is because it is important to remember that the mental health of teachers and all those in schools has also taken a battering over the last eighteen months. In the same way that a parent puts their own oxygen mask on before getting their child into a life jacket, so should schools ensure that staff wellbeing is promoted and supported through a positive culture in school, championed by the trained designated lead. This will empower staff to support students more effectively whilst upholding a clear understanding of the limits of their role. In light of this, the mental health and wellbeing awareness training should also make clear the support available for frontline mental health staff.

* See Appendix 2 for full tables from our poll of teachers

87% of teachers think that mental health training should be refreshed annually in a similar way to safeguarding training*

* See Appendix 2 for full tables from our poll of teachers

RECOMMENDATION:

Schools should restrict mobile phone use during the academic school day and educate students on how to be safe online.

The classroom should be a sanctuary

"Social media has got so much influence on [anxiety for girls]. We have a lot of girls self-harming, and even they can't access CAMHS."

- Female, Assistant Head Teacher, Secondary School, London

"A lot of the issues that we have between students actually is coming from outside of the classroom, and it's coming from conversations they're having on social media. So, we do a lot of digital safety, but I do feel like when I'm participating in the training, I'm not sure it's right at the forefront of what's happening. I feel like we're always an app or two behind."

- Female, Secondary School Teacher, Manchester

"It really worries me, Tik Tok and Instagram and social media. It worries me about social development and relationships where it's all just from a phone. I think they lose out on other life skills - arranging and organising things, meeting friends, and it keeps them indoors when they should be outdoors more, I think to get a better balance of life. I think they grow too fast. I think there's a certain erosion of values sometimes."

- Father of two, Manchester

"I think having that ability to speak to your friends on social media, it's boosted my self-esteem and I think probably everyone's really, over this last year. But I mean, at the same time … I think some of my friends' self-esteem has negatively been impacted because of social media, because scrolling through it and feeling not productive, thinking you should be doing this with your time, or seeing your friends are doing this and you're not. I think it can really go either way."

- Female Sixth Former at an Independent School, London

"I think it can have a negative impact, like watching everyone else, especially if you think they're being productive and you're not. But I do always feel like it's used as a bit of a scapegoat by adults. Like it's the first thing they want to blame, like, 'Oh, it's social media, everything social media's fault.' And I do think that like it has really helped with being able to stay in touch with friends in a way that a lot of people don't recognise.

- Female Sixth Former at a State School, Leicestershire

There have been many positives to social media during the pandemic enabling children and young people to keep in contact with their classmates whilst stuck at home for long stretches of time. Parents, especially of teenagers, often reflect that it made a big difference to the lives of young people through the two lockdowns. Certain apps, for example, can help equip young people experiencing mental health difficulties with coping mechanisms.

Nonetheless, many participants in our research and polling, especially teachers, believe that constant access to mobile technology has played a role in increases in the diagnosis of mental health issues.

We do not believe you can close the school gates and pretend mobile phones do not exist. For many schools, especially boarding schools, access to mobile phones is an essential way for students to communicate with home. Therefore, an important part of any whole-school strategy and a clear curriculum through PSHE is to teach children how to navigate the challenges that they may face in using social media and mobile phones.

But the classroom should be a sanctuary, where the nudges and prods of competing apps and messages are left at the door. This way we will give children and young people the space to build those high-quality peer relationships and the ability free from distraction to focus on learning.

RECOMMENDATION:

Recommendation: All schools to teach at least one properly timetabled lesson of PSHE education each week

Taught well, PSHE can have a huge impact on the wellbeing and mental health of children and young people, but it is often an afterthought in schools

"There's been loads of very similar PowerPoints about wellbeing but, to me, they don't feel well researched, they just feel like somebody just found a few PowerPoints about wellbeing and are throwing them out there just to make sure we're ticking a box."

- Female, Secondary School Teacher, Manchester

"PSHE teaching is the last thing that goes into our timetable. It's an afterthought. There's not a single, qualified specialist PSHE teacher at our school, and there hasn't been any at the four schools that I've taught at."

- Female, Secondary School Teacher, Midlands

"If there's something more important - PSHE would be the first to go"

- Female Sixth Former at a Independent School, London

Personal, Social, Health and Economic education (PSHE education) has had a renewed focus recently, with the government bringing in a statutory requirement for schools to teach mental health and wellbeing from September 2020.[42] This compulsory content sits alongside the requirement for schools to teach students about relationships and sex education in all secondary schools and Relationships Education in all primary schools. PSHE has been a longstanding requirement for independent schools.

Dame Sally Davies, the former Chief Medical Officer and Chief Scientific Advisor at the Department of Health, said that PSHE "**forms a bridge between health and education by building resilience and wellbeing**."[43] When taught well, PSHE education can not only have an impact on the wellbeing and mental health of children and young people, but also have a positive impact on academic attainment – a DfE impact review highlighted that PSHE education can 'improve the physical and psychosocial well-being of students. A virtuous cycle can be achieved, whereby students with better health and well-being can achieve better academically, which in turn leads to greater success.'[44] It is long understood that children can only truly flourish academically if they are well and happy.[45]

However, historically, PSHE has not consistently been taught well in schools. A 2013 Ofsted review found that the quality of PSHE education varies widely in schools and is often poor. The review found that PSHE was inadequate in 40% of English schools.[46] Ofsted's 2021 review of sexual harassment in schools found that statutory elements of PSHE – though now compulsory – still suffered from a lack of sequencing, planning and effective implementation in many schools.[47]

We heard time and time again from teachers and young people we spoke to that PSHE lacked currency in their school. There are a number of reasons for this, including lack of regular curriculum time in many schools that would allow effective planning, sequencing and teaching.

PSHE education also suffers from being seen as less important in some cases due to it not being an examined subject (there is good reason why PSHE is not examined: a student should not feel they have 'failed' mental health for example). At the same time, monitoring and assessment of progress is key to establishing that students have gained knowledge and understanding.

There should be a commitment to at least one timetabled lesson of PSHE education every week for every student from Year 1 to Year 10, and where possible in Year 11 too (rather than a "drop down day"/focus day or in assemblies and form time). This would allow effective planning, sequencing and teaching as well as greater legitimacy among staff and students.

DfE statutory guidance on Relationships, Sex and Health education states that "Schools should have the same high expectations of the quality of students' work in these subjects as for other curriculum areas". It is impossible to see how schools could fulfil this requirement without regular timetabled lessons.

For students to make progress in any subject, teaching must be carefully sequenced, building on prior knowledge and making effective use of formative and summative assessment. One-off events or lessons at irregular or long intervals inevitably mean superficial coverage that 'starts afresh' each time. And whilst assessment might look different in PSHE education (where it is not primarily preparing for examinations), it is every bit as important. Without effective use of assessment strategies, it is impossible to measure progress or ensure that teaching is pitched correctly, relevant and age/developmentally appropriate for a particular cohort of students. Delivery models other than weekly timetabled lessons do not allow for effective assessment over time.

However, weekly timetabled lessons alone are not enough.

* See Appendix 2 for full tables from our poll of teachers

RECOMMENDATION:

The government to invest £11.6 million pounds a year from 2023 into a new ITT route to ensure every secondary school in England has a specialist trained PSHE teacher by 2030

PSHE is taught best by teachers who are trained to teach it

"Some of the [PSHE] topics were pretty straightforward, you can follow the PowerPoints and get into discussions, but a lot of it was difficult to deliver and I don't think we were trained to do that - we were just thrown into the deep end in September."

- Male, Secondary School Teacher, London

Whilst many schools may have a sole teacher responsible for the PSHE education curriculum, very few outside of the independent sector have a specialist trained teacher delivering the content to all students. Part of this stems from timetabling convenience for schools. It's much easier to give it to teachers who haven't quite got enough contact hours and so need some more lessons to fill up their week, or to shoehorn it into form time. But it is also because there is currently no pipeline of trained specialist teachers through the current lack of an Initial Training Teacher (ITT) route.

The current use of non-specialist teachers to deliver PSHE in schools means teachers are often delivering a lesson that somebody else has created for them or that they've pulled off the internet the night before. There is a risk that this approach could do more harm than good given the sensitive nature of many of the topics discussed during these lessons, and the variable quality of some available materials. In some cases, teachers lack the fundamental training necessary to choose safe, effective, evidence-based resources.

*3/4 of teachers teach PSHE in schools but almost 2/3 think they do not have adequate training to be able to do so effectively**

* See Appendix 2 for full tables from our poll of teachers

The PSHE Association – a charity and membership association who support schools in delivering the PSHE curriculum have been calling for PSHE to be taught:

- **Regularly**... regular lessons on the timetable like other subjects
- **as a whole subject**... from RSE to mental health, online safety to careers education
- **by trained teachers**... covered in ITE with ongoing learning opportunities
- **in all schools**... including maintained, academies, free schools and independents
- **to all students**... from year 1 to finishing secondary school[48]

Having a new pipeline of specialist teachers would ensure the subject was taught safely and well, and would also allow for the evolution of stronger professional networks to develop which are key in facilitating the development, sharing, and promotion of effective practice in the subject. Whilst there are numerous resources available for teachers, PSHE education lacks the research base and academic traditions of more established subjects. This is something we would like to see changed, and the best way to do it is through a specialist ITT route. Having an English teacher, for example, cover PSHE as an add-on can be ineffective or even harmful if they lack confidence, interest, and expertise in doing so.

A new training route for specialist PSHE teachers

The Institute for Fiscal Studies (2016) calculated the average cost to the central government to train a secondary school teacher at £20.8k.[49] When inflation is taken into account, this suggests that in 2021 the average cost to the government to train a secondary school teacher is £23.2k.

Therefore, to train 3.5k new secondary school teachers by 2030 (500 per year from 2023) would cost **£11.6 million** (in 2021 pounds) per year.

We think 500 new secondary school teachers for this subject is reasonable because it is comparable to the number of new secondary school trainees in religious education in 2019/20 (478 out of 16,816 total newly trained secondary school teachers).[50]

*25% of teachers would have liked to have trained as a specialist PSHE teacher if the route had been available to them**

Many younger teachers coming through the system are highly aware of issues around mental health and relationships, and are really passionate about these topics. For some of them, it is the reason they're going into teaching. With a subject that covers sensitive and critically important issues, it makes sense to ensure those teaching it are not only suitably qualified but also engaged, passionate, enthusiastic, have chosen to teach the subject, and have received appropriate training to do so. Giving them this new route and asking schools to timetable regular weekly lessons would give PSHE education the prominence on the curriculum it deserves, enabling a culture of best practice to develop and would crucially have a significant positive impact not only on wellbeing but also on academic outcomes in schools.[51]

* See Appendix 2 for full tables from our poll of teachers

THE MISSING MIDDLE

"I felt a little bit guilty going to my subject teachers when they were all really stressed out by the pandemic. They were all overworked and seemed to be in as bad a position as a lot of the students."

- Female Sixth Former at a State School, Leicestershire

With a rise in the prevalence and acuteness of mental health issues amongst children and young people, there is a feeling within schools that although they are trying their best with limited capacity and funding to put in place a coherent and evidence-led whole school approach, more needs to be done urgently to help them support children and young people already experiencing mild to moderate mental health issues.

School staff are not mental health professionals, and we shouldn't expect them to be so. Even with the training of a Mental Health Senior Lead in every school, their role should be to facilitate and signpost support for students struggling, rather than to actually deliver the support themselves. The lack of a middle tier of mental health professionals in schools exacerbates the upward movement to already stretched external services such as CAHMs by allowing more students to reach crisis point before they receive the care they need. But equally, as staff's time is increasingly taken with more serious cases, it makes it difficult to put in place the whole school approach focused on building resilience and early intervention that we know is so crucial and which staff can be best placed to deliver.

The Government has begun to recognise this is an issue and are currently rolling-out NHS commissioned Mental Health Support Teams (MHST) for schools. These teams include support for things like mild-moderate anxiety or worries, exam stress and friendship issues for students, and offer advice and guidance for staff and parents, as well as facilitate the link to more specialist care if needed. However, the current aspiration is that only a fifth to a quarter of students will have access to a MHST in their school by 2023, and there are no current plans to expand this further.[52] Furthermore, each MHST will support up to 8000 students and around 10 - 20 schools each.[53] This is not good enough.

England is an outlier in this respect - Scotland, Wales, and Northern Ireland have statutory funded school counselling services. In Wales and Northern Ireland this has been in place for a decade, and Scotland has recently begun to roll-out a government supported programme for putting in place a counsellor in every school.

89%

of secondary schools have access to a counselling service

48%

of teachers state that they do not have enough capacity within their current counselling service to give access to all students who need it

73%

of teachers think that a counselling service in their school has improved the mental health outcomes for the students who use it *

* See Appendix 2 for full tables from our poll of teachers

RECOMMENDATION:

The government should centrally fund a school counsellor in every school.

We need school counselling to bridge the gap between school staff and CAMHS

School counselling is effective. It has been found to lead to significant reductions in students' psychological distress over the long-term, as well as significantly improve students' self-esteem compared to students who only received pastoral care.[54] Research from Place2Be suggests that 'every £1 invested in the service in 2016/17 results in benefits of £6.20 in terms of improved long-term outcomes.' [55]

"We have a counsellor but we can only afford to pay for one day a week"

- Assistant Headteacher, Secondary School, Derbyshire

How much would a counsellor in every school cost

There are 3,500 secondary schools in England teaching around 3.5 million students.[56]

It would cost around £40,000 to employ a counsellor full time in a school during term time including on costs.[57] A full time counsellor doing 4.5 sessions a day in term time would be able to run 830 sessions. Assuming each student who needs it has 5 sessions this would mean they could see 166 students over the year.

The average size of a secondary school is 965 students.[58]

The prevalence of mental health disorders in students is 16%, which for an average school would be 153 students.[59] Therefore a full time counsellor for an average school would be sufficient.

However, there will be schools that are smaller and larger. In order to maximise flexibility, we recommend the most straightforward way of funding additional counsellor support would be to introduce a ring fenced '**Counsellor Guarantee**' of £40 per student in secondary - in other words, around £40,000 for the average size secondary school, sufficient to fund a full time counsellor. On this basis, such a guarantee would cost £140 million a year.

The total funding allocated to schools in England was £47.6 billion in the year 2020/21.[60]

However, hiring more counsellors is not a panacea. For school counsellors to have the biggest possible impact on a students' mental health and wellbeing, they must be embedded in a school with a trained Designated Senior Lead for Mental Health who can facilitate referrals and guard their independence.

Further, we recognise that there are different types of counselling and therapeutic services that work better for different students - for example, art therapy or play therapy can be particularly useful for younger students. Therefore, our vision for the 'Counsellor Guarantee' is that it would be implemented flexibly, giving schools the opportunity to spend it on whatever form of counselling or therapeutic service is deemed appropriate in the context of their school.

Case Study: the role of Place2Be at Reach Academy

At Reach Academy, our 4-day Place2Be model allows us access to an in-school counselling provision from Year 1 upwards. We average 5 counsellors plus the School Project Manager, allowing for a significant number of students to be in session during each term. All students in school have access to the Place2Be services in the form of regular weekly counselling sessions (if deemed appropriate following assessment) or accessing the service on an ad hoc basis in Place2Talk. The service includes:

- One-to-one counselling for students who are struggling
- Short appointments to talk about worries, booked by students
- Group work about friendship, self-esteem and other issues
- Training for school leaders and staff to make schools more mentally healthy
- Consultations for school staff about behaviour and wellbeing
- Advice and support for parents to help them look after their child

As a school, we recognise that significant mental health problems can and do occur in children, and due to the nature of the students in our school community, many of our students have faced adversity and trauma. By having Place2Be on site and integrated into our school, it allows a continual responsiveness to the school's needs and for those most vulnerable students, it allows them the opportunity to overcome these challenges.

Being fully integrated and embedded, Place2Be is effective in enabling consistent support for our students. Due to the strong relationships we have with the families in our school community, this allows for robust early intervention. A whole school approach, with Place2Be and the families we support working collaboratively, ultimately gives the best therapeutic outcomes for the students.

Our Place2Be Place2Think service provides support for teachers and staff, fosters and develops a deeper understanding of working with mental health. It is this reflective practice where Place2Be supports teachers to widen their understanding around ways of working with individual students, or groups who present with particular challenges, therefore enabling these students to access their education and achieve their academic potential despite the difficulties they may face.

RECOMMENDATION:

A new apprenticeship trailblazer route to increase the diversity of school counsellors

Counsellors who reflect the diversity of the student body can help break down the stigma of accessing mental health support

Even with a counsellor in every school, there will still be students from diverse communities in which stigma or cultural differences could act as a barrier to accessing support.[61] Recruiting more school counsellors from the surrounding areas, who reflect the diversity and culture of the local community, would help overcome this issue.

However, becoming a school counsellor is a relatively long and self-financed endeavour.[62] This puts a significant cost on the individual and has resulted in systemic privilege limiting the diversity of the workforce. According to a member survey of the British Association for Counselling and Psychotherapy, 84% of counsellors are female, the average age is 53, and the average counsellor works 12-13 hour per week and earns less than £10,000 per year. However, the average counsellor also falls into the survey's 'affluent achiever' bracket* - the difference between the average income and expenditure suggests that on average counsellors are not the household breadwinner.[63]

The apprenticeship levy pot, which many MATs pay into due to their size, and which all schools can access to receive funding for recruiting apprentices, is often under-used across the sector.[64] Part of this is due to a lack of education focused apprenticeship routes.

Given the likely increase in demand for school counsellors if the government 'Counsellor Guarantee' is put in place, combined with the desire for more diversity, we believe a pragmatic solution would be to create a new apprenticeship standard focused on school counselling. This would reduce the burden on individuals for whom the upfront training cost is a barrier and crucially not require additional funding from government but rather better utilise the apprenticeship levy already available to schools. The new standard which would need to be approved by the Institute for Apprenticeships and Technical Education should be equivalent to the current requirements embedded in the Level 3 and 4 counselling diplomas that need to be followed now.** We envisage that each school that trains a school counsellor through this new apprenticeship route would draw down £6,000 over two years, similar to the apprenticeship for Children, Young People and Families Practitioner.***

* Defined in this survey as having a detached house, luxury car, buys wine and books on the internet and has an iPhone.
** Training to become a counsellor or psychotherapist (bacp.co.uk)
*** Children, young people and families practitioner / Institute for Apprenticeships and Technical Education

CONCLUSION

It is clear that schools need more resources to properly address the growing mental health crisis amongst young people, which has only been exacerbated by the Covid-19 pandemic. Our research shows that schools want to play their role in supporting students' mental health but lack the time and resources to move from "firefighting" to a more proactive approach.

The recommendations in this report will go a long way to helping schools improve the mental health of their students, however, we recognise that many of the factors influencing young people's mental health is outside of schools' control. There is therefore a need for more community-wide thinking - bringing parents, young people, social workers, schools, local authorities, mental health services, and others across communities together to consider the factors impacting mental health across all parts of a young person's life.

Furthermore, there is a need for more evidence about what techniques work to support young people's mental health – both in schools and externally. For example, what types of therapeutic services should schools employ? How impactful are different mindfulness techniques? What helps young people build resilience? How effective are CAMHS interventions? More evidence on the outcomes of different interventions will help ensure our efforts to improve the mental health of our young people are as impactful and effective as possible.

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