Department for Education

Supporting Mental Health in Schools and Colleges

Qualitative case studies

Final report - August 2017

Clarissa White, Jo Lea, Jen Gibb and Cathy Street – NCB Research and Policy Team

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Contents

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Steering group membership:
Matthew Bawden: Assistant Headteacher overseeing Student and Staff Wellbeing and Skills for Life at Queen Elizabeth's Grammar School Derbyshire
Nick Brook: National Association of Head Teachers (NAHT)
Alice Chicken: Department for Education - Character PSHE and Citizenship
Anna Cole: Association of School and College Leaders (ASCL)
Helen Duncan: Public Health England (PHE)
Eva Elks: Department for Education - Alternative provision and exclusions team
Dr Mina Fazel: University of Oxford
Prof. Alissa Goodman: Institute of Education, UCL
Nick Haisman-Smith: Family links
Tom Harrison: Jubilee Center for Character and Virtues, University of Birmingham
Andre Imich: Department for Education – Special educational needs policy team
Kathy James: National Association of Head Teachers (NAHT)
David Lockwood: NHS England
Margaret Oates: NHS England
Kathryn Pugh: NHS England

Claire Robson: Public Health England (PHE)
Anne Spence: Department of Health
Angela Walker: Department of Health

Advisory member:
Liz Maudslay: Association of Colleges

Department for Education, project leadership:
Ade Alao: Character division
Kristi Beak: Schools research team
Matthew Hopkinson: Children and young people's mental health team
Elizabeth Jones: Schools research team
Viv McCotter: Children and young people's mental health team
Catherine Newsome: Strategic analysis and research
Vicky Petrie: Strategic analysis and research
Paul Trenell: Strategic analysis and research
Jamie Weatherhead: Character division

NatCen Social Research:
Neil Smith, Lydia Marshall and Emily Tanner

Summary

This research was commissioned to provide learning about how schools and colleges are supporting the mental health needs of children and young people. It was commissioned by the Department for Education (DfE) as part of a programme of work to inform the focus of policy activity on mental health and character education in schools and colleges in England. The research was set against a backdrop of growing evidence demonstrating the positive impact of emotional wellbeing on the outcomes for children and young people.

Research approach (Chapter 1)

- The research formed part of a broader project which involved a mixed method approach, combining a survey and case studies of schools, colleges and PRUs. The survey was carried out to provide a representative profile of character education and mental health provision and an understanding of the issues that institutions face in delivering this (Marshall, Wishart, Dunatchik and Smith 2017)[1].
- Twenty-six case studies were carried out to build on the findings from the survey and to identify and share practice across the school and college sector. They were followed by a workshop at the DfE to consolidate the learning and recommendations from the research.
- This report presents the findings from the 15 case studies focusing on the provision of mental health. A complementary report presents the findings from the 11 case studies focusing on the provision of character education (White, Gibb, Lea and Street, 2017)[2].

What role and approach did schools take to support mental health? (Chapter 2)

- All case study settings reflected on the pivotal role schools and FE colleges played in supporting the mental health needs of children, but the priority they attached to this varied.
- The approaches adopted ranged from: promoting and developing wellbeing by creating an environment where children felt safe and happy; to identifying need; providing support; and referring to and delivering specialist therapeutic provision. The mental health provision on offer varied by size, type and phase of school.

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[1] Marshall, L; Wishart, R; Dunatchik, A and Smith, N. (2017) *Supporting Mental Health in Schools and Colleges: Quantitative survey.* London: DfE

[2] White, C; Gibb, J; Lea, J; and Street, C. (2017) *Developing Character Skills in Schools.* London: DfE

- Primary schools provided a nurturing environment to support the emotional wellbeing of children and develop emotional literacy. Their approach was more preventative in focus and aimed to involve and build a relationship with the family. They viewed the provision of support as equally important to their teaching role; to ensure children were able to attend and ready to be taught.
- The approach adopted by secondary schools and FE colleges was driven more by the need to enable students to achieve academically. They focused on raising awareness and reducing stigma through a variety of events and activities. Secondary schools and FE colleges understood the importance of engaging families although this was harder to facilitate because of the more limited contact they had with parents.
- Special schools and PRUs tailored their responses to the needs of the student and provided the most extensive range of provision. Supporting mental health and promoting wellbeing was integral to their role as an educator. They believed engaging with families was important to support the needs of the child fully.

How did schools promote good mental health? (Chapter 3)

- Schools and FE colleges created a whole organisational culture that would help to normalise attitudes and promote positive mental health. This was intended to raise awareness of mental health issues and show children and young people how to support their own mental health and wellbeing to develop emotional literacy.
- Having a pastoral support team with clearly defined roles and responsibilities, as well as encouraging staff to be responsible for promoting good mental health, was critical to developing a whole organisational approach.
- Embedding the discussion of mental health across the curriculum and specifically during Personal Social and Health Education (PSHE), or similar, had helped to promote good mental health. School assemblies and form/tutor time were used to share information and promote an open environment for discussion about mental health. Organisational structures including a supportive house system helped staff to build relationships with students. Information about mental health and the support that was available were provided on websites, in newsletters and on displays throughout settings.

How needs were identified and assessed? (Chapter 4)

- Children and young people were identified as having a potential mental health need in three ways: through staff or other mental health professionals; during the admissions or inductions process; or through children referring themselves, or through their friends or parents doing this on their behalf. All settings relied on staff

observing and identifying any problems children were having. Primary schools were also reliant on parents disclosing any mental health problems while secondary schools and FE colleges relied on students to disclose a problem.

- The assessment process, in case study schools, involved the child, their parents, staff and any other professionals who were already working with the child. Assessments resulted in three main outcomes: observing and monitoring the child; advice and signposting to other services for the children and parents; or either providing support or making a referral to specialist provision.
- Children arrived at special schools and PRUs with a range of previously identified needs which often included mental health issues. They had formal procedures in place for reviewing and managing these previously identified needs; identifying additional needs and carrying out further assessments.

How did schools and colleges support mental health? (Chapter 5 and 6)

- Schools and colleges supported all children through teaching meditation and relaxation techniques; incorporating physical activity at key points during the day; and implementing initiatives and programmes designed by external organisations to support mental health.
- Counselling was available for students in both schools and colleges. Peer mentoring and buddying schemes were also used to support children, especially for those suffering from anxiety. Other targeted support included anger management and self-harm sessions; support groups; and a range of interventions including art, play, music and Lego therapy. Parents were involved either in relation to the support provided for their child, or through their own parenting needs, and sometimes both.
- Having a dedicated space was pivotal to supporting mental health in schools and colleges. These spaces were often calming environments used for children and young people to have a break from the classroom.
- All case study settings made referrals to NHS Children and Young People Mental Health Services (NHS CYPMHS) for more specialist clinical provision. Waiting lists and increasing thresholds resulted in long delays accessing these services. Having a named contact and/or regular contact with a person at NHS CYPMHS helped to build relationships, ease the pressure on the referrals process and to provide specialist support and guidance for settings.
- Schools and FE colleges reported three main challenges supporting the mental health needs of their students. Firstly, coping with the increasing numbers of children presenting with complex needs. Secondly, a lack of time and staff

capacity to create the whole organisational culture, to identify needs, to support students alongside teaching commitments and provide enough counselling and therapy. Finally, engaging young people, who either did not acknowledge they had a problem, or were reluctant to seek or receive help. Parents might also deter children where they were concerned about the stigma of mental health and the repercussions for their children.

What is key to success for mental health provision? (Chapter 7 and 8)

- Successful mental health provision depends on creating a whole organisational vision and approach to supporting mental health. It needs to be driven forward by a senior lead, along with the support of governors, or an executive board.
- The relationship between support staff and young people is crucial to build their trust and work effectively together. Staff need to be trained about mental health and to appreciate the benefits of supporting young people. They need access to a diverse range of evidence informed activities and interventions which can be tailored to the needs of students.
- The government and wider sector could helpfully support schools and colleges by providing: more resources and tools, more training, more funding for specialist services, a directory of local services, a range of tools and activities that have been proven to work, as well as advice about how to monitor and assess progress on these.

1. Introduction

NatCen Social Research (NatCen) and the National Children's Bureau (NCB) Research and Policy Team were contracted by the Department for Education (DfE) to carry out research investigating mental health and character education provision in schools and colleges in England. This research was commissioned in response to growing evidence demonstrating the positive impact of emotional wellbeing on the outcomes for children and young people. It is part of a programme of work being carried out by the DfE to inform the focus of further policy activity on mental health and character development.

The research involved a mixed method approach combining a survey and case studies of schools, colleges and other educational institutions. The survey was carried out to provide a representative profile of character education and mental health provision and an understanding of the issues that institutions face in delivering this (Marshall, Wishart, Dunatchik and Smith 2017)[3]. Twenty-six case studies were carried out to extend the findings from the survey and to identify and share practice across the school and college sector. They were followed by a workshop at the DfE to consolidate the learning and recommendations from the research. The qualitative research was carried out between May 2016 and February 2017.

This report presents the findings from the 15 case studies focusing on the provision of mental health. A complementary report presents the findings from the 11 case studies focusing on the provision of character education (White, Gibb, Lea and Street, 2017)[4].

1.1 The policy and research context for mental health

Mental health problems cause distress to individuals and all those who care for them[5]. Overall, it is estimated that one in ten children and young people have a diagnosable mental disorder – the equivalent of three pupils in every classroom across the country[6]. In 2016, over a quarter of a million children and young people in England were in contact with mental health care services[7]. Yet it is estimated that less than 25% of children with a diagnosable mental health condition access medical support.

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[3] Marshall, L; Wishart, R; Dunatchik, A and Smith, N. (2017) *Supporting Mental Health in Schools and Colleges: Quantitative survey.* London: DfE
[4] White, C; Gibb, J; Lea, J; and Street, C. (2017) *Developing Character Skills in Schools.* London: DfE
[5] Department of Health and NHS England (2015) Future in mind - Promoting, protecting and improving our children and young people's mental health and wellbeing London: DoH and NHS England.
[6] Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. (2004) *Mental health of children and young people in Great Britain*, Basingstoke: Palgrave Macmillan.
[7] NHS Digital (2017) Mental Health Services Monthly Statistics, Final November, Provisional December 2016.

Concerns about the increasing prevalence of mental health problems among children and young people, and the adequacy of mental health services to meet these needs, have dominated the mental health policy context in recent years. *Future in Mind,* the NHS England and Department of Health 2015 report of the Children and Young People's Mental Health and Wellbeing Taskforce, is a key document driving the current mental health agenda to improve mental health services for children and young people[8]. The report underpins the *Five Year Forward View for Mental Health*[9] and highlights three overarching principles:

- **promotion** of good mental wellbeing and resilience by supporting children, young people and families to develop appropriate behaviours that support good mental health;
- **prevention** of mental health problems; and
- **early identification** of need so that children and young people are supported as soon as possible to try and prevent more serious problems developing.

Future in Mind emphasises the important role of universal services in mental health promotion, prevention and early intervention, with identified services including schools, school health services and colleges. It references schools developing whole organisational approaches, noting evidence that shows these have a positive impact on both physical and mental wellbeing outcomes. In concluding the section on schools, the Children and Young People's Mental Health and Wellbeing Taskforce encourages all schools to continue to develop whole organisational approaches, noting that this could build on the Department for Education's work on character building, Personal, Social and Health Education (PSHE) and counselling services in schools.

In response to *Future in Mind*, in 2015 the government made a number of policy announcements and financial commitments. These included an additional £1.4 billion to be invested in improving children and young people's mental health and eating disorder services over a five-year period. It also provided updated guidance for schools[10], which emphasised the role of schools in supporting pupils to be resilient and mentally healthy. The Mental Health and Schools Link Pilots were also launched and funded by DfE and NHS England to improve joined-up working between schools and health services. They were building on *Future in Mind's* proposal for every school to have a named mental health lead or contact point.

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[8] DH and NHS England (2015) *Future in mind. Promoting, protecting and improving our children and young people's mental health and wellbeing* NHS England Publication Gateway Ref No 02939 www.gov.uk/uploads.file/ChildreninMind

[9] NHS England (2016) *The Five Year Forward View for Mental Health* A report from the independent Mental Health Taskforce to the NHS in England https://www.england.nhs.uk/2016/02

[10] DfE (2016) *Mental health and behaviour in schools*. Ref: DFE-00435-2014 www.gov.uk

The Prime Minister's speech in January 2017 emphasised the importance of children and young people's mental health and wellbeing; and the key role of education settings in carrying out preventative work, early identification, providing support and where needed, signposting to specialist mental health provision. Announcing a Green Paper to be jointly developed by the Department of Health (DH) and Department for Education (DfE), the speech also noted there would be a thematic review of NHS Children and Young People's Mental Health Services (NHS CYPMHS)[11] by the Care Quality Commission (CQC). With specific relevance to schools, it was also announced that:

- Mental Health First Aid training would be made available to all secondary schools in England, with an aim of having at least one teacher in every secondary school trained by 2019.
- The Single Point of Contact pilot programme would be extended to take in 1200 more schools from 20 additional Clinical Commissioning Groups (CCGs).
- Pilot peer support programmes would be extended across a variety of educational settings.
- A programme of Randomized Controlled Trials (RCTs) would be launched to build the evidence base for mental health preventative activities in schools.

1.2 Research aims

The research was commissioned as a single project focusing on character education and mental health provision. The combined aims of the qualitative research were to amplify and extend the understanding of the survey findings and illustrate the range of activities used to deliver character education, and the support for mental health provided in schools and FE colleges. Specifically, the case studies and subsequent workshop aimed to:

- Provide in-depth understanding of the way schools, FE colleges and Pupil Referral Units provide character education (CE) and support the mental health (MH) and wellbeing of pupils.
- Understand what underpins judgements and decisions about identifying and assessing need; the range of provision offered; who provides it; how it is integrated into school or college programmes; and how it is funded and delivered.

[11] Mental health provision for children and young people in England is provided under the umbrella of Children and Young People's Mental Health Services (CYPMHS). The CYPMHS framework incorporates all professionals working with children and young people, from universal provision through to specialist inpatient and outpatient services. The services that are funded by the NHS are known as NHS CYPMHS. These are services that were previously (and still are in many areas of the country) called NHS CAMHS.

- Learn about what works best in terms of practice and delivery for universal or targeted approaches; and the range of staff needed to deliver this.
- Understand the facilitators and barriers for delivering character education and mental health support.
- Identify examples of specific activities which schools and colleges have found effective in supporting mental health and developing character.

1.3 Research approach

The qualitative research used a case study design comprising 26 case studies. Of these 15 were focused on mental health and 11 on character education.

The case study sample was designed to focus on mainstream primary and secondary schools that were more actively engaged in provision for mental health and character development (Table 1). FE colleges were only included in the mental health sample. Five special schools and five Pupil Referral Units (PRUs) were added to the sample to provide transferable learning about more specialist practice. For this reason special schools were selected with a focus on social, emotional and mental health (SEMH) and communication and interaction needs. The full sample was selected from the survey findings based on high levels of reported activity for mental health provision and character education.

Table 1: Case Study Sample

Educational institution	MH case study	CE case study	Total
Primary LA maintained	2	1	**3**
Primary academies	1	1	**2**
Secondary LA maintained	1	1	**2**
Secondary academies	2	2	**4**
Independent schools	1	2	**3**
FE Colleges	2		**2**
Special schools – primary	1	1	**2**
Special schools – secondary	2	1	**3**
PRUs – primary	1	1	**2**
PRUs – secondary	2	1	**3**
Total	**15**	**11**	**26**

Quotas were set to ensure the inclusion of settings reporting:

- A wide range of activities to develop character and support mental health
- Experience of specific challenges and barriers to delivering their practice
- A range of training for all, or specific, staff to support mental health, or deliver character education.

The remainder of the report focuses on the mental health case study design and findings.

1.3.1 Mental health case studies

The 15 two-day case study visits to each school or FE college were carried out between October and early December 2016. They were designed to explore how schools or FE colleges were supporting the mental health needs of children and young people. During each visit up to 12 interviews were carried out with key staff and health professionals involved in their mental health provision (Table 2).

Table 2: Mental health case study participants

Mental health case study participants
• Senior staff: governors, headteachers/deputy and assistant heads and other senior managers • Curriculum and Group leads: Director of Learning Services, Head of House, Head of Year • General and specific teaching staff (including Personal Tutors) • Pastoral and wellbeing staff (including safeguarding leads, student support and engagement officers, coordinator for outreach provision) • Counsellors, psychologists and therapists (including NHS CAMHS workers) • Learning support: SENCO, educational psychologist, coaches, mentors, education adviser, inclusion team adviser • Programme coordinators or leads for a range of programmes including: Mindfulness, Nurture Group, ASDAN, Thrive, and Forest School • Wider support staff: family support workers and key workers

The 15 mental health case studies were selected from eight predominantly urban regions across England. Seven of them were located in economically deprived areas, measured by the percentage of students provided with free school meals.

All interviews were based on topic guides which outlined the main issues that were to be addressed and the coverage was tailored according to the role and experience of the participant. A copy of the topic guide used with the lead person for mental health can be seen in Appendix A and a list of the main topics covered during interviews is in Table 3. Interviews with the lead person for mental health lasted up to two hours and all other interviews were around 60 minutes in duration.

Table 3: Mental Health Topics

Mental Health Topics
• Policy and goals for supporting mental health • Developing and funding mental health provision • The range of mental health provision offered to children, young people and parents • How mental health is integrated in the curriculum • Training, supporting and supervising staff to support mental health • What works for identifying and assessing need and supporting mental health • Facilitators and challenges encountered in developing their approach and support for mental health • Changing or developing the approach to supporting mental health

1.3.2 Workshop

In January 2017, participants from all case study sites were invited to take part in a half day workshop hosted by the DfE and facilitated by the research team. This provided the opportunity to share the research findings with participants, discuss the recommendations and consider how key areas of practice could be adapted for mainstream school provision. The workshop findings were incorporated into the analysis and reporting of the case studies.

1.3.3 Analysis

The case study interviews and workshop were recorded, transcribed and then analysed using the Framework approach. This involved summarising the views and experiences of participants in a series of *Excel* worksheets which focused on the research themes. This process ensured that the findings were based on, and could be traced back to, the accounts of participants. It also made it easier to draw comparisons across different types of educational institution.

In the reporting of findings, special schools and PRUs have been grouped together as their approaches and provision were broadly similar. This allowed this group of settings, who provided more specialist support, to be compared with mainstream primary, mainstream secondary and FE colleges.

1.4 Report coverage

The findings have been organised under the key research questions that we set out to address. The remainder of this report is divided into seven chapters:

- Chapter 2 – Developing an approach for mental health - explores how schools and colleges viewed their role and responsibility in supporting the mental health needs of children in their care.
- Chapter 3 – Promoting good mental health - describes the way in which case study schools and FE colleges promoted good mental health.
- Chapter 4 – Identifying and assessing need - describes the approaches adopted by schools and colleges to identify and assess need.
- Chapter 5 – Supporting mental health – describes the activities schools and FE colleges employed to support needs, refer to and deliver specialist therapeutic provision.
- Chapter 6 – Delivery challenges – considers the main barriers and challenges that schools and colleges encountered supporting the mental health needs of children and young people.
- Chapter 7 – Key learning – reflects on what participants perceived was key to identifying and supporting mental health in schools and colleges, and the nature of the support they would value from the government and the wider sector.
- In the final chapter 8 – Conclusions – we draw together some of the key messages arising from the case studies and workshop and consider some of the specific recommendations for the sector.

Quotations and case examples have been used from across the sample to illustrate and substantiate the findings. The purposive nature of the case study sample means that it is not appropriate to draw any conclusions about the prevalence of the findings. For this reason the main survey findings have been integrated in the report to help set the case study evidence in context. In order to preserve participants' anonymity, case examples have not been identified in the report and quotations are labelled only with the type of school in which the participant was based.

2. The role and approach to mental health

This chapter explores how staff in schools and colleges understood their role and developed their approach to support the mental health of children in their care. It is based on the 15 case study schools and FE colleges that were selected because of their high level of reported activity for mental health provision. It considers how schools and colleges viewed and explained their role and responsibility for supporting mental health (Section 2.1); their views about whether there was a need for a specific policy for mental health (Section 2.2); how they developed their approach (Section 2.3); and how they staffed and funded their provision (Sections 2.4 and 2.5). The chapter concentrates on the findings from the mainstream schools and FE colleges and draws comparisons with special schools and PRUs to provide transferable learning about more specialist practice.

Summary of key points

- The case study schools and FE colleges typically believed they had a pivotal role and moral responsibility to support the mental health needs of children. This role encompassed raising awareness and understanding about mental health; promoting good mental health; identifying and assessing needs; providing support and referring to specialist provision.
- Wellbeing and mental health was included in a variety of relevant policies, such as safeguarding, behaviour or special educational needs (SEN) and inclusion policies, or they had developed a broader health and wellbeing policy.
- The approaches adopted ranged from promoting and developing wellbeing, by creating an environment where children felt safe and happy, to referring to and delivering specialist therapeutic provision. The mental health provision on offer varied by the size, type and phase of the school.
- **Mainstream primary schools** provided a nurturing environment to support the emotional wellbeing of children to ensure children were able to attend class and be taught. The approach was dependent on staff building relationships with the children and engaging families to ensure a holistic approach to the support.
- **Mainstream secondary schools and FE colleges** were generally providing mental health support to help students achieve academically. The focus of the support was on raising awareness and reducing stigma through a variety of events and activities. Secondary schools and FE colleges understood the importance of engaging families, although this was challenging at times due to the reduced face-to-face contact with parents that primary schools experienced.
- **Special schools and PRUs** were flexible in their approach and tailored their responses to the needs of the student and provided the most extensive range of provision. Supporting mental health and promoting wellbeing was integral to their

roles as educators. Staff believed engaging with families was important to support the needs of the child fully.

- A number of defining features influenced the approach adopted and the ease with which schools or colleges were able to develop their mental health provision. These included the size of the school; the length of time a student was in a setting; the age of children; the catchment area; leadership; levels of demand for mental health support; and access to external support.
- Mainstream schools and colleges tended to fund their provision through money obtained from the local authority. Supporting mental health was prioritised as an area that needed additional funding. Not all schools were able to access the same level of funding to support mental health.

2.1 Role and responsibility for mental health

Participants in all the case study settings reflected on the pivotal role they played supporting the mental health needs of children. Echoing a key theme in the research and policy literature, schools are in a unique position because of the time children spend in their care, and the opportunities this affords them to build relationships, and offer support to both children and their families[12]. While these schools and colleges were selected to be a case study because of their higher levels of activity; the survey findings (Marshall *et al.* 2017) suggest that actually most institutions viewed mental health as a high priority; as only 6% of institutions identified 'a lack of priority' as being a barrier to mental health provision.

> *"I think mental health, as part of a wellbeing agenda, is a vital part of school's activity. In order for students to thrive supporting good mental health and not just the sort of picking up the problems, but promoting good mental health from the outset is really important. I think it should be quite high on schools' agendas."*
>
> (Secondary academy)

Staff at mainstream case study schools and colleges felt they needed to raise awareness, increase understanding and promote good mental health. Beyond this they viewed their role as identifying and assessing needs; providing low level support for issues, such as bullying, that impact directly on the mental health of children; and more

[12] DH and NHS England (2015) *Future in mind. Promoting, protecting and improving our children and young people's mental health and wellbeing* NHS England Publication Gateway Ref No 02939 www.gov.uk/uploads.file/ChildreninMind

tailored support being provided either by specific individuals in the school or from external agencies.

> *"It's almost like a triage, in a way. What do we need to hand on? What can we deal with in-house? What skill set have we got? At some point we've got to say that is the top of our skill set and we can't do any more than that. This has to go to GP; this has to go to CAMHS."*
>
> (LA maintained secondary)

In contrast special schools and PRUs saw their role as doing all of the above but also to provide more in the way of tailored specialist provision.

2.1.1 Drivers for supporting mental health

Both schools and colleges described how supporting the mental health of children was part of their **role to safeguard children**. They had a responsibility to promote and protect the welfare of students which included mental health. This aspect of their role stemmed from what was sometimes described as a 'duty of care' for the children and young people they were educating. Supporting mental health was viewed in the same way as supporting other additional needs.

> *"One of our priorities is to ensure that no student in the college is disadvantaged and to make sure that our students who declare, whether it be mental health, dyslexia, autism, that they have the right support so they can achieve their full potential."*
>
> (FE college)

Schools also believed they had a **moral responsibility** to support the mental health of children and that it would be negligent to ignore the mental health issues of children in their care. Participants argued schools need to normalise attitudes to mental health and create a supportive and safe culture. For this reason, staff and young people were encouraged to talk about their feelings and any problems they have; thereby helping them to develop emotional literacy.

> *"It's about creating a culture of emotional literacy and where children feel safe to express how they're feeling or even safe to say if they don't want to express how they're feeling. A culture of them understanding what their rights are [and] that actually you have the right to share or not share but, equally, you have the rights to share in a way that doesn't infringe on other people's rights. It's having this open, free dialogue in every single classroom that is consistent and safe for them, where they can learn about themselves as a person. They can learn about their emotions, about how they're feeling, about the way they deal with their emotions and how they're feeling in a safe and secure environment that is non-judgmental."*
>
> (LA maintained primary)

The other main reason why schools and colleges viewed their role as pivotal was that they would struggle to **teach children** if their social and emotional needs were not being supported or addressed. It was pointed out that ultimately, *it is impossible to separate the education* [of children] *from* [their] *mental health*. If a child is unhappy then they are not going to take advantage of opportunities or be able to be taught effectively.

> *"Our primary purpose is to educate and… that is about academic learning, but many of our children come in, in no way ready to do academic learning because they need nurture. That takes three, four years for us to get our children ready to learn."*
>
> (LA maintained primary)

2.2 Views about the need for a mental health policy

Marshall *et al.* (2017) found the majority of institutions who took part in the survey had a plan or policy about supporting pupils with identified needs (87%) and promoting the mental health and wellbeing of all pupils (57%). However, it is not clear from the survey whether this was a specific mental health policy, or part of other broader policies. Only one case study school reported having a separate mental health policy in place. Instead wellbeing and mental health were included in a variety of relevant policies, such as safeguarding, behaviour or special educational needs (SEN) and inclusion policies, or they had developed a broader health and wellbeing policy. This may reflect the integral role that mental health played in schools.

The one school with a mental health policy based it around the practice and experience developed at the school. However, writing the policy had given staff an opportunity to reflect upon their practice, and develop a more preventative approach for students who had not reached a *crisis situation*; allowing them to be less reactive in their approach. They found it useful to refer to the document and to share it with students and parents.

> *"It keeps us on track…We're quite often thinking on our feet, so it's quite good to have 'this is what we do' when we are faced with certain situations."*
>
> (Independent secondary)

It appeared a mental health policy may be more useful for larger mainstream schools who have not yet developed their approach. Spending time writing a policy might help to focus the school's approach to supporting mental health; build awareness; and set out procedures and practice for staff. However, others, particularly those working in special schools or PRUs, questioned the value of having a specific mental health policy. They were concerned their practice was too complex and wide ranging to capture in a policy which would need to be updated on a regular basis to reflect changing practice. One Assistant Headteacher from a special school reflected that a document explaining a school's procedures might be more useful to develop rather than a specific policy.

2.3 Developing an approach for mental health

While all case study settings reflected on the pivotal role they played supporting the mental health needs of children, the priority they attached to this in their approach varied. The approaches ranged on a spectrum from promoting and developing wellbeing by creating an environment where children feel safe and happy; to identifying need; providing support; and referring to and delivering specialist therapeutic provision. The mental health provision on offer varied by the size, type and phase of the school. Since mental health problems can be influenced by the age of a child or young person or by the stage of their development, settings had to tailor their provision to meet the needs of their students. Figure 2.1, at the end of this section, summarises the different approaches described in the following sections.

2.3.1 Mainstream primary schools

Mainstream primary schools described developing an approach that would provide a **nurturing environment to support the emotional wellbeing** of children and develop emotional literacy. As a consequence, their approach was more preventative in focus and these settings strongly believed that by supporting the emotional wellbeing of children they would ensure children were ready to be taught. They saw their **role of providing support as of equal importance to their role as an educator**. Participants talked about the importance of striking the right balance for this age group in terms of support versus education. If time was spent nurturing a child at a young age then this would help to develop their resilience for the future.

The approach was often dependent on staff **building relationships with the children**. Having a strong relationship between the staff and the child was key to mainstream primary schools' approach as it enabled them to create more child centred approaches to support mental health. Linked closely with building a relationship with the child was building a relationship with their family. Primary schools emphasised the importance of **engaging families** to ensure a more holistic approach to their support. If families were more engaged in the support being provided to a child then they could help to reinforce the messages and approach at home and help to improve the outcomes for the child. Mainstream primary schools worked hard to make their schools welcoming and accessible for parents to help with this engagement.

Mainstream primary schools provided a variety of support but focused on **preventative approaches** to promote good mental health (see section 5.1).

2.3.2 Mainstream secondary schools and FE colleges

While mainstream secondary schools stressed the importance of developing an approach to support mental health; this appeared to be driven more by the need to

enable students to be taught and achieve academically. These sites often reflected on the pressure to achieve academic outcomes when discussing their approach to supporting mental health.

The focus of the support appeared to be more about **raising awareness and reducing stigma** and a variety of events and activities were organised to achieve this aim (see section 3.4). While mainstream secondary schools and FE colleges attempted to be preventative, they often ended up being more reactive in their approach. This was due to the limited time they spent with individual students and the fewer opportunities they had to build a close relationship with them compared with primary schools. FE colleges also described treating their students as young adults which meant their approach encouraged students to take more responsibility for proactively identifying and seeking support for their mental health needs.

Secondary schools had also noticed a rise in need for mental health support from children at a younger age. This change in need had resulted in secondary schools having to adapt their approach. Previously, secondary schools started their preventative approach once a child started in the school and generally the more targeted support was not needed until they were older. However, schools were faced with a greater number of children arriving at the school needing some form of targeted support.

Flexibility was an important feature of the approach taken, especially by FE colleges. For example, academic timetables were adapted to meet the needs of their students. This involved either being more flexible with deadlines for course work, or where possible reducing the content of timetables, or allowing students to complete a two year course over three years. Both secondary schools and FE colleges also adopted a flexible approach to respond appropriately to specific needs, for example, letting certain children leave the classroom unchallenged, if this helped to reduce anxiety.

Secondary schools and FE colleges understood the importance of engaging families. However, this was more challenging than for primary schools as they had less face-to-face contact with parents. There were fewer **opportunities to have an informal chat with parents** as they were less likely to be dropping off, or collecting their children from school or college. However, attempts were generally made to engage parents when support was being provided to a specific child.

2.3.3 Special schools and PRUs

Special schools and PRUs viewed their approach to **supporting mental health and promoting wellbeing as integral to their role as an educator**. Indeed, they viewed this as a precursor to engaging students in their education and described their role in relation to mental health as being of equal, or sometimes even greater importance than their responsibility for producing academic outcomes.

“We deliver a holistic provision....we don't separate the education, the health, the mental health, the sort of social-worker stuff…. We try and meet individual need. We of course have those arguments within the school. How much therapy do they get? If they're doing therapy, how much of their education are they missing? Need to balance the importance of mental health alongside everything else…. If they're not in a good mental state, they're not going to learn anyway so let's sort that bit out....because they'll never learn until we've got them in a good position to learn.”

(Secondary special school)

Understanding the physical and mental health needs of children in these settings was integral to understanding their barriers to learning. For this reason, their approach to mental health was embedded across everything they did and they often described a **whole organisational, whole staff approach;** with all staff having responsibility for supporting a child’s mental health.

"Our approach is 360 degrees to every child. So as part of that, there's the academic side, and bringing them on academically, but then the pastoral side... it's everybody's responsibility…. you will see how everybody comes together with that child at the centre."

(Secondary PRU)

Special schools and PRUs **tailored their approaches** to the needs and presenting issues of the children and young people in their care. Their approach was **flexible and as individualised as possible** to accommodate and be responsive to students with a wide range of presenting issues. These settings were working with children and young people who often had previous negative experiences of education, as a result of being excluded, or removing themselves from education, which often resulted in extensive barriers to learning. They described their approach as being a *fresh start every day* and stressed the importance of moving on from previous incidents, as this might otherwise undermine the confidence of young people, and cause them to disengage with their education.

These settings provided the **most extensive range of provision**, and often delivered it themselves or worked very closely alongside NHS CYPMHS professionals. They employed a wide range of therapeutic provision (see section 5.2). These settings believed **engaging families was important** to support the needs of the child fully. However, they sometimes found it hard to have meaningful discussions with families who were not supportive of their child’s education, or if a parent had their own mental health problems; or if the family saw a stigma attached to mental health problems. Special schools and PRUs often did not have the same contact with parents as children were often transported to and from home by school transport which reduced the face-to-face time with parents.

Figure 2.1 summarises the different approaches adopted by mainstream primary schools, mainstream secondary schools and FE colleges, and special schools and PRUs.

Figure 2.1: Approach to supporting mental health by different types of schools

Primary schools	Secondary/FE provision	Special schools and alternative provision
• To provide a nurturing environment to support the emotional wellbeing of children and focus on developing emotional literacy in all children • Support role equally as important as the educator role; emotional support ensures all children are ready to be taught • Staff building relationships with the child • A holistic child-centred approach that involves families where they will engage • Preventative approaches to promote good mental health.	• Greater focus on achieving academic outcomes (particularly secondary provision) • Supporting mental health needs so students can achieve academically and remain in education • Focus on raising awareness of mental health, reducing stigma and informing students how they can support their own mental health • A tendency to be more reactive in approach • Less likely to involve families (due to number of students and lack of resources) • Flexibility to tailor courses	• Dealing with mental health is as important, if not more so, than academic outcomes • Embedded in everything schools and staff do • Students may have extensive barriers to teaching • Understanding the physical and mental health needs is integral to understanding the barriers to teaching. • A flexible child-centred approach that is individually tailored to the needs of students • Involvement of families wherever feasible • Focus on targeted support and delivery of therapeutic interventions • Lack of time to support students (PRUs)

2.4 Underpinning influences

A number of defining features influenced the approach adopted and the ease with which schools or colleges were able to develop their mental health provision.

- **The size of the school** had a bearing on the staff-pupil ratio and the degree to which it was possible to support individual needs. Smaller settings, including smaller mainstream settings, found it easier to provide individualised support as a higher ratio of staff to children afforded them more time to understand and support the needs of individuals, and the barriers to teaching them.
- **Length of time in a setting:** The longer the time a student was at a setting, the greater the opportunity to understand and manage individual needs. Conversely, moving and changing schools frequently, which in itself could cause mental health

problems, restricted the speed and the time schools had to respond to any problems.

- **The age of children:** The younger the age group, the more preventative the focus and the more involvement of parents and families.
- **The location of the school:** The degree to which schools were part of their local community could make it easier to understand the needs of children and build relationships with families. The locality could also lead to greater pressure and demand for mental health support if, for example, the school was in an area of high deprivation.
- **The number of local authorities a school was drawing its students from**. Schools with a large catchment area straddling a number of local authorities were forced to operate across different local areas and CCGs, which could make referring to external provision more problematic. A deputy head in one school reflected on the challenges of having to work across eight local authorities.
- **Leadership:** An inspiring head or lead was important for developing an approach to mental health and for driving this agenda forward, as well as investing more time and resources in it. New staff were also reported to bring different ideas to settings which helped to develop the support on offer.
- **Level of demand:** Mainstream settings and colleges described having to develop and adapt their approach to meet an increasing number of students presenting with higher levels of need.

  "We have more and more young people presenting to us in crisis and at risk and we've got to be responsive. That has been a build-up really over the last couple of years. That's happening more and more regularly. So I think we need to be - we are responsive to that."

  (FE college)

- **Partnerships with NHS CYPMHS:** Having a NHS CYPMHS worker in the school, or a NHS CYPMHS school link worker based at NHS CYPMHS, or another similarly qualified mental health professional was influential in developing the approach.
- **A theoretical approach:** Settings that adopted an evidence based (e.g. Thrive and Philosophy4children) or theoretical approach (e.g. Maslow's Hierarchy of Needs, Social pedagogy theory and the Growth mindset) described how it had influenced the way they were working with children. In contrast settings that developed their approach in a more organic way learnt through trial and error what worked best to the meet the needs of their students.

  "Well it's based on the fact that we want the best from the students, but then to me it's trial and error. We've already got systems in place, we review our systems…

but if something isn't working then bin it and find something else. We're not experts so we have to try things and see if they work for us."

(LA maintained secondary)

2.5 Staffing

A range of professionals were involved in supporting the mental health of children and young people across the case study schools and FE colleges. There was a wider range of staff available to support students in special schools and PRUs. Marshall *et al.* (2017) found that nearly half (49%) of all institutions had a dedicated mental health lead. Among state maintained schools, secondary schools were more likely to have a mental health lead than primary schools (59% vs. 48%)

2.5.1 Mainstream primary, secondary schools and colleges

The size and composition of the pastoral or support teams varied across mainstream schools and colleges. There was always a strategic lead even if this was not a designated role as such; this was often a deputy or assistant head in secondary schools or headteacher in primary schools. Other staff involved in pastoral or support roles included designated safeguarding leads, SENCOs, personal tutors, student support managers, senior tutors or heads of year, learning support assistants, teaching assistants, learning mentors, family support workers and school health professionals.

As well as internal staff having responsibility for supporting mental health there was also a range of external staff commissioned from outside agencies. These included a counsellor, a school nurse and an educational psychologist.

Separating the support role from behaviour management was perceived to be vital for the wellbeing of students to be supported properly. It was said that behaviour management often required an immediate response whereas supporting mental health took longer; and when the roles were combined the supportive side could get neglected. The support role was seen as quite different and by having it separate helped to make the role more independent and encourage students to open up. Having two defined roles for behaviour and support also allowed staff to respond differently to the same situation. This was particularly helpful when having to manage behaviour but also offer support at the same time.

Box 2.1: Supporting student's mental health in college
This further education college recently redesigned their personal tutor system with students being assigned a progress tutor. Previously personal tutors were teaching staff who had the pastoral element added on to their role. This meant that some staff engaged more in providing this support while others did not engage fully, resulting in students not receiving the same level of support. To rectify this the college developed the role of progress tutors whose sole responsibility was to provide pastoral support to students. Now there is one team providing the support there is a consistent approach and the progress tutors have a team to discuss any issues with, resulting in higher quality support for the students.

Dividing the workload amongst staff worked well, although staff commented on the need to have one person with a strategic overview of the support the setting provided. The value of more staff being involved in providing support ensured greater levels of support for children and continuity of provision when individual members of staff were absent. It also helped to embed practice across settings and encouraged more staff to take on the supportive role.

2.5.2 Special schools and PRUs

As in mainstream schools, there was often a strategic lead, either a headteacher or deputy, who had a designated responsibility for mental health and was a driving force for delivering support. Staffing levels reflected the high level of need in special schools and PRUs. Unlike mainstream schools, special schools and PRUs typically employed a range of health professionals to support their students. These included play and art therapists, psychologists and counsellors and other mental health professionals, or those who were very experienced in supporting young people with mental health needs. Therefore, all staff, even more so than in mainstream schools, had a responsibility to support mental health.

> *"All our children do have a statement or EHCP saying that they have social, emotional and mental health needs. That needs to be threaded through everything that we do. It needs to be on everyone's agenda. Everyone needs to support that child."*
>
> (Primary special school)

Due to the number of students with mental health needs in these settings the separation of the behavioural role and support role was less of an issue than in mainstream schools. The roles and responsibilities that were shared between a few in mainstream schools were more widely taken up by all staff in special schools and PRUs. For example,

monitoring the progress of a child's mental health after a specific intervention was invariably carried out by teachers, pastoral staff or therapists, either based in special schools and PRUs, or via NHS CYPMHS; but in mainstream schools this role was undertaken more by pastoral, or external health professionals including NHS CYPMHS.

2.6 Funding

Mainstream local authority maintained schools tended to fund their provision through the money obtained from the local authority. There were examples of schools using pupil premium to fund their school's mental health support, but not all of the mainstream settings had access to such funding. These schools wanted to expand their mental health support but had conflicting and competing demands on their budgets. They were faced with using a set budget to support academic and special educational needs as well as supporting mental health. However, some mainstream schools and colleges prioritised spending their budgets on mental health support as they felt they had no other option.

> *"Because now I certainly am looking at, right, okay, so this child needs art therapy but that might mean a dyslexic child is not getting the dyslexic support that they need because that pot has got to cover those two different areas now and I'm stretching it even thinner."*
>
> (LA maintained primary)

Funding in mainstream schools and colleges was also obtained from various initiatives set up to support mental health in schools. These included Thrive Hub schools, Extra Life, and being part of the Mental Health Services and Schools Link pilots (Day *et al.* 2017[13]). Schools and colleges accessed funding through bids to local and national businesses, grants and trusts but this was often to pay for a specific tangible item such as building a new wellness centre, or developing nurture provision and creating a wellbeing garden. Schools also received goods in kind such as resources for a wellness library, pets and a mindfulness garden.

In all settings, local charities and practitioners, such as newly qualified counsellors needing to build up their contact hours, provided some interventions either for free or at a low cost. These interventions included mentoring and counselling and could be as a trial for a new intervention. However, there were concerns about the appropriateness of using this type of support. A setting might agree to an intervention being provided because it was free but then realise it was unsuitable for its students. Schools were fearful of taking

[13] Day, L; Blades, R; Spence, C; and Ronicle, J. (2017), *Mental Health Services and Schools Link Pilots:Evaluation report*, London: DfE

up all the offers of free, or low cost support in case they were unable to manage the support appropriately. There were concerns about the sustainability of using such interventions. If a charity or practitioner provided free or low cost support to the school for a trial period, there was uncertainty whether the school could sustain the funding for the intervention in the future.

> *"A lot of the things that we do come in pockets of money or a pilot, so you can have it for free. It doesn't make it sustainable and the difficulty is finding that sustainable model, especially when you have something that works and then having to think about, well, it's free this year, but next year it's not going to be, so how am I going to account for that money next year when my budget is getting smaller and smaller every year?"*
>
> (LA maintained secondary)

A lack of funding and pressure on resources to fund activities was a common concern across all case study settings. The challenges for high achieving schools appeared to be slightly different as they felt it was harder to generate funds to address the needs of their pupils who were achieving academically. They received very low levels of pupil premium funding because they did not have pupils with special educational needs, although there were other issues affecting their progress. They reported that, despite a perception that they did not have any mental health issues in their school, there were more 'hidden' levels of anxiety and eating disorders associated with the pressures and stress that these high achieving students experienced.

Special schools and PRUs had access to a wider range of funding streams to support their mental health provision. Being smaller with more tailored provision and being able to focus slightly less on the academic outcomes for their students enabled special schools and PRUs to use their income flexibly, compared with the way budgets were controlled in mainstream provision. This finding was echoed by Marshall *et al.* (2017) research which reported 60% of alternative providers and 47% of special schools said a lack of funding was a barrier to supporting mental health, compared with 77% of state maintained schools.

> *"I think we can be a bit more fluid with our spending. It's not so tight. We don't departmentally control budgets quite the same way as many secondary schools do: here's your geography department, you've got £1,500 for this year. We're a bit more fluid than that. If someone comes up and says, 'Fred needs something', if the need is there we'll find the money, within reason."*
>
> (Secondary special school)

There were concerns reported about special schools and PRUs accessing pupil premium funds. If a student was joining the setting mid-way through the academic year, or had a shared placement with a mainstream school, then the special school or PRU reported they rarely received any of the pupil premium.

3. Promoting good mental health

This chapter describes the way in which case study schools and FE colleges adopted a whole organisational approach to promote good mental health. Depending on the type and phase of institution, settings achieved this through:

- creating a supportive culture (section 3.1);
- by raising awareness and understanding through team structures and the role of staff (section 3.2);
- embedding the discussion of mental health through the curriculum (section 3.3) and the day-to-day activities (section 3.4)
- creating a community where staff and students can come together in smaller groups (section 3.5); and
- providing information and promotional activities for children, parents and families (section 3.6).

These six areas are interconnected in terms of how the whole organisational approach was created and were crucial to the promotion of good mental health.

Marshall *et al.* (2017) reported most institutions built a culture and ethos that promoted mutual care and concern to support positive mental health among their pupils (92%). Alongside the provision of information the survey identified the most common types of activities used to promote positive mental health included skills sessions such as coping skills or mindfulness (73%), worry boxes or drop-ins for advice or signposting (68%) and support programmes for specific groups of pupils, such as cared for, or adopted children, LGBTQ pupils or victims of bullying (70%).

Summary of key points

- Schools and FE colleges created a whole organisational culture that would help to normalise attitudes to mental health; promote positive mental health; raise awareness of mental health issues; show children and young people how to support their own mental health; and support the development of emotional literacy.
- Having a whole team structure with clearly defined roles and responsibilities as well as encouraging staff to be responsible for promoting good mental health was critical to developing a whole organisational approach.
- Embedding the discussion of mental health across the curriculum and specifically during PSHE and SMSC lessons, or similar, was another vehicle used across all settings to promote good mental health. These provided opportunities to signpost children to sources of advice and guidance and to offer an open space where children could talk about their feelings and concerns.

- School assemblies and form/tutor time were also used to share information about mental health, to normalise and promote an open environment for discussion about mental health and to share potential sources of support. There was flexibility in the way the time could be used which enabled settings to tailor it to address pertinent issues that emerged.
- Case study sites also promoted good mental health by creating a community through organisational structures. A supportive house system was used to help staff build relationships with students. Meal times, in some settings, were seen as an important time for staff to spend with children. Eating together helped to create a family atmosphere, and encouraged children to talk about their concerns and created a feeling of belonging.
- Schools and FE colleges used a variety of means to share information with students. These included having information readily available about mental health and the support that was available on the school website, in newsletters and on displays throughout the setting. Schools and colleges participated in national activities focusing on mental health, for example World Mental Health Day to raise awareness, provide information, signpost students to support organisations, and reduce stigma attached to mental health.

3.1 Creating a supportive culture

Case study schools and FE colleges promoted positive mental health through creating a supportive culture that would help to:

- Normalise attitudes to mental health
- Raise awareness of mental health issues and where to go for help
- Show children and young people how to support their own mental health
- Support the development of emotional literacy, in order that children and families, to an extent, can explain, understand and find ways to manage their emotions and emotional responses.

Underpinning these broader aims were more specific goals which were seeking to reduce levels of anxiety and build resilience, self-esteem and confidence. These skills were viewed as essential for developing good mental health and without them it was believed children and young people could be at risk of experiencing poor mental health[14].

[14] For further information about how schools developed character skills to support mental health see White, C; Gibb, J; Lea, J and Street, C. (2017) *'Developing Character Skills in Schools'.* London: DfE

The **underlying philosophy and approach to supporting mental health** in a setting was instrumental to developing a whole organisational culture and ethos. This depended on a strategic lead (e.g. headteacher) driving the agenda forward; a set of values or beliefs (e.g. in faith based schools) that governed the setting and underpinned their mission; and creating an open and supportive and accepting environment. If staff were willing to discuss any concerns and problems they had then it was believed that children would be more willing to follow suit. If a school then properly supported a member of staff when they had a mental health need it would also encourage children and young people to seek help as they would know that the school was willing to help.

The involvement in local and national initiatives also helped to promote the ethos and culture across settings. For example, a partnership between an FE college and their local authority was set up to help to improve wellbeing and address the physical and mental health inequalities in the area. This involved undertaking activities to increase the awareness and understanding of mental health problems and develop resilience in students. While another mainstream primary school adopted the Growth Mindset approach (Dweck, 2017[15]) across the entire school which involved staff using positive language and rewards to praise a child for trying to achieve something rather than achieving it. This approach was said to promote good mental health as it helped to build a child's confidence and self-worth.

3.2 Team structures and role of staff

The **team structure** was reported to be critical to develop a whole organisational approach and promote good mental health. All staff needed to have a responsibility for supporting mental health and awareness about mental health issues. Having a separate support team with clear and defined roles for supporting mental health was also reported as being important for promoting good mental health. The wider staff team needed to be made aware of their role and who to pass information on to when they felt unable to support the child themselves. Having a visible structure was also important for ensuring that children and young people knew who they could talk to if they had any problems or concerns.

Staff had a pivotal role to play in promoting good mental health. Participants described needing the 'right' staff in place in terms of their own attributes and attitudes towards mental health. Staff needed to be empathetic and understanding about mental health

[15] Dweck, C. (2017) '*Mindset - Updated Edition: Changing The Way You think To Fulfil Your Potential'.* Little, Brown Book Group.

issues to encourage children and young people to approach them and discuss their concerns.

Otherwise staff needed to have: a good awareness of mental health issues and how they could best support children and young people with these issues; knowledge of when and where to signpost children to; or to recommend specific interventions or other support to children. Training in the techniques included in programmes like Emotional First Aid were viewed as critical for enabling all staff to feel confident about promoting good mental health across settings. One mainstream secondary school was also taking part in the Mental Health Services and Schools Link pilots to help build staff awareness about mental health as well as to improve joint working between NHS CYPMHS and the school (Day *et al,* 2017).

To ensure a whole organisational approach to support mental health all staff needed to build relationships with children and young people. This was important to enable staff to identify potential needs (see chapter 4) through being alert and noticing changes in behaviour of children. Staff also had a responsibility to be good role-models in terms of their own wellbeing and emotional literacy. If staff were responsive to their own mental health needs it was believed this would help children and young people to understand the importance of mental health and help to normalise talking about mental health.

3.3 The curriculum

PSHE and SMSC lessons, or similar, were another vehicle used across all settings to promote good mental health. Again, these were opportunities to signpost children to sources of advice and guidance, both within the school and externally. They also provided another opportunity to reinforce the development of character traits that would promote good mental health. They were an ‘open space’ where children could talk about their feelings and concerns and a way of promoting awareness.

In these lessons mental health was covered as a topic in itself but also as a cross-cutting theme that underpinned many of the PSHE or SMSC topics. Focused sessions were used to normalise talking about mental health and to develop children’s emotional literacy through discussing particular issues. In primary schools this might mean focusing on an emotion and discussing how it made people behave. One primary school used circle time, or group activity time, in their PSHE lessons to help raise awareness around issues like bullying. While these sessions were not focusing directly on mental health they were used to help promote and raise wider awareness of mental health issues. Sessions were targeted at specific year groups to address specific needs they were perceived to have. For example, students in Year 6 had sessions relating to transitioning to secondary school as this was identified as a particularly stressful point, while students in Years 10 and 11 often received sessions focused on anxiety and, particularly, exam anxiety.

A FE college delivered the Advantage Programme which ran alongside students' main course. This included both mandatory and voluntary options and there was a specific session on mental health, which included video clips. This session had been developed because there was felt to be a gap in promoting good mental health to students. There were also a range of wellbeing options including about sleep, diet, caffeine, alcohol, exercise, relaxation techniques and some Cognitive Behavioural Therapy (CBT) approaches. These were provided through the external Improving Access to Psychological Therapy (IAPT) provider.

3.4 Day-to-day activities

Case study settings also made use of their day to day activities – principally assemblies, and tutor groups – as vehicles to promote good mental health.

3.4.1 School assemblies

School assemblies provided an important means for sharing information about mental health, promoting an open environment to talk about mental health and to share potential sources of support. Case study schools and colleges used assemblies to discuss various issues such as bullying, anxiety and coping with stress. Assemblies were run by staff at the school and by external organisations. In Christian schools, worship during assemblies was used to promote mental health as it gave children the opportunity to be reflective and to relax. There were also examples of celebration assemblies that rewarded positive behaviour which could also be beneficial for mental health.

3.4.2 Form time and tutorial programme

Form time in secondary schools and tutorial programmes in FE colleges provided an important opportunity for staff to raise awareness about issues. Some of the activities were structured, such as a series of workshops around resilience; self-esteem; and managing stress and coping strategies. However, the fluid structure of form time and tutorials allowed staff to talk about pertinent issues that were affecting students. This support could either be carried out through informal chats something that had arisen in class, or more specific group activities undertaken. One secondary PRU used circle time during their daily form time to discuss issues that might be upsetting students.

> *"The ideal scenario is that if there's an issue we have, so we have a circle every day that if there's an issue someone will go, I ask you how you're feeling today. You go, 'Well I'm not feeling great, this happened today, I would like it resolved', then the group will resolve among themselves and say what the best outcome is."*
>
> (Secondary PRU)

Having form time and tutor time also enabled an open environment for students to talk about any concerns or worries that they might have and a mechanism for staff to identify needs (see chapter 4). This time with students also provided an opportunity to share information about support that was available both from the school and from external organisations.

The Social and Emotional Aspects of Learning (SEAL) programme in a special school was their equivalent of the tutor groups and the first lesson of every day was a SEAL lesson. These sessions would cover mental health issues, as well as helping pupils with their social and emotional communication and understanding. All children and young people in the school were placed in eight mixed age groups. Students stayed in their SEAL group for the five years they were at the school.

3.4.3 The structure of the day

In order to create a supportive environment settings thought carefully about the structure of the day. Timetables were structured around having proper breaks throughout the day and in one special school time was dedicated at the start of the day to mindfulness exercises to help the young people be ready to for class. Time for relaxation, physical activity and extra-curricular activities were all important to promote good mental health.

3.5 Creating a community

Case study sites also promoted good mental health by creating a community through supportive organisational structures.

A **supportive house system** was used in secondary and independent schools to encourage students to work together and support each other. The house structures were arranged vertically to ensure there were mixed age groups. This was found to be particularly beneficial as it helped with bringing young people together, providing role models for the younger children and to help break down any barriers. In one school the house system had a House and an Assistant House Captain who were elected from the sixth form year groups and they organised house assemblies and other activities throughout the year. They were also responsible for encouraging everyone in their house to work together on community projects. The schools placed children very carefully in their house to ensure there would be others with similar interests and attitudes. These house systems acted as families providing support to all the children in them much the same way that a family would do.

Meal times also provided another opportunity to create a supportive environment and bring staff and students together. Eating and spending time with each other helped to create a family atmosphere encouraged children to talk about their concerns; it helped to

create a feeling of belonging. It enabled staff to see if children were eating properly and to listen to conversations that might highlight potential issues. In other settings, this community was achieved through particular sessions and lessons. In a primary school food technology lessons were longer so that children could sit down and eat what they had made together and it became a social event as well as a lesson. Spending this time together helped children to feel part of the school community and for staff to build a relationship with them.

3.6 Providing information and promotional activities

Case study schools and colleges provided information about mental health to raise awareness and understanding of mental health, and to signpost students to advice and support. Information was provided to children and young people through a variety of mechanisms including:

- **Headteacher updates and newsletters** to children, that discussed particular issues and the support the setting was providing.
- **School websites and student virtual learning platforms**, which included information about support organisations and their contact details through school materials, such as diaries the school provided to students with a list of support organisations and their contact details.
- **Posters and plasma screens** throughout the school or college advertising what support was available both within the school and externally.
- **Children developing their own materials** about mental health, such as brochures and information sheets, to share with other students.
- **The induction process** was a key way for FE colleges to share information and signpost students to where they could access support for any mental health problems. Information leaflets and talks were provided by external organisations and by any services provided by the college.
- Staff recommended **apps** to young people that would help to support their mental health.
- A **wellbeing library** with self-help books and books on different types of mental illness ranging from anxiety, self-esteem to depression and bipolar disorder, to support children and young people.
- Participation in **national activities focusing on promoting the awareness of mental health issues**, for example World Mental Health Day, Mental Health Awareness Week, anti-bullying week, and stress down week. These were opportunities to raise awareness and provide information to children and young people about mental health; to signpost them to support organisations; and reduce

stigma attached to mental health by encouraging students to talk about the subject. External organisations providing support often came to schools during these times to promote their work and raise awareness more generally about specific mental health needs. Colleges also reported promoting these events on their student portal, or through social media.

3.6.1 Sharing information with parents

Parents were also informed about a schools approach to mental health through:

- Parent evenings and information sessions where counsellors and staff talked through the support on offer
- Parent assemblies to raise their awareness about mental health
- Letters, newsletters, text messages and emails sent regularly to parents to keep them informed
- A parent portal (on the school website) contained information on organisations that provided support
- Health champions (students in a secondary school) regularly wrote articles for the parents newsletter about mental health
- Workshops for parents about mental health.

4. Identifying and assessing need

This chapter focuses on how schools and colleges identified and assessed need. There were two main roles for schools and colleges in relation to identification and assessment of mental health needs: to identify and assess needs themselves; or to manage and review existing needs that had been previously identified. Marshall *et al*, (2017) found that almost all schools and colleges (99%) sought to identify pupils with mental health needs. The most commonly cited approaches to identifying pupils with particular mental health needs included ad hoc identification based on concerns of members of staff (82%), the use of information from external agencies (76%), and the assessment of mental health needs alongside SEN or other similar assessments (65%).

This chapter describes the identification and assessment approaches employed by mainstream settings (Section 4.1) and special schools and PRUs (Section 4.2). The activities used to support children and young people's mental health will be discussed in chapter 5.

Summary of key points

- In mainstream settings, children and young people were identified with a potential need through three main pathways: staff or other mental health professionals identifying potential needs; during the admissions or inductions process; or through children referring themselves, or their friends or parents doing this on their behalf. All settings relied on staff being able to identify potential mental health needs. Primary schools were more reliant on parents disclosing any mental health problems while secondary schools and FE colleges relied on students disclosing.
- Once a child had been identified with a potential need, settings undertook an assessment process which included talking to the child, their parents, staff and mental health professionals already involved with the child to identify the nature of the need.
- Assessments resulted in three potential outcomes: monitoring the child to see if there was any further deterioration of their mental health; advice and signposting provided by a member of staff to children and parents; or either providing targeted support or referring them to specialist provision
- Good communication between staff was vital throughout the identification and assessment stages. All staff who interacted with a child needed to be aware if a child had an identified mental health need so that they could support the child appropriately. All staff had a responsibility to feed information back to the pastoral, or support team as a way of ensuring that needs were not being missed. Having clear lines of communication enabled schools to identify needs much more quickly and efficiently.

- Special schools and PRUs were inevitably different because the majority of children arrived with previously identified social and emotional and mental health needs, often specified in an Education Health Care (EHC) plan. Their role was described as reviewing and managing previously identified needs, as well as identifying additional needs that emerged, or that had been masked by other behaviour or learning difficulties.

4.1 Mainstream provision

Figure 4.1 shows the procedures for identifying and assessing needs in mainstream settings[16]. The first row indicates the different **pathways** mainstream schools used to initially identify a potential need including the admissions process and induction; through children, friends and parents; and through school or college staff, or mental health professionals identifying a potential need. Where children arrived at a school or FE college with a learning or mental health difficulty previously identified, there was documentation to read, and other external professionals to discuss the needs of the child with, and jointly to agree the support required. In these circumstances schools continued to profile the needs of these children throughout the appropriate process, and to maintain any plan that had already been set up for the child.

Once a child had been identified with a potential need settings undertook an **assessment process** which included talking to the child and parents; and staff and mental health professionals already involved with the child. Generally a designated staff member (e.g. a deputy headteacher, a safeguarding lead, SENCO), completed some form of risk assessment such as the Strengths and Difficulties Questionnaire (SDQ). These were used to identify the level of support that might be required. If it was decided more targeted support was needed then a referral was made to mental health professionals who undertook a more formal assessment.

Once a child had been identified and an assessment made as to the possible level of need, there were **several potential outcomes**, as shown in the final row of figure 4.1. A child might be monitored and reviewed by staff to establish whether further support was required. Advice and signposting might be provided by a member of staff, which often meant a child would also be monitored to see if their mental health deteriorated. Alternatively, targeted support might be provided or a child may be referred on to specialist provision (see section 5.3).

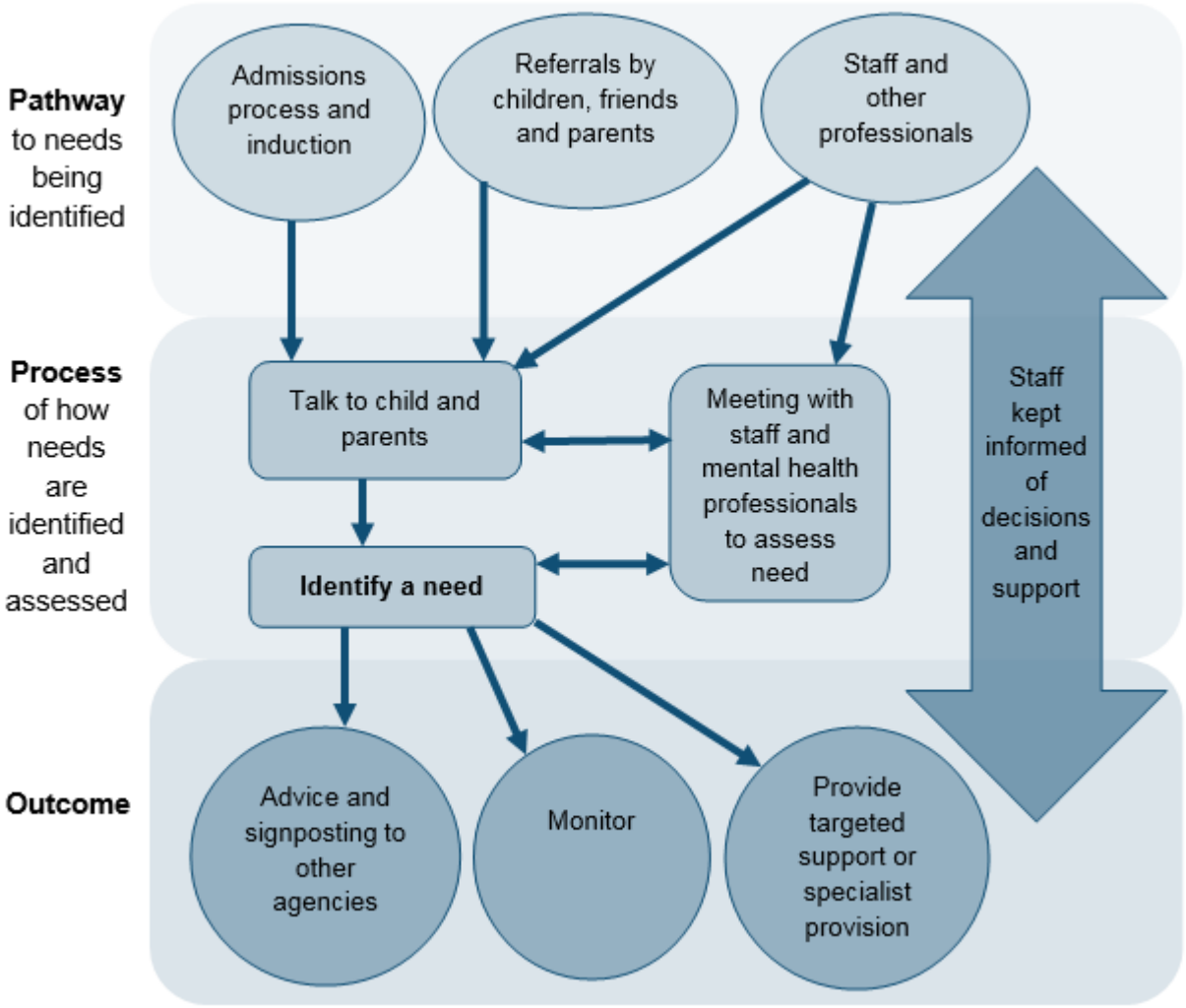
[16] As already highlighted these case study settings were chosen because they reported more active engagement in supporting mental health and therefore their identification and assessment processes in this sample may not be reflective of all schools and colleges.

The importance of maintaining good communication between all staff was vital throughout the identification and assessment processes and during any support that was subsequently provided. All staff who interacted with a child needed to be aware if a child had an identified mental health need so that they could support the child appropriately. All staff had a responsibility to feed information back to the pastoral, or support team as a way of ensuring that needs were not being missed. Having these lines of communication open and used by all staff enabled schools to identify needs much more quickly and efficiently.

Engaging parents and families throughout the identification and assessment process was important. Schools and colleges would contact parents to get their views about the child's mental health. Where a child had a need identified parents were asked whether they would consent to their child taking part in a particular intervention or being referred to specialist provision.

There were variations in terms of the different pathways, processes and outcomes used by settings related to the size and type of school or college and the age of the child. These differences are discussed below.

Figure 4.1: procedure for identifying and assessing needs



4.1.1 Primary schools

Primary schools, initially, worked in quite ad hoc and informal ways to identify and monitor children but, once a child had a mental health need identified, the process became much more structured. While they did not describe having formal admissions procedures they nevertheless took the opportunity to explore and understand any potential needs. The case study **primary schools described either doing home visits, or setting up family meetings with new applicants to understand the family context and background.** They also contacted previous settings that the child had attended to gather any additional information on needs.

The family meetings and information provided by other settings and professionals enabled schools to identify any potential barriers to teaching, or additional needs, early on. Some primary schools completed a 'barriers to learning' form which was used, to varying degrees, to keep a record of the child while at the school. The form was reviewed on a termly basis and could trigger further assessments for special educational needs

(SEN) or a Common Assessment Framework (CAF) assessment. One school described using this to keep ongoing records of a pupil's SEN status; their pupil premium status; their attendance levels and punctuality; any behaviour issues; medical needs; and levels of parental engagement (measured by attendance at parents evening, whether they were easy to contact, their response to information sent home and staff views about their level of engagement).

Unless anything was raised at the point when a child joined the school, identification of a need resulted from teachers identifying or observing issues; a parent asking for support for their child; or other agencies raising issues. Marshall *et al,* (2017) found that 83% of state maintained primary schools identified needs through staff reporting their concerns about particular children, suggesting the importance of this pathway for primary schools.

Case study primary schools also reported that children sometimes sought help for a problem, but this was more exceptional than for older children. Primary schools developed approaches to encourage children to express their concerns. For example, a mainstream Christian primary school used a prayer chair for children to leave messages for the prayer team to pray about. While another mainstream primary school used worry boxes in classrooms. Both allowed children to express their concerns in a non-threatening way and alerted staff to any potential needs.

As discussed in the previous chapter, primary schools talked about adopting a 'whole staff approach' where they worked together to keep an eye on children. It was suggested that, unlike in secondary schools, teachers at primary school could identify issues more easily as they had more time to build a connection with a child. This makes it easier for staff to detect small changes in behaviour and mood which may relate to a more serious problem.

> *"I feel like we have a deeper connection with the children because we have the same children most of the time all day every day. So, we're seeing those children day in, day out. They come and talk to us at break time, at lunchtime. …In secondary I can't imagine that …some teachers will have strong relationships with particular children…they're seeing hundreds of children every day for, what, 45 minutes to an hour, maybe a bit longer, in sets."*
>
> (LA maintained primary)

Once a child had been identified with a potential need through any of the pathways, staff either reported this to the head, to other designated pastoral lead, or discussed it at staff meetings. At this stage assessments of mental health needs were carried out, often by someone at school, for example the head, SENCO or designated member of the pastoral team, or by another professional involved as part of a multi-agency meeting where a CAF had been completed.

Primary schools worked hard to encourage parents to disclose any concerns they might have about their child. They contacted them once a child had been identified with a potential need, to explore whether they had noticed any changes in behaviour, or were aware of any particular needs. Parents could be signposted to potential support from external agencies and schools also kept parents informed of any support they were providing for their child. As discussed in section 2.3.1, primary schools were in a good position to build a relationship with parents and the child's family. This relationship between a parent and the school was essential if parents were to help with the identification and assessment of needs of their child.

4.1.2 Secondary schools

Secondary schools reported relying on **staff to identify needs**, which confirms the survey evidence (Marshall *et al*, 2017) which found that 86% of state maintained secondary schools used staff to identify pupils with particular needs. The case studies showed that staff identified mental health, or emotional needs through their day to day contact with young people, during lessons and tutor groups, along with other more casual or informal conversations. As in primary schools this pathway to identifying a need relied on staff having a good knowledge of the young person, but was also underpinned by a pastoral or support team, who were meeting regularly and sharing knowledge about students. One school described it being like a '*jigsaw puzzle'* that was based on good communication between staff and having regular meetings to discuss cases.

> *"What makes this school different to other schools is that every single person in the school sees it as something that's not just their business but that they're actively involved in. Whether it's safeguarding or mental health... so on a daily basis, I get sent information - and I always say to them, 'It doesn't matter whether it's something really tiny or really huge, you can't rely on... somebody else. It might just be that tiny thing that's missing to glue the whole thing together…You do get those things that, when you look at them individually, they don't really mean anything, but when you start to get a pattern of a child who won't roll up her sleeves three days running, and then in PE refused to get changed. Individually, that just means nothing, but collectively... what's under those sleeves?"*
>
> (Secondary Academy)

The typical role for staff was to be aware of and notice change; as discussed in section 3.2, the attitudes and knowledge of staff about mental health was crucial for this pathway of identification to be successful. Once staff were aware of a potential mental health need they either talked directly to the child and signposted them to support, or passed their concerns on to the pastoral team, or others in the school to provide the support. Where raised, school staff were clear that it was not their responsibility to diagnose problems, just to identify there might be a problem. The range of staff who were specifically involved

with identifying and assessing young people varied in schools but could include the head/deputy head (or equivalent), or the lead for safeguarding or wellbeing (where different to the deputy head), teachers, personal tutors, pastoral or support staff, the SENCO, directors of learning, heads of year, and health professionals.

There were other methods used by staff to identify needs, for example, wellbeing surveys. Although these were anonymous, schools found them useful to understand some of the lower level needs for specific year groups, for example, concerning anxiety issues. This allowed schools to be responsive and to tailor their universal and preventative strategies to address these concerns. Schools commonly monitored data collected around attendance, behaviour and academic progress and this was seen as another useful method of identifying needs. If a student's behaviour or performance in school suddenly changed, this would sound an 'alarm bell' and would result in staff talking to the student about any concerns and issues they may have. In one secondary school they actively used this data to create a list of vulnerable students who they monitored more frequently and which was shared with staff on a regular basis. Marshall *et al,* (2017) research also showed similar findings with 60% of state maintained secondary schools using attendance and other data to identify students with mental health needs.

Identification of needs in secondary schools also resulted from requests for support for a particular young person. The request for help could come **directly from the young person themselves or their friends** who could have identified anxiety problems or stress related issues**. Parents were another pathway to the identification of a potential need** with them contacting the school if they were concerned about the behaviour of their child at home. All routes were seen as important means of identifying needs and young people and parents were encouraged to raise their concerns if they thought a child or young person had mental health problems.

As discussed in chapter 3 schools used posters and visual displays to promote the different sources of advice and guidance available. These provided the contact details for young people should they wish to seek help themselves from counsellors, or other external organisations.

One key element used to identify and assess children with mental health needs was having frequent pastoral or support meetings amongst key staff. These meetings generally occurred every one to three weeks, or they were part of other meetings where pastoral issues were discussed. Occasionally these meetings would also involve external agencies who would be asked to provide advice and guidance about a particular mental health issue. These meetings enabled staff to discuss any concerns about a particular child, decide upon a course of action and to review the impact of any support already being provided. Staff valued these meetings as a means of identifying need early and

thought they were extremely important to prioritise, even given other competing demands on their time.

> *"These meetings are vital. If we want to identify students that need help, and to do it when they need it, we need to have these meetings. I know my staff team are very busy but I think we all think this is time well spent."*
>
> (Independent secondary)

Once a child had been identified and an assessment made if it was decided that targeted support was needed then an awareness or wellbeing plan might be written in conjunction with the young person. These covered the general needs of the student and strategies for supporting them, information could then be shared with teachers to ensure that they remained fully informed about the situation.

4.1.3 FE Colleges

FE Colleges relied mainly on students disclosing any mental health issues as it was harder for them to build the kind of relationships that primary and to a certain extent secondary schools could develop. Colleges also saw it as their responsibility to encourage students to talk about their mental health before they left education, as they believed getting support at this time would be easier and in the long term better for the student. For this reason the **admissions or enrolment process and induction was the primary way in which FE colleges identified needs**.

Marshall *et al,* (2017) found that 88% of FE colleges used information from external agencies to identify students with mental health needs. The case study colleges emphasised the importance of information being passed on about students, but found that they could not rely on school records to always follow students. They also had more limited opportunities to build a relationship with parents and, as a result, could not rely on parents' necessarily reporting or disclosing information about their child.

> *"I think sometimes we miss things, because - and it's when we don't know, when things have not been passed on to us from either a previous school, or parents haven't disclosed, the student hasn't disclosed, or no one knows there's an issue, it's just transpired half way through a student's course, and sometimes that happens too late to put the right support in place."*
>
> (FE college)

There were a number of opportunities created for students to disclose any needs they had, initially, through their application form, or subsequently during an admissions interview. Colleges did, however, recognise that young people might be reluctant to disclose a need in case it affected their application to the college. Once accepted at college, students were further encouraged to disclose any mental health issues during

their induction. There were opportunities to discuss their needs during introductory meetings with the support staff at the college. The induction was used at the start of the academic term, to promote the mental health support that was available both within the college and from external organisations. These opportunities were felt to be more effective for identifying needs, as a disclosure would not affect their place at the college. There was also one example of an induction meeting for parents of new students at a college which led to some parents disclosing mental health issues for their young people.

Otherwise the identification and assessment of needs resulted from college staff identifying needs through observing students' behaviour and talking to young people in much the same way as occurred in secondary schools. The findings from Marshall *et al*, (2017) were similar with 72% colleges using staff to identify mental health needs. The case study colleges described a variety of staff specifically involved in this process including tutors, student engagement and support staff, careers advisers and learning support teams. As already acknowledged, staff in colleges needed to work harder to build relationships with young people if they were to encourage them to disclose issues to them. FE colleges also relied on monitoring data around attendance, behaviour and academic progress and this was seen as another useful method of identifying needs.

One college reported that introducing an online referral form for students had increased their referrals for counselling by 20%. The online referral form also incorporated an assessment questionnaire which incorporated the PHQ-9 (which looks at symptoms of depression and low mood) and GAD-7 (which looks at generalised anxiety, worry) to assess risk of struggling with particular problems.

4.2 Special schools and PRUs

The pathways in special schools and PRUs were inevitably different because the majority of children arrived with previously identified social and emotional and mental health needs, often specified in an EHC plan. **Their role was described as reviewing and managing previously identified needs, as well as identifying additional needs that emerged, or that had been masked by a behaviour or learning difficulty.** Marshall *et al,* (2017) indicated that 77% of special schools and 83% of alternative education providers (including PRUs) used information from external agencies to identify students with mental health needs.

There were **formal procedures in place for carrying out an induction for all students joining special schools and PRUs**. The induction process took longer to complete than in mainstream settings and usually involved more visits between the setting and the young person and family, including home visits by senior staff to assess the suitability of the placement. The process may also have involved contact with a previous school, along with reviewing assessments, annual reviews and reports.

In order to help with the transition arrangements, there were also procedures and protocols in place for sharing information from previous schools and other agencies about any additional needs including mental health issues. Using these sources of information allowed the setting to put appropriate support in place before the child started. During the induction process baseline and academic assessments were carried out using a range of different tools (e.g. PASS, SDQ, Boxall Profile, SNAP-B and CORE) to explore their needs, their attitudes to school and their strengths and weaknesses. It was suggested that having a long induction helped to build a relationship with the young person and ease their integration into the provision which in turn was believed to be helpful in identifying needs.

Once a young person had started at the school or PRU, ongoing identification and assessment of need was typically carried out by the staff who were working with the young people. While these schools and providers had much higher ratios of staff to young people, which helped with the identification and assessment process, there were challenges distinguishing between mental health issues and other conditions, such as autism or Attention Deficit Hyperactivity Disorder (ADHD). Staff had the opportunity to observe the young people for longer periods of time which made it easier to reflect on any changes in their mental health. Parents could also ask for various interventions for their child, the appropriateness of which could then be assessed by the school. Overall, there tended to be less of a focus on students having to disclose mental health concerns in these settings.

Any referrals made by staff were typically for more targeted support involving some kind of therapy which was often provided by therapists based in the school, or it involved a referral to NHS CYPMHS. In these circumstances, there was typically a referral form which would be completed and sometimes an accompanying SDQ or alternative screening tool, which was completed on behalf of the school. The referral would then be discussed and agreed with parents.

Meetings to review the needs of young people generally occurred daily in special schools and PRUs. These meetings were used to discuss any needs a young person may have and not specifically their mental health needs. Recording information from these meetings and from observations made by staff was vital in terms of identifying patterns and trends. This was helpful to identify needs and monitor the impact of any interventions. It also ensured that decisions were made about how best to support a young person using all the experiences of the staff and not just one person making a decision.

> *“So it might take a few weeks, people might then start saying, 'Actually, I've noticed this', and it might take a couple of weeks to get things going but then it's put through that way so it isn't just one person just going, 'Right, I've made that decision'. It is collective.”*

(Secondary PRU)

Special schools and PRUs highlighted the importance of ongoing and regular assessments of students' needs. These regular assessments were completed for a variety of additional needs (e.g. SEN assessments) but included mental health needs. They monitored and recorded young people's behaviour closely to ensure any changes could be identified quickly and discussed at team and review meetings.

5. Supporting mental health

In this chapter, we discuss the activities offered by the 15 case study schools and colleges to support their students. As previously highlighted, this varied according to their type, size and phase. While the research set out to explore provision in terms of universal, targeted and specialist activities, schools and FE colleges did not tend to view their provision with these classifications. Also the distinction between the different levels of intensity was blurred for schools as there were some universal and targeted applications of the same activity. What might be seen as a targeted activity in the mainstream sector could be used universally in a special school or a PRU.

The activities have been organised according to whether it was a universal activity undertaken with, or available to, *all* students at school or class level (Section 5.1); targeted activities which were provided to an individual child or a distinct group of children or young people (Section 5.2); externally provided specialist provision (Section 5.3); or support provided to parents/carers and families (Section 5.4). The chapter ends with a brief discussion of the way in which the progress of activities were tracked and monitored (Section 5.5).

Summary of key points

- Schools and colleges provided a variety of activities that were available to support all children. These included sessions teaching meditation and relaxation techniques; incorporating physical activity in the school day with the specific aim of improving mental health; and implementing initiatives and programmes designed by external organisations to support mental health.
- Counselling was frequently available for students in both schools and colleges. The amount of time children and young people could spend with a counsellor varied. Peer mentoring and buddying schemes were another important way of providing targeted support to children, especially for those suffering from anxiety. Other targeted support included individual or group sessions to address specific issues (e.g. anger management and self-harm); and the use of different therapeutic interventions such as art, play and music therapy.
- Having a dedicated space, whether for universal or targeted support was pivotal to the provision that schools provided. These spaces were often calming environments used for children and young people to have a break from the classroom. There were also examples of more specialist provision being provided such as a nurture room for reception and Key Stage One (KS1) children and a sensory room used for children with additional needs. The sensory room helped to support a child's mental health by providing them with a place where they could release their anger and anxiety.

- All case study schools made referrals to NHS CYPMHS for more specialist clinical provision. Views varied about how well these arrangements worked and there were difficulties reported accessing these services. Having a named contact and/or regular contact with a person at NHS CYPMHS helped to build relationships and address some of the difficulties with the referrals process. It was also valued for providing specialist support and guidance for schools.
- Parents were provided with support either in relation to issues their child had or for their own needs, and sometimes both. They took part in training and events to raise their awareness about mental health problems. In addition, mainstream schools might involve them in the support they were providing for their child or to provide parenting or other support for them. Special schools and PRUs were more actively attempting to involve and support parents, as they believed this was essential for addressing their child's mental health and ensuring any intervention they were delivering would have a lasting impact.

5.1 Universal level activities

Settings employed a variety of activities to support the wellbeing and mental health of children and young people.

There were **extra-curricular activities** dedicated to supporting mental health. These activities were intended to help build resilience and teach techniques for managing stress and how to relax. They included meditation, relaxation, mindfulness and yoga classes. Marshall et al (2017) found that 73% of all schools used skills sessions such as mindfulness sessions to promote good mental health. Case study settings offered these sessions to all students, or used them, for example, to target secondary school students struggling with anxiety or anger issues. Sessions were run in the morning, during form time and lunchtimes and all children were encouraged to attend. Alongside these more dedicated activities were a wide range of other arts and crafts and sporting clubs which could be used to help children develop skills and build self-esteem through achieving success.

Physical activity was also encouraged as a way to improve mental health as schools were aware of the positive link between physical exercise and improved mental health. For example, primary schools had encouraged children to start the school day with some form of physical activity, or to run, or walk a mile on a daily basis to help improve their mental health. These physical activities were reported to have improved mental health as well as providing social benefits as children were spending time with their friends and staff.

"The relationship building, the confidence building that that all creates is huge. It's not just a walk; it's much, much, much more than that."

(Secondary PRU)

Settings also used education programmes from **other organisations** to help support mental health. For example, an FE college used the Amy Winehouse Resilience Programme to provide alcohol and drugs education to all students. The universal part of this programme was delivered through assemblies and smaller workshops during the college's tutorial programme attended by all students. The aim of the programme, through the use of life stories and interactive discussions, was to focus on peer pressure, risky behaviour and self-esteem in relation to alcohol and drug use. There was more targeted support provided for eligible students in need of further help.

5.1.2 Dedicated space to support mental health

Settings with the room to create a dedicated space to support wellbeing and mental health stressed how helpful it had been. Having this resource provided a space for students to take some 'time out'; it was a place for **all students to relax** and gather their thoughts and was viewed as a positive place to go. As well as being a relaxing and calming environment there was often space for young people to study while they were away from class.

Secondary schools and FE colleges developed their support facility as a universal approach encouraging all students to use it when needed. They also attempted to create a supportive and accepting culture in relation to mental health so as to help reduce any stigma attached to the use of such a facility. Children and young people were widely encouraged to use the provision by all staff. The facility often provided teaching and behavioural support, character skills development as well as supporting mental health needs of students. The facility was run by support staff who generally had basic counselling training so that if a distressed student came to the facility then they would be able to engage in a supportive discussion with them. The staff in these dedicated spaces often signposted students to other support in the setting (e.g. counselling or mindfulness courses), or to external support organisations. Students were reported to have disclosed concerns and mental health issues to staff in these facilities.

"It's a really supportive environment….even if something might be small or not a major issue like I've no friends and I'm moving from a school on my own then the way I explain the study base is it's an open door policy. There's no stigma attached to using that area. There could be students on five A stars in the second year that just love going in there because you can have a cup of a tea and a chat to someone and then they go. … I think because we rely on students telling us what's wrong then we need somewhere for them to go to do that."

(FE College)

Box 5.1 describes an example of a dedicated space used to support mental health in a mainstream secondary school.

Box 5.1: Student support room

A mainstream secondary school realised they needed to develop a student support room for all students to use when they were struggling. The school developed a relaxing and welcoming environment for students to use when they needed time out. It was open to all students but was used most frequently by students suffering from anxiety. The aim was for students to use the room to calm themselves down and gather their thoughts before returning to the classroom. Students could use the computers to study in the room, or to relax. It had a 'no questions asked' policy around the use of the room to encourage students to use it freely. At first staff were concerned about the impact of students missing lessons, but they later realised that taking a student out of their lesson for a short period of quiet time when they were struggling could be very beneficial for supporting their mental health and their ability to engage.

Other schools created an outdoor space to support mental health. There were examples of 'Mindfulness' and 'wellbeing gardens' used by children and staff to relax. There was a 'hanging garden' in one primary school where children were encouraged to hang upside down as this believed to help to release endorphins. Another setting had a nurture woodland which was described as a "*calm natural space that helps mental health".*

Schools also adopted **forest school activities** and **nurture group approaches** to support mental health for all students or all those in a class. Box 5.2 provides an example of a mainstream primary school using the philosophy and ideas of forest schools in their own setting to support mental health.

Box 5.2: Forest School for primary children

The Forest School used activities to develop character, support general wellbeing and social skills via one 40 minute weekly lesson which all children in the school attended. The Forest School provided an alternative setting to teaching in a classroom and gave children the opportunity to learn from new experiences and develop skills such as decision-making and understanding responsibility. Being in a different environment also helped children to open up and disclose information about potential mental health problems, which they might be less likely to do in a classroom setting. Children engaged in outdoor activities, including some set activities, for example making a fire. Other activities were child-led, including cutting wood and den building. The approach was tailored to the child's needs, taking into account the group dynamics. The success of Forest School was attributed to it encouraging children to try harder in school *"because they're able to succeed and be good at some things it enables them to have the courage to have a go at things that they find difficult within a class setting."* It was felt to have positive benefits for mental health when the children completed a team activity, and spent time outside helped to boost morale.

5.2 Targeted activities

At the targeted end of the provision, schools and colleges provided a wide range of different targeted support and activities which could be offered to individual students with an identified need, or groups of students with similar needs. As with the previous section, mainstream schools and special schools and PRUs are discussed together as there was little difference in the type of activities they offered; although special schools and PRUs offered a wider range of provision.

5.2.1 Counselling and mentoring[17]

Marshall *et al* (2017) reported that 61% of schools provided counselling. Of the settings that provided counselling 51% offered five hours or less a week, and 11% provided counselling for 20 hours or more a week.

[17] In this section mentoring refers to services provided by trained professionals who, however, are not as highly qualified as counsellors.

Case study settings typically provided counselling and mentoring for students. This was often seen as low-level support, an opportunity for students to talk to someone and covered bereavement, stress, anxiety, depression and low self-esteem. Colleges also promoted an online counselling service. The amount of counsellor time available within schools varied significantly from a few hours a week to three or more days. Face to face counselling sessions typically lasted for 45-50 minutes and might be offered in blocks of 6 to 10 sessions although the duration could be extended for longer. Most of the case study schools wanted to expand their counselling provision, as they typically had more demand than they could cater for, and there were waiting lists to see the counsellor. Specialist counselling was also provided around addiction, domestic violence, and anger management. These sessions were often provided by external counsellors or from the local authority youth offending team.

Models of support varied in terms of whether the counsellor was employed directly by the setting or commissioned externally. One counsellor had experience of both situations. They described how being an on-site counsellor was beneficial in terms of understanding the pressures being placed on a child. However, there were challenges in terms of being seen as independent from the school and not being able to provide counselling sessions on an ad hoc basis just because they were based in the school.

> *"I think* [there is benefit in being an on-site counsellor because]… *you do see everything. You see not just how they are, around school, but the pressures on the school itself, on teachers, on the lessons. So you… know more, and I think that makes you more in tune to it, and therefore, probably will try and take all of that into consideration. … I think one of the tricky things about being in school is that they can drop in on you. You do have to be quite boundaried. Because I'm there … they want to come and have a chat outside of a counselling session and that can be hard to manage as I don't have the capacity to do that."*
>
> (LA maintained secondary)

Box 5.3 is an example of a counselling service provided in a mainstream secondary school.

Box 5.3: The counselling service in a mainstream secondary school
A counsellor was employed 2.5 days a week and had a full caseload. The aim of her counselling was to give young people a place where they could speak to a professional, get advice, be listened to, take time-out and review their situation, in a calm careful and considered way. She provided client centred listening skills and reflection although she sometimes directed the conversation because of the young age of the child. The sessions ranged from two sessions to long term support, or if they were waiting for a NHS CYPMHS appointment until that came through. The longest client had been seen for two years and was still having counselling at the time of the case study visit. The counsellor used CBT as part of their counselling approach to support students to change the way they were thinking and feeling about things. She gave the young people worksheets and programmes to work through and laminated cards with tips about what to do when they started getting anxious.

5.2.2 Peer mentoring and buddying schemes

Peer mentoring was covered in the survey (Marshall *et al,* 2017) and found that 53% of schools and colleges offered peer mentoring to promote positive mental health amongst students and 36% provided peer support to help children with their mental health.

Children and young people in the case study schools also provided support to others. There were examples of buddying (especially in primary schools), and peer mentors (especially in secondary schools) for all children in a setting to talk to and to ask for advice and help. Children invariably received training to undertake these roles and were there to provide low level support. Having these roles in the school helped to generate acceptance of other people's mental health and an ethos of supporting others. One school had mental health peer 'champions' who promoted awareness about mental health through the organisation of events and assemblies. Having these mental health champions was a good way of engaging other students to talk about mental health and break down some of the stigma attached to it.

> *"I think it's about getting students talking about it, talking about mental health and that asking questions about it is fine and to not think about it as this taboo subject that we don't want to talk about."*
>
> (LA maintained secondary)

Box 5.4 gives an example of a peer mentoring scheme in a secondary school.

Box 5.4: Peer mentors in a secondary school
Students in Years 11 and 12 could ask to become peer mentors and go through an application process. Once accepted, they received 15 hours of training covering listening skills, bereavement, bullying, mental health issues, sex and relationships and organisational and study skills. Peer mentors were promoted throughout the school so students knew who they can talk to. Having peer mentors was an opportunity for students to talk to another young person rather than a member of staff which may be a preferred option for some young people. Staff also referred students to peer mentors. If staff thought a student was feeling isolated they would ask peer mentors to organise social activities and encourage that student to join in. Peer mentors supported low level mental health needs through offering advice and guidance and being someone for students to talk to about a variety of problems. Once a peer mentor saw a child they completed an online form which the pastoral team monitored, to ensure that the mentors are not dealing with anything too serious.

Peer mentoring was also targeted at young people who were on the fringes of needing higher level support. In special schools and PRUs this generally involved mentors who had similar life experiences to the young people at the setting rather than other young people currently attending the setting. This was viewed as beneficial as these mentors were able to relate to the young people.

5.2.3 Group interventions

There were a variety of group interventions and therapies used to target specific groups of children and young people with similar mental health needs. There were **sessions on specific topics** around anger management, self-esteem (e.g. Comparison and Analysis of Special Pupil Attainment, CASPA), exam stress and self-harm delivered in a variety of formats across settings. These were run or co-facilitated by trained members of staff and professionals from CYPMHS. **Group therapies** such as music, play, Lego and theraplay, were also run by trained members of staff, or external organisations specialising in the therapy. These were often run in small groups for children experiencing similar issues.

Wellbeing courses were targeted to young people who might be suffering from anxiety or low self-esteem. These courses covered a variety of topics including sleep, diet, caffeine, alcohol, exercise and relaxation techniques. One primary school ran PACS (positive assertive and confidence skills) courses with students who needed some support but fell under the radar for higher level interventions to improve their wellbeing.

Support groups were set up in schools and colleges for specific groups of children and young people. The survey findings (Marshall *et al,* 2017) highlighted that 44% of all schools provided support groups for specific groups of students such as looked after children, or victims of bullying. Examples from the case study sites included an FE college which set up a support group after the death of a student for those that were most closely affected. A mainstream primary school also ran Emotional Literacy Support groups for targeted children with low self-esteem and confidence. These sessions provided children with an opportunity to achieve something outside of the classroom and boost their confidence levels.

One mainstream primary school also organised a **radio team** which was aimed at specifically helping children with low self-esteem. Children with low self-esteem were selected to take part in this team if staff believed that the child had the skills needed to succeed in creating a radio programme to be broadcast to the school. The radio team helped to build confidence in children, support them in being taught new skills and provided the opportunity to form new friendships.

Particular techniques were used to support specific children with mental health needs. For example, in one primary school, **Circle of friends** was used to encourage the development of a support network for a specific child displaying signs of distress or difficult behaviour. Other children in the class were shown what it would be like to live with the additional need which included mental health problems. Staff found this intervention particularly helpful as it increased tolerance and understanding. **Time out cards** were another technique used to support vulnerable children and were used by children to excuse themselves from a class. The card entitled them to leave a class without having to explain their departure to the teacher. These were thought to be particularly useful when supporting children who were feeling anxious, or depressed and may not want to discuss this in class.

Some of the **universal initiatives also had targeted applications that could be used by schools and FE colleges to provide more intensive support**. For example, the Amy Winehouse resilience programme for students suffering from alcohol and drug misuse in a FE college and mainstream secondary school had an independent service provider offering drop-in sessions for the same topic. In one primary school, the Seasons for Growth programme was used to support students suffering from loss and bereavement. This programme lasted up to eight weeks for a small group of children suffering from loss and separation and focused on group discussion and paired work to allow children the opportunity to talk about issues affecting them, often related to their home life (e.g. parental separation). The programme encouraged children to talk to their parents, share their concerns and resolve issues.

5.2.4 Dedicated space for targeted support

Schools and FE colleges also had dedicated space to provide more targeted support for children and young people with mental health needs. As with the dedicated space to support mental health discussed under universal provision (see section 5.1.2) this was a calming place for children and young people to go to if they were struggling. However, in some settings the use of this provision was for specific children and young people only and played a much more targeted role in the school or FE colleges support to mental health. Box 5.5 provides an example of targeted provision which provided a calming environment for students struggling to access mainstream lessons. Dedicated space could also be used for a very specific group of children. Box 5.6 gives an example of a school creating an alternative classroom, building on the principles of nurture for reception and KS1 children who were identified as being at risk of exclusion from the school. Box 5.7 describes a targeted space that had specialist equipment to provide the right support for children with additional needs, including mental health problems.

Box 5.5: The Skill Centre

One academy secondary school developed The Skill Centre which was a dedicated place for vulnerable children and those struggling to access mainstream lessons. It was a quiet, calm environment with a member of staff there all the time. The centre was managed by a senior teaching assistant who had teaching and pastoral responsibilities. Normally, three to six students used the centre at any one time but this could fluctuate. Students used the facility on an ad-hoc basis, but they knew that they could go there whenever they needed to leave their classroom if they were feeling stressed or anxious. Students could take their work from their lessons to do in this room. The aim was to get students to engage with teaching while respecting that sometimes they needed a quieter environment to do this. This was seen as a short-term intervention for students with the ultimate aim of them being fully reintegrated into their lessons.

Box 5.6: Nurture provision for Reception and KS1 in a LA maintained primary school

The 'Tree House' was set up to support children who were at risk of being excluded from a primary school. Children who were referred to the provision were emotionally distressed and could be withdrawn, angry or chaotic. The provision was used to nurture and support a child to successfully return to the classroom. This was an early support intervention for reception and Key State 1 (KS1) children. The school wanted to focus on this young age group to help the children progress later and to help support mental health issues earlier. Referrals were passed from the teaching staff to the pastoral leader to assess the child's social and emotional development using the Boxall Profile. There were two sessions a day (morning and afternoon) which lasted up to three hours. Six to eight children spent half a day in the provision and returned to their class for the other half day. This ensured they kept in touch with their class and ensured a smooth transition at the end of the intervention. The provision was designed to mirror aspects of the home and classroom. For example, in the morning staff and children shared a meal together. Children used the provision for two to three terms depending on their needs.

Box 5.7: The Sensory Room

A primary school invested in the development of a sensory room which was used by children with additional needs. The room was padded so that children could *kick and shout* without getting hurt. There were also various sensory experiences in the room, for example different textures, lighting, music and a glowing carpet. These were all designed to encourage children to calm down. The room helped to support a child's mental health as it took them out of a classroom setting to let go of their anger or anxiety and calm down. It provided a break and change of scenery which could be very beneficial to improve a child's mental health. The aim was for the child to return to the classroom once they calmed down. Staff talked to the child about how to manage their emotions and behaviour for the future. This facility was also used as a reward for some children as they enjoyed using the room.

If dedicated provision was not available settings used other spaces such as a medical centre so that students had a space to calm down. One setting provided tailored support

to a high needs child as they had their own cordoned area in the playground and a den in the classroom to give them the space that they needed.

5.3 Accessing external provision

Therapeutic interventions were either delivered on site by a therapist employed by the school, or referrals were made to NHS CYPMHS, including to specialist provision such as an eating disorder clinic. Marshall *et al,* (2017) found 93% of all schools had accessed some form of specialist mental health services through NHS CYPMHS.

Case study schools made referrals to NHS CYPMHS for CBT; therapy such as art or play therapy; counselling; or to work with a family. Once a child or young person had been referred to NHS CYPMHS, the role of the school was to act as a 'conduit' providing updates and monitoring how a young person was progressing. At this point schools typically withdrew any other support they had been providing for the young person, as they did not feel it was helpful to have more than one therapy being delivered at a time.

Referrals were less of an issue for special schools and PRUs because children and young people were often already accessing NHS CYPMHS, and there were named contacts and pre-existing relationships to build on. For all schools and FE colleges, having a named contact at NHS CYPMHS was critical for creating good working relations and information sharing. It also ensured that school staff had access to professional advice which had helped them to support children more effectively.

There were various ways in which schools and NHS CYPMHS worked together including:

- A joint working arrangement had been set up between a counsellor working in a secondary school and an external NHS CYPMHS worker. The school counsellor worked with the young person during the school term and then passed the young person back to work with NHS CYPMHS a week before the school holidays started. At this point a hand over meeting was held with both professionals, the school and the parents.
- A secondary PRU had recently won a bid with the NHS to have a full time NHS CYPMHS worker on-site for one year. Having the increased access to this specialist clinical support had helped to improve engagement as more and more young people were using the service. This new way of working with a NHS CYPMHS worker was perceived by staff, at the PRU, to be better than the previous model of limited support being provided; as young people were now viewing the support as part of the school and were therefore more likely to use it. The PRU had been concerned that students were not engaging sufficiently with the support provided by NHS CYPMHS and had sought to change this. The NHS CYPMHS worker was running group sessions with students and parents

simultaneously about issues such as anger management. The NHS CYPMHS worker was also available to carry out clinical assessments on young people which had reduced waiting times for this support significantly.

- A secondary school was sharing a NHS CYPMHS worker with the five other schools in the county funded by the 'Thrive' programme. Each school had 10 hours a week of the NHS CYPMHS worker's time which was used for drop in sessions for staff, staff training as well as seeing students on a short term basis. This relationship had also helped broker referrals to NHS CYPMHS, increased awareness about mental health with parents and young people and supported the staff. At the time of the case study visit the NHS CYPMHS worker was setting up a six week programme of sessions for young people on skills and strategies for anger management. Other groups were planned for self-esteem, exam stress, self-harm.

The main problems reported with working with NHS CYPMHS were the long waiting times and high thresholds. The lack of time and capacity in NHS CYPMHS was the biggest barrier to joint working between schools and NHS CYPMHS with 67% of all schools reporting this as a barrier (Marshall *et al,* 2017). Case study schools reported it was common for students to have to wait for anywhere between four weeks to six months for an assessment and between 12 to 18 months for treatment. During this time schools often put in place interim support, such as counselling. For example, a special school offered counselling as an interim measure when the waiting list for NHS CYPMHS was too long. In these circumstances schools would discuss the proposed interim support with the parents and mental health practitioners; making it very clear that it was an interim solution.

Other issues with NHS CYPMHS resulted from difficulties in encouraging young people to turn up to appointments once they had been accepted for treatment. There were concerns expressed about NHS CYPMHS discharging young people, who were suffering from anxiety issues and depression, after they missed two or three appointments.

5.4 Supporting parents

The survey (Marshall *et al,* 2017) reported that the most commonly cited ways in which schools involved parents were as part of interventions they were delivering to pupils (59%), face-to-face sessions about their child's mental health (57%) and one-to-one support (such as counselling) for them (47%).

Among state maintained schools, secondary schools were more likely, compared with primary schools, to share information about their mental health plan with parents and carers (40% vs. 31%) and to provide written information and advice about children's

mental health (47% vs. 33%). Primary schools were more likely to offer parents and carers one-to-one support (50% vs. 36%).

Case study schools and colleges varied in the degree to which they supported parents and families. Some schools had members of staff whose specific role was to engage and support parents and families. Box 5.8 provides an example of a primary school that provided support to parents who were struggling to support their own children.

Box 5.8: Supporting parents in a mainstream primary school
The primary school decided it needed to improve the engagement and support to parents to help improve the mental health of its children. The family support role was created for this purpose with the aim of providing more targeted support for parents who were struggling. Having someone in the school providing support for parents encouraged parents and families to open up about any concerns parents had. The family support worker provided advice and signposted parents to other sources of support and was there for the parent to talk to and to discuss any concerns they had. The school created what was called an open school partnership approach so parents could access support, speak to a counsellor and have family learning sessions in schools. They had a parents' room and organised open sessions for parents to come and take part in lessons with their children. They also held activities to engage parents and to link these with other nurseries in and around the community. Parenting and mediation services were also provided to support parents.

Other settings provided support to parents in a range of ways. For example one mainstream secondary school provided parenting programmes such as Triple P and a tailored programme dealing with conflict management, listening skills, and setting limits. Parents were reported as finding this type of support particularly useful and welcomed the school providing this training. Another mainstream secondary school ran workshops and courses about specific mental health issues, for example on self-harm and depression. The aim of these sessions was to help raise awareness amongst parents about how to support a young person dealing with these issues. Schools reported that parents were very positive about this support.

Once a child was referred to counselling or therapy, parents would be contacted on a more regular basis to discuss how the treatment was progressing. Either the therapist, counsellor or a member of the pastoral team if the parent already had a relationship with them, would make the contact. Whilst staff understood the importance of supporting both the parent and the child they highlighted the importance of confidentiality and the need to limit the information passed to parents. However, having a conversation with parents was

still important to discuss how the parent could also support their child and potentially be involved in the intervention being carried out with their child. Examples included inviting parents to have tea in the Forest School with their child in a primary school to see how they were progressing.

If a child was being seen by NHS CYPMHS, school staff sometimes accompanied family members to appointments to provide support. Staff at the schools and colleges were aware how sensitive and difficult it could be for parents to come to terms with their child's need to access NHS CYPMHS. If staff felt that providing support to the parent would ensure the child attended NHS CYPMHS appointments then they viewed this as something they should do.

When it came to providing support for parents and families, special schools and PRUs often went further. They understood the need to and, importantly, appeared to have more capacity to, support a parents' mental health needs. A headteacher at a secondary PRU felt it was essential to provide mental health support for families, if the work they were doing with the young person was going to have any lasting impact. The causes of a young person's poor mental health may stem from family problems but the family could also reinforce the school's approach at home. The support the PRU provided relied upon the family support worker building a relationship based on respect with the parents. This relationship was seen as critical to the provision of support.

> *"I think parents also like to have somebody in the school that they know, that they've met and that understands and respects them, respects their home. It's not just a name or someone they've met at parents' evening,… but someone who really knows them and understands what they are going through. Once parents have this they will listen to me and I can really start to help them get support for their own problems, which will in the end help the young person too."*
>
> (Secondary PRU)

5.5 Monitoring provision

Case study sites were asked how they tracked and monitored the progress of their provision. They typically reported that it was hard to assess the impact of their promotion activities and universal support. A headteacher of a primary school explained that the main challenge for them was that children experience the interventions differently making it much harder to draw generalisable statements about how successful an intervention had been. Nevertheless they used the attendance, behaviour and achievement data they collected to assess whether a particular intervention was having a positive impact on a child or young person.

For some of the more targeted activities there were specific monitoring tools used to assess the impact of the support on a child or young person. These included SDQ, a tracking sheet designed by the setting, the Outcomes Star and the SNAP-B behavioural assessment.

Special schools and PRUs more frequently assessed the children in their setting which was important to understand the impact of any support interventions. When reviewing the young people's mental health needs, they also took into consideration the package of care and interventions they were receiving. The sequencing of support was managed appropriately as there was concern not to overload young people with interventions, and to ensure that the interventions they were providing were suitable and worked well in a combination with other interventions.

6. Delivery challenges

This chapter considers the main barriers and challenges that schools and FE colleges encountered in supporting the mental health needs of their students. These challenges covered: the wider context and economic climate in which schools and FE colleges were operating (section 6.1); the organisation, staffing and quality of the provision in schools and FE colleges (section 6.2); and issues engaging with students and families (section 6.3).

The most commonly cited barriers identified in the survey (Marshall *et al*, 2017) included difficulty commissioning services locally (because of lack of availability or capacity) (74%), a lack of funding in the school or FE college (71%) and lack of capacity in the setting (59%). Marshall *et al* (2017) found that institutions with a mental health lead in place were less likely than those without a lead to report facing most of the barriers relating to mental health provision. In particular, schools and FE colleges without a mental health lead were considerably more likely to report a lack of knowledge and understanding (43% vs. 30%) and/or a lack of capacity in their setting (61% vs. 56%) than schools and FE colleges with a mental health lead.

Summary of key points

- Settings encountered a number of different challenges supporting the mental health needs of their students.
- The tough fiscal climate in which schools and colleges were operating resulted in challenges coping with increasing numbers of children presenting with complex needs; a lack of funding for mental health provision; and a lack of timely specialist provision when children needed it.
- A lack of time and staff capacity limited the scope to create the whole organisational culture and develop staff awareness and skills for identifying and supporting mental health alongside teaching commitments. The offer of counselling and therapy was often limited to one or two days a week.
- The final set of challenges revolved around the difficulty engaging young people who either did not acknowledge they had a problem, or were reluctant to seek or receive help. Parents might also deter children where they were concerned about the stigma of mental health and the repercussions for their children. They might obstruct the process by not providing the information that a school needed, or by not reinforcing the support at home that schools were providing. Otherwise families were sometimes thought to be contributing to the problems for young people either because they had a mental health issue themselves, or as a result of them placing additional stress on their child.

6.1 External context and economic climate

The external context in which schools and FE colleges were operating, underpinned by the tough financial climate, resulted in five main challenges for schools and FE colleges. These related to:

- **Coping with increasing numbers of children presenting with complex needs around their emotional and social development**. This was attributed by setting to the increasing financial pressures facing families, but also a perception that family life had become more complex, more problematic and difficult to manage. This resulted in increasing levels of stress and mental health issues.
- **A lack of funding to support the mental health needs of children.** This challenge was raised by all settings. While it was arguably easier for special schools, PRUs and mainstream schools with high levels of pupil premium to use their existing budgets more flexibly, they emphasised that they were working with children who required much more complex, intensive, and costly support. Where opportunities arose applications were made for grant and trust funding, although these required considerable time and effort to produce and could not be relied upon for the budget. A secondary school discussed the challenge of trying to evidence the impact in funding applications of their early intervention and preventative approaches where that impact is preventing problems occurring.

  "How do you manage that underlying issues of supporting emotional and mental wellbeing when actually what you're trying to prove is stuff doesn't happen; the kids that don't go absent because they're anxious; the kids that don't get angry and have behaviour problems, because their depression or stress has been supported, and kids that don't self-harm. It's really hard, because so much of what I'm asking for resources for is stuff that doesn't get seen and that's hard to justify."

  (Secondary Academy)

- **External services were being withdrawn and cut back**. A particular issue for schools was the withdrawal of the services of a designated school nurse, although some schools acknowledged there were plans to introduce a new centralised service.
- **The availability of timely specialist provision when children needed it** was a key and recurring challenge raised by both schools and FE colleges. Much of this discussion was levelled at the excessively long waiting lists and high thresholds for NHS CYPMHS. The difficulties accessing specialist provision appeared to be magnified if a school catchment area crossed a number of local authority boundaries; particularly when different referral procedures and processes were in operation. As already mentioned schools and FE colleges reported having to put

alternative or interim provision in place, such as counselling, albeit recognising that this may just be a holding strategy.

"In the wider community, through no fault of anyone, it is a matter of funding, really, but often external help is either not available or it's not enough, so we really do have to plug a hole for many of our students, as much as we possibly can. We don't want to set ourselves up as an alternative to mental health agencies, but we do have to take more responsibility than, perhaps, we would necessarily want to do, because we think that it's so much better."

(FE college)

- **A lack of recognition of the way schools were supporting wellbeing.** Despite wellbeing being added to the Government and Ofsted performance and assessment framework, schools perceived that the framework was overly focused on academic achievement; and did not give sufficient credence to the work they were doing to support mental health. In particular, it was suggested that the framework and inspections process were resulting in much more pressure on schools with an academic focus to deliver curriculum outcomes, and served to side-line or even overlook the importance of mental health and wellbeing.

  "The whole procedures around schools is completely missing the point, because if you start from the point of academic outcomes, you're on an absolute hiding to nothing. If you start with, let's find a way of ensuring that our emotional, social wellbeing needs are met initially, then from that we will all learn well, because all of us, no matter how old we are, learn well when we're happy and we're engaged and we're motivated and contained."

  (Primary Special School)

6.2 Infrastructure challenges

The second set of challenges revolved around the organisation, staffing and quality of the provision in schools and FE colleges.

- A **lack of awareness about mental health issues** and the time it takes to develop understanding and build the culture was a particular challenge for mainstream schools. There were reports that members of staff lacked understanding about mental health and the impact it can have on students and their learning; and misconceptions that it is easy and quick to 'fix'.
- There were **reports of staff initially resisting or being concerned about children and young people missing lessons** to attend counselling or therapy sessions. Schools reported having to champion the role of counselling and therapy, or to encourage some teachers to appreciate that students need to be

supported holistically in order to be taught effectively; as students are not just *'academic learning machines*'.

- Schools and FE colleges reported a number of **capacity challenges**. These related to a lack of time for staff to explore and identify issues as well as to support and engage with students alongside their teaching commitments. While settings reflected on how they would like to expand their provision they struggled to find the funding to do this.
- Other capacity issues were to do with **not having enough specialist and trained staff to support the mental health needs of young people**. Where schools, and particularly mainstream schools had a counsellor or therapist, this was often limited to one or two days a week.
- There were **challenges in identifying need** and particularly in large secondary schools and FE colleges where it was much harder for teachers to get to know their students and be on top of the issues. As a result, there was a fear that some young people may be *'slipping through cracks'*. Equally there were concerns that problems may not be identified early enough. There were also inherent difficulties judging and distinguishing between a mental health issue and conditions like autism, or social and emotional problems.
- A number of the challenges identified related to **the quality of provision**. A key issue was concerned with the training of staff and **the ability to quality assure practice and training provision.** A school that converted to academy status reported finding it hard to judge the quality of the training provision on offer. Previously they had relied on the local authority to provide support and training. Other quality issues related to settings being able to judge which activities will work best to support children and young people. Other quality issues resulted from expertise and practice not being shared across schools or FE colleges, or a consistent approach being developed and adopted.
- Related to the above issue about training was the **difficulty of finding and commissioning provision** and the lack of central support for schools to buy, or access, or judge the quality of this. This was identified as particular challenge for academies who, unlike the maintained sector, have no central services to rely and have to purchase their own services.
- There were **varying degrees of support for supervision** and often a lack of capacity within schools or FE colleges to provide this, or provide the funds to commission clinical supervision externally.
- Other logistical and organisation challenges revolved around the **delivery of support and particularly counselling outside of school times and during holidays**. Even in situations where schools managed to find a location to provide

counselling over a school holiday, they were often faced with the problem that the child or the counsellor were on holiday.

6.3 Engagement issues

The final set of challenges revolved around difficulties engaging young people, their parents and families. The difficulty engaging young people who either did not acknowledge they had a problem, or were reluctant to seek, or receive help, was an issue for both schools and FE colleges. Young people were also reported to have refused help because of a previous experience with NHS CYPMHS. Otherwise young people were reported to have been put off seeking help because of the stigma associated with mental health.

> *‘‘They've got to be in a place where they're ready to have help, really, and often, we'll find that they're not ready to start to learn until that's in place. They've got to feel safe, they've got to feel like they can trust you, they've got to feel like you respect them and until that point in time, the education is not going to happen.”*
>
> (Primary Special School)

Young people might also have been deterred from accessing provision as a result of resistance from their parents or families. Parents were reported to have obstructed the process by not providing the information that a school needed, or by not encouraging or reinforcing the support at home that schools were providing. Otherwise families were sometimes thought to be contributing to the problems for young people either because they had a mental health issue themselves, or as a result of them placing additional stress on their child. A lack of engagement by parents and families was attributed to:

- Previous poor experiences of education and/or dealing with professionals themselves.
- A failure to recognise their child had a problem or a cultural belief that mental health was not acceptable and their child would have to pull themselves together.
- Concern about the stigma attached to mental health and a reluctance to have their child labelled in this way, particularly if it was likely to be on their school record. A fear that admitting that there was a problem might result in their child being taken away.

> *"I think parents feel worried that their kids are going to be labelled… I think sometimes it's really hard for the parents to acknowledge that we're not making a judgement on them, it's about what's best for the child, and I think that's quite difficult."*
>
> (Secondary PRU)

7. Key learning about mental health provision

Chapters 2 to 6 have considered how 15 case study schools and FE colleges were identifying and supporting the mental health needs of their students. They provided a wide range of universal and targeted support and, to varying degrees, either referred young people on to specialist therapeutic provision, or delivered it themselves.

This chapter draws together the learning from the case study findings. It identifies what participants perceived was critical for developing and supporting the mental health needs of their students (section 7.1) and what worked best for successfully supporting staff (section 7.2). The chapter ends with the support they would value from the government and the mental health sector (Section 7.3).

Summary of key points

- There is a need to create a shared whole organisational vision and understanding about the approach to supporting mental health. This will ideally sit alongside and have equal prominence to the teaching strategy. The approach needs to support the mental health needs of staff as well as students. Supporting the parents and the wider family may be equally important even if it feels beyond the remit of the school/college.
- A senior member of staff, along with support from governors or executive board, is needed to drive the agenda forward in terms of the mental health support a school provides. The most appropriate way to organise the support will vary according to the size and type of school. Mainstream schools recommended the need for a strong and distinct pastoral, or support team, with clear roles and responsibilities.
- A whole school or college approach is critical for successful early identification of need and taking a preventative stance. Assessments and support pathways need to be fluid and flexible, and constantly reassessed. Alongside observing children, there is a need for a clear process to follow when staff are concerned or have something specific to report, much as they would for a safeguarding issue.
- The relationship between support staff and young people is crucial to them being able to build the trust and work effectively together. Staff need to be trained about mental health and bought in to the benefits of supporting young people. They need access to a diverse range of evidence based activities and interventions in order that there is scope to tailor the support to the needs of students.
- The government and wider sector could helpfully support schools and colleges by providing: more resources and tools, more training, more funding for specialist services, a directory of local services, a menu or bank of tools and activities that have been proven to work as well as tips on how to monitor and assess progress on these.

7.1 What works best for supporting pupils

Building on the evidence presented in this report, this chapter reflects on some of the key principles put forward for supporting the mental health of children and young people. These are based on the collective thoughts of all case study participants. They have been organised around developing the approach, promotion and prevention, the identification and assessment of need, and the delivery model or offer.

7.1.1 Developing an approach

The approach to supporting mental health needs to be developed and driven forward by a senior lead, or an inspiring champion along with the support of governors, or an executive board. The most appropriate way to organise the support will vary according to the size and type of school. Mainstream schools recommended the need for a strong and distinct pastoral, or support team, with clear roles and responsibilities; to avoid the boundaries between education and support becoming blurred.

A mental health and well-being agenda will ideally sit alongside and have equal prominence to the teaching strategy. It needs to be underpinned by a shared whole organisation vision about supporting mental health. The approach will address the management of universal, early intervention and preventative support at one end and specialist provision at the other.

Settings also emphasised the importance of allowing time to develop a 'wellbeing' approach or policy, and the need to engage the whole staff, students and parents in its development; as well as taking advice from health professionals providing specialist provision. The emphasis should be placed on managing and supporting mental health issues, instead of looking for a cure or a *'quick fix'*; and any support needs to allow for the possibility of future repercussions or a reoccurrence of a problem.

> *"I think it's important to say it's a journey that you're on. It's not a quick fix. It's not you go to a book, you read a chapter and then that's how you do it. You've got to be set on where you want to get to but be happy to meander along the way and try things out. And it is the principles of leadership …and if you can … get everyone working for the same reason, get the pastoral team on board. ….So it is a journey."*
>
> (Secondary Academy)

Otherwise the key recommendations and principles for developing the approach included the following:

- **Staff need to have been educated about mental health** and to appreciate the benefits of supporting young people's mental health needs.

- The approach needs to **support the mental health needs of staff as well as students**.
- **Supporting the parents and the wider family** may be equally important even if it feels beyond the remit of a setting.
- Assessments and **support pathways need to be fluid and flexible**, and regularly reassessed.
- The **relationship between support staff and young people is crucial** to building the trust and working effectively together.
- There is a need to offer a **wide range of high quality, evidence informed and timely provision** including whole school and targeted activities and interventions.
- The **type and size of school will have a bearing on what is possible.** A small primary school will find it easier to nurture pupils and their families than large secondary schools.
- **Processes, procedures and agreements need to be set up** to facilitate effective communication between staff in schools and FE colleges and external agencies. There needs to be an information sharing protocol between all parties; and a team around the family (TAF) process, where this is needed.
- For the larger schools and particularly FE colleges where resources are even more constrained, it may be helpful to **consider partnerships with other specialist service providers.**

7.1.2 Promotion and prevention

As a preventative strategy schools and colleges identified **the importance of a whole organisation approach for the promotion of good mental health**. This will help to normalise pastoral issues, and help to break down any fear or stigma associated with talking about mental health. Discussion of mental health and how to prevent and support it should become part of the school or college culture. Promotion and awareness-raising activities need to be embedded in the curriculum as well as through 'one off' activities. Any promotional material needs to positively focus on 'being well' or 'wellbeing' rather than mental health. It also needs to consider how to appeal and engage both young men and women as the former were believed to be less willing to engage and disclose a problem.

Recommendations for the best way to promote and raise awareness of the approach included, the use of:

- Transition days and induction processes
- National campaigns and activities
- Day to day activities such as assemblies
- Introductory meetings with the pastoral or student development team.

- Posters and other visual displays with an accompanying tear off strip with a phone number tag for helplines and other counselling services.

7.1.3 Identifying and assessing need

The **importance of developing a whole school or college approach** was pivotal to recommendations for successful early identification of need and taking a preventative stance. Schools stressed the importance of all staff – including teaching and other staff - in a school or college working together to be observant, to be aware of, to notice and communicate with each other about issues facing children and young people. This was described by a headteacher of a primary school as *'having lots of eyes looking at a situation'*.

Underpinning the whole organisational approach was a need to **create an open and supportive culture and ethos** where both staff, children and families feel comfortable about raising and sharing issues and concerns about mental health (see chapter 3 about promoting good mental health). This was helped by:

- Staff building a rapport and being encouraging and responsive when children and young people approach them.
- Creating opportunities to build positive and trusting relationships with families, children and young people so they feel comfortable about sharing and disclosing issues; and ensuring staff have a better grasp of the context and underlying issue.

Inevitably this was perceived as being much easier for smaller schools where staff had fewer children to get to know and where there were more opportunities to share information informally. However, despite the challenges of having large numbers of students in secondary schools and FE colleges, having some kind of tutor group or similar structure can help to ensure that there is at least one person who is building a relationship with a student and observing their development through their time at school or college. FE colleges also emphasised the importance of finding ways to continue to remind and encourage students to disclose issues to their personal tutors, as that was colleges' main pathway for identification.

Alongside observing children, there was a need for **a clear process to follow when staff were concerned or had something specific to report**, much as they would for a safeguarding issue. Schools emphasised the importance of setting clear procedures and practices for identifying needs, referring young people to any kind of provision and guidance and procedures for information sharing.

Having a central pastoral or support team who can oversee and monitor all information and records about students will also help to ensure problems are identified earlier and handled more effectively. They can work with staff to identify the warning signs and

symptoms, provide appropriate support and can encourage parents to seek help for their child. Collecting information and creating ‘a pupil profile’ or compiling a list of ‘vulnerable’ students to monitor will also ensure that schools and FE colleges can intervene earlier and prevent the escalation of problems.

In order to enable staff to be alert to, and capable of identifying risk, they all need to take part in **training to raise awareness of mental health and the identification of mental health issues.**

The successful and effective assessment of mental health needs depends on having some kind of assessment form or diagnostic tool which provides a framework for the process. The assessment will help to build a rounded picture of the student and will involve meetings with the student, their family (if appropriate) and speaking to any other professionals who may be involved. This is critical to tailoring and personalising the support to meet the needs of the student. The appropriately trained person in the setting (for example, the pastoral lead, the SENCO, family support worker, or head of safeguarding) needs to carry out the assessment process which will involve:

- Reading the paperwork and history of the child; and tracking the behaviour or symptoms back to when they first started.
- Understanding the child’s mental health needs, the circumstances and underlying causes, or root cause of the presenting issue.
- Understanding the wider context, the background about the child and their family.
- Observing the young person and their behaviour and understanding the challenges and difficulties they are facing and their requirements for support.
- Considering what would be best for them in terms of support.

At the end of the assessment process a bespoke and tailored plan should be developed to meet the individual’s needs. The plan needs to be clear and simple, with small achievable and gradual steps for the student to take. It needs to have goals and targets to aim for but also to retain some level of flexibility so that it can be realistic for the student. The student needs to be central to the plan and to have ‘bought into it’.

There were fewer recommendations relating to tools that could be used to assess need, perhaps reflecting the variation in practice and lack of knowledge about these. A PRU and special school recommended the SDQ, PASS and CORE and the Boxall assessment for carrying out a holistic assessment of needs, circumstances and surroundings. A FE college recommended an online referral system which had helped to encourage more students to self-refer. This also incorporated an initial assessment using the PHQ-9 and GAD-7 scores to assess risk for the young person. These findings suggest there is a need to provide more advice and information to schools and colleges about appropriate screening tools they might use.

7.1.4 The delivery model

Case study sites made a number of recommendations about how to organise and deliver any mental health support, including to:

- **Consider the physical location and organisation of provision**. A 'Hub' on site or some way of locating the pastoral team, or even an emotional wellbeing centre, away from the main school may be helpful. Where feasible it will also be helpful to include the use of outdoor space as part of the facility.
- **Consider providing a time out area** and system for using the facility to support students when there is a need. This needs to be a positive comforting space where students can relax, talk to a member of staff, or work. Ideally there will be a designated member of the support team who will be based in the room.
- **Consider who is best placed to support the child.** It may be helpful to set up a dedicated team so as to separate the academic and pastoral, or support staff roles. As a consequence they can develop a different type of relationship and students may feel less like they will be 'in trouble'. If feasible it may also be helpful to consider adopting a dedicated or ‘key worker’ approach where individual staff are specifically responsible for working with specific young people.
- **Provide as much of the core support internally rather than relying on external provision.** It was often felt to be better to develop internal staff rather than buying in external provision. However it is also important to ensure that students are clear about the confidentiality and the independence of any support they might use, such as counselling.
- **Consider the coordination and timing of preventative support.** There may be a need to provide preventative support around key 'crunch points' for students including, for example, transitions from or into a school or FE college and when choosing a course or taking exams.
- **Develop local networks** with other local schools and colleges to share resources and practice.
- **Get to know the external agencies** so there is a list of people or organisations to contact when there is a need to refer young people to external provision. This will also make the process of working together easier and improve information sharing issues. Explore opportunities for working in partnership and the feasibility of having a NHS CYPMHS practitioner based in the setting to provide support to staff and students.
- **Establish a clear referral process** and information sharing protocols when working with other external agencies and particularly NHS CYPMHS.

- **Provide a diverse range of evidence informed** activities and interventions to provide tailored support for students.
- **Counselling and therapy** should take place in a private room with a window that is not overlooked nor isolated. It may be helpful to have an activity for children and young people to be doing while in counselling or therapy sessions to enable them to talk. Art, play and Lego therapeutic interventions may be worth considering.
- **Be creative about how to involve parents.** Try to make it accessible and non-threatening for parents who may be wary of engaging with the school, or with the process of their child needing to access NHS CYPMHS.

7.2 What works best to support staff

Case study schools and FE colleges differentiated between the role and requirements of support and teaching staff emphasising that teachers are not mental health specialists. However, as already noted the wider staff were also acknowledged as being critical to supporting a whole organisational, whole staff approach.

Participants discussed the need to have a diverse team of people with the 'right' skills and aptitude, and an understanding of mental health issues. The following qualities and requirements were raised by participants as being important for supporting children and young people, however it was not clear the extent to which these were necessary for all staff, or just those actively supporting children. They ideally need to be:

- Good listeners
- Non-judgemental
- Emotionally intelligent and resilient (particularly in special schools and PRUs)
- Empathetic or have personal experience of and understanding of specific mental health needs
- Caring
- Calm and patient
- Creative, flexible and open minded

Aside from identifying the requisite skills, abilities and characteristics, they also stressed that staff who were providing support be appropriately developed, supported and supervised. They need to have been trained in the specific interventions they are delivering and have access to high quality training on a regular and frequent basis and regular supervision.

Participants highlighted that schools and colleges needed to achieve the following to properly support staff:

- Create an open, honest and non-judgemental culture for staff as well as students that does not talk about blame and mistakes.
- Build the emotional intelligence and resilience of staff and support their personal needs before they are asked to support students.
- Provide time for staff to reflect on their practice, manage their boundaries and have supportive colleagues whom they can talk to, informally and in regular formal supervision. There is a need for staff who are directly supporting students to have access to appropriate and regular clinical supervision, although the cost of this was mentioned as a considerable barrier.
- Provide regular training and CPD for all staff to support their learning about mental health, and for those directly supporting students to teach new practices, activities and strategies to try with different mental health conditions.
- Develop a formal set of procedures for staff to follow when young people come to staff wanting to discuss a problem.

The importance of providing an on-going programme of training for staff was recurrently emphasised by school and college participants. There were requests for:

- basic mental health training and understanding different mental health conditions;
- how to spot early (and later) signs of mental health issues;
- how mental health can affect the attitudes and behaviour of young people;
- information about the availability of provision in the school or college; and
- resilience training, solution focused training, specific training on the interventions being delivered, and more focused courses on mental health, attachment theory, ADHD, obsessive compulsive disorder (OCD) and autism.

There were preferences expressed for both online and face to face options being delivered internally, as well as by external specialists. In addition they also stressed the importance of more informal ‘on the job training’ and the option of engaging in activities, such as, role modelling for dealing with tricky situations.

7.3 Supporting schools and colleges

Case study schools and FE colleges had extensive ambitions and plans for expanding their range of mental health provision. These typically covered the range of activities they were offering, their identification processes, the way they were developing and training their teams and the way they were working in partnership. More exceptionally they discussed developing a policy for mental health and wellbeing. To help facilitate the development of their mental health provision, case study participants were briefly asked at the end of their interview about the support that they ideally need from the government and the wider sector. Their requirements covered four broad areas.

The first requirement was about **recognising and acknowledging the important work that schools and FE colleges are doing to support the mental health needs of their students**. It was suggested there is a need to encourage Ofsted and the government to consider the way they are assessing settings and take a broader approach that is not simply about academic measurement. The focus should involve observing and recognising the ways in which schools and colleges are developing well-rounded and happy students. Ofsted should look at the emotional wellbeing of children and young people and how schools are dealing with this and monitoring it.

> *"Until that aspect of it changes where the external scrutiny is looking at it, I just think teachers feel like they're fighting a losing battle really. Even if they know the two things are linked, the emotional wellbeing and learning are completely implicitly linked, even if they know that they still feel like they are measured on just the learning and not on the other ways."*
>
> (PRU Secondary)

The second requirement was **for funding for more services to help meet the gaps that they observed in their local mental health provision**. Aside from the inevitable request for more funding and more resources for schools and FE colleges to provide services, they advocated increasing the availability of mental health services in the wider NHS. Not surprisingly they recurrently stressed the need for more readily available support from NHS CYPMHS professionals. However, they also identified a need for more services and interventions to support students just below the threshold for NHS CYPMHS provision.

Mainstream schools reflected on the gap between what they can feasibly provide in terms of lower level anxiety support; anger management; self-esteem groups and what is available for the highest levels of need catered for by NHS CYPMHS. They identified a need for a service that is delivered by trained health professionals who can meet the needs of these children and young people. For those who did not have a named contact or close relations with NHS CYPMHS it was suggested that this would be helpful. It was suggested that this person would not necessarily need to be a doctor or psychiatrist, as a psychiatric nurse would be able to filter and triage cases and help address the difficulties they had contacting NHS CYPMHS.

The third requirement was for **providing more resources for schools and FE colleges.** A key area of concern was how to navigate their way through the array of information and resources that are currently available. Mainstream schools and FE colleges, in particular, were in need of support which would direct them to appropriate and high quality resources for them to use. They also requested more opportunities for them to share practice and ideas with other schools and colleges. A related concern was how to judge and assess the quality of external provision they required, whether for counselling or therapy or some other intervention, and how to judge and assess the wide range of

training provision which they needed to commission for their staff. While this appeared to be an issue for all schools and colleges, the issue was specifically raised in relation to academies who have no access to commissioning guidance for training and buying in provision.

Specific requests for resources covered:

- **More information about mental health issues**, how to recognise and identify the underlying issues and behaviour, the management and support of different mental health issues.
- **Tools to track, monitor and assess the impact** of their activities.
- **A directory of local services** and how to judge and assess their quality.

Case study sites proposed that resources could be delivered in different formats so as to appeal to a range of needs including links to publications, online resources, webinars and a website with clips of real life scenarios of people being interviewed who work with people with mental health issues, so they can talk through different situations and their experiences.

The final requirement was to expand and provide more training for trainee teachers to help them develop their skills and knowledge in this area.

> *"If I wear my purely headteacher hat and I came into education to educate, the system that I came through...I would love my teachers to be able to come to school and...teach children the curriculum. My teachers are not trained to be social workers, but that's what you have to be, almost, in this type of school. Now, if that's the way the government wants to take education, that's fine, but then you've got change...the training colleges. They've got to put more emphasis on understanding behaviour, emotional awareness of children..., and they have to make sure that that becomes part of their standards that they're measured by. We have NQTs every year; we train every year."*
>
> (LA Maintained Primary)

Individual participants spoke of the need for specific training approaches including: a mandatory rolling programme of greater mental health training within teacher training on mental health awareness and information; on how to identify the risks, early warning signs and symptoms; early clinical intervention; and more focused courses on mental health and autism.

8. Conclusions

This research was commissioned to provide learning about how schools and colleges are supporting the mental health needs of children and young people. It was commissioned by the DfE as part of a programme of work to inform the focus of policy activity on mental health and character education in schools and FE colleges in England. The research was set against a backdrop of growing evidence demonstrating the positive impact of emotional wellbeing on the outcomes for children and young people. This final chapter reflects on some of the key messages and recommendations resulting from the research.

8.1 Key messages from the research

- Schools and colleges explained the pivotal role they played supporting the mental health needs of children and young people in their care. To varying degrees, their approaches covered the promotion of good mental health and the creation of an environment where children felt safe and happy; the observation, identification and assessment of need; the provision of support and referrals to, as well as the delivery of, specialist therapeutic provision. Supporting the parents and the wider family were considered equally important but were often felt to be beyond the remit of a school or FE college.
- Successful mental health provision was felt to depend on having a shared whole school or FE college vision and approach for supporting mental health which was embedded in the teaching strategy. This needed to be driven forward by a strong and inspiring leader or advocate for mental health, and adopted and delivered by teaching and pastoral staff who had the appropriate skills and time; and access to resources and external provision that could be tailored appropriately to the needs of the students. Mainstream schools and FE colleges recommended the need for a strong and distinct pastoral, or support team, with clear roles and responsibilities.
- A whole school or college approach was also viewed as critical for successful early identification of need and adopting a preventative approach. It ensured staff were aware, were observing children and alert to the process they should follow when they were concerned, or had something specific to report, much as they would for a safeguarding issue. This helped to ensure schools reached students early on, as they recognised the warning signs and symptoms. The relationship between support staff and young people was crucial to them being able to build the trust and work effectively together.
- The research has provided evidence of the wide array of ways in which case study settings were promoting wellbeing and supporting the mental health of their students. They were using a wide range of universal and targeted activities and, to

varying degrees, either referred young people on to specialist therapeutic provision, or delivered it themselves. Parents were involved either in relation to the support provided for their child, or through their own parenting needs, and sometimes both.

- Inevitably the type, phase, size, location and resources of a school or FE college affected the approach adopted and the ease with which they could deliver their mental health 'offer'. Smaller settings with higher ratios of staff to children, with a stronger culture and ethos for engaging and nurturing children; with more resources and skilled staff, or with access to good facilities appeared to be building from a stronger foundation and infrastructure. In the context of competing pressures for delivering academic performance a lack of time and capacity to build relationships with students was often raised as a challenge.
- The availability of specialist provision when children needed it was a key and recurring challenge for all schools and FE colleges. There were reports of long waiting lists and high thresholds for accessing NHS CYPMHS. This resulted in schools and FE colleges having to find the resources to provide an interim solution to support the student while they waited. Having a named contact and/or regular contact with a person at NHS CYPMHS helped to build relationships and address some of these difficulties. It was also valued for providing specialist support and guidance for schools and FE colleges.

8.2 Recommendations from the research

In this final section we reflect on the recommendations that were made to inform the DfE and wider sector about the future policy direction for mental health provision in schools and colleges. There is a need to:

- **Appreciate that teaching staff are not mental health specialists** and they may not feel comfortable about having to take on this role alongside their teaching commitments. Staff may require additional training in order to provide appropriate mental health support in their school or FE college, including training about assessment tools and the use of interventions.
- **Take into account the increased demands and pressures being placed on teaching staff to achieve academic targets.** It would help for the government and wider sector to recognise and value the important work that schools and FE colleges are already engaged in to support the mental health and wellbeing of children in their care.
- **Support schools and colleges with the resources they need to build their infrastructure to develop a whole organisational approach** to supporting mental health. Teachers and pastoral staff need to be better prepared and

supported for their respective roles. They all need to have a good understanding of mental health issues and the confidence to identify needs and provide support to varying degrees (depending on their role). Schools would also like to have mental health resources that are adapted to the school environment and more widely available. Staff also need to be better supported through access to high quality training and supervision. Participants said the teacher training syllabus did not currently prepare teachers for the level of social emotional support they were required to handle.

- **Direct schools and colleges to information and advice they can use** and support the development of a directory of local services. Currently provision for supporting mental health appears to schools and colleges to be rather patchy and uncoordinated. As a result they seem to chance upon useful sites and tools more by luck than design. They also have no way of judging the quality of the resources and support they are accessing.
- **Provide a menu or bank of evidence based resources and tools**, plus guidance about how to measure and assess progress and impact of these. For example, a risk assessment tool used to identify and assess mental health needs which is designed specifically for a school setting.

Appendix A. Mental health lead topic guide

*Exploring how schools and colleges provide character education and **support the mental health** of pupils*

Topic Guide for Head/Deputy/School Lead

Aims of the Case Studies - to:

- Provide in-depth understanding of the way schools, colleges and alternative education institutions provide character education (CE) and support the mental health (MH) and wellbeing of pupils;
- Understand what underpins judgements and decisions about the range of provision offered; who provides it, how it is funded and delivered;
- What works for identifying and engaging children and young people in different circumstances; and how their needs are assessed;
- Explore decision making about how activities are integrated into school or college programmes; learn about what works best in terms of practice and delivery, including around universal or targeted approaches; and the range of staff needed to deliver this;
- Understand the facilitators and barriers for delivering effective character education and mental health support;
- Explore how the workforce have been developed and supported; and the ease with which school, health and other community based professionals are working in partnership;
- Identify best practice approaches which facilitate effective, innovative and high quality approaches to the provision of support for mental health and character education.

Definitions: Researchers will avoid providing a definition of CE as we are keen to explore the way their school defines CE. Where the participant is struggling with this - we are defining CE as any activities that aim to develop certain character traits in pupils. So this might include traits associated with academic attainment or employability, or traits that will help pupils make a valuable contribution to society as good citizens

Focus of CE: Researchers to focus on both the 'caught' and 'taught' aspects of character education. Much of CE is delivered through the way the school is set up, its core values, the teacher/student relationships / activities it offers etc (referred to as the 'hidden curriculum').

1. Introduce self and Research Team

- The National Children's Bureau (NCB) (working with NatCen who carried out the survey) have been commissioned by DfE to carry out research to:
  - Explore how schools/colleges support the social and emotional wellbeing pupils
  - Reflect and identify effective practice to develop key 'character' traits and support the mental health of pupils
- The findings will be used to share and promote good and effective practice across the sectors; and to identify any additional support that is needed
- We are carrying out 26 case studies in a cross section of schools and colleges
- Consent for digital recording

- Reassure about confidentiality – we will not be sharing information between colleagues or passing on any personal or organisational information to the DfE.
  - Explain that we will not name any of the case study schools/colleges in the report
  - We will present a short profile of each of the 26 schools/colleges in the introduction but only refer to them as Case Study A etc. and will ensure that nothing is written that is unique to the school/college or that could lead to identification of the school or college.
  - We will send a copy of the report and the case studies of good practice to them when published
- Emphasise voluntary participation
- Check interview length (Up to 90 minutes)
- Any questions/concerns

2. Participant Background (BRIEF)

- Briefly describe role(s) and responsibilities; length of time in post
- What specific role do they have supporting the mental health of pupils/families
- Can they (briefly) provide a profile of the pupils/students who come to their school/college; how many in total; and where is their catchment area

3. Developing an approach/policy for MH provision

- What do they see as the **role and responsibilities** of their school/college in promoting the wellbeing and supporting the MH of children; what should they be responsible for/not responsible for
- Do they have a **mental health policy**; reasons why/why not
- What is the aim of their policy or approach for supporting the MH needs of pupils
  - Who is their policy or approach targeted at; whole school or specific age groups – and if so, which
  - How is it promoted; can we see it (*if we have not already been given a copy*)
- **Why they adopted this approach**; what influenced their decisions
  - What (if anything) informed their approaches to MH provision; how helpful was any information and evidence they drew on
- How did they **develop their policy/approach** to supporting MH of pupils; who was involved in developing it (governors, staff, pupils, parents etc.)
  - What role did staff play in the development of their approaches/policies
  - What (if any) role did parents/ carers and children/ young people play in the development of their approach to MH provision
- How easy was it to develop a policy/approach; what if any challenges or difficulties did they encounter; how did they address these
  - What (if anything) would have made it easier to develop their approach
- Where do they **get their information and evidence** about effective approaches for supporting MH needs
- How have they **funded their provision**; what funding streams have been available to them; any issues experienced with this
- FOR SPECIAL SCHOOLS AND PRU'S ONLY: How do their different funding streams (e.g. they have access to wider funding streams than mainstream schools such as through an EHC Plan) enable them to offer a greater range of provision
- How do they **promote their MH provision** through their school/college to staff, parents and pupils (e.g. prospectus/website, mission statement)
  - What words do they use to describe it to staff; to pupils and parents
- How well-informed are staff about the approach/policies; how well do they understand them
- What has helped to promote and engage children, young people and parents
- How does their **approach fit with other school policy/agendas**; the broader school/college ethos

- How (if at all) do they see their approach for MH provision relating to the **development of character traits and delivering CE**
  - To what extent do they try to join up their approach to supporting the MH needs of pupils with the development of character; how well does this work
- How familiar are they with their **local CAMHs Transformation Plan**
  - How does their approach align with their local CAMHS Transformation Plan

4. Overview of their approach to supporting MH needs
School College Lead: Ask all questions
Head/Deputy: Ask questions according to their level of involvement

- Who is responsible for **organising and coordinating** their MH provision in the school/college

- How do they **decide what provision children need**; who allocates them to provision; who sets up a plan for the child/young person
- How do they **identify and assess children's needs**; who is responsible for identifying and assessing needs
  - Which children do they assess; all or just those who they think need extra support
  - What tools do they use to identify and assess needs (e.g. SDQ, Boxall profile)
- How does the approach vary for assessing different levels of need or for determining eligibility for different types of support (e.g. children and young people with SEND, LAC and homeless children and young people)
- How easy is it to identify risk early and prevent the escalation of problems

- **SPECIAL SCHOOLS AND PRU'S ONLY**: How does the **EHCP process** (in special schools) and other identification processes used in PRU's **help to identify mental health needs**
  - How well do they integrate the identification of children with different needs (e.g. identification of SEN needs vs identification of MH needs)

- Can they describe all the ways in which they support the the MH of children in their school/college (***Use survey responses to prompt people***)

- What **universal, preventative activities do they undertake with the whole school/college** (E.g. information and advice, resilience training, Mindfulness)
  - What is the aim of the different activities they are providing
  - Who is it offered to; what age are the children/young people
  - How are these activities delivered; who delivers them
  - How are they integrated into the curriculum (e.g. whole school approach through an assembly or classroom based activities, PHSE, etc.)

- What **other more targeted support do they provide (e.g. counselling)**; who is this targeted at
  - What is the aim of the different activities they are providing
  - Who is it offered to; what age are the children/young people
  - Who delivers these activities
  - When and how are these activities delivered
  - How is this support integrated into the curriculum

- How do they **support children/young people with more complex needs** who need more specialist provision (E.g. individual therapy, group therapy, play therapy, educational psychologist)
  - Who delivers this support(e.g. CAMHS workers, clinical and educational psychologists, individual and group therapists, mental health nurses and specialist practitioners)

- How is this support delivered (in the school or college or accessed elsewhere)

- How (if at all) do they **involve/support or work with parents/carers** (inform them about the initiatives or engage them in family activities etc.)

- How **easy has it been to engage students, staff and parents in their provision**; what worked best for engaging students, staff and parents
- What **challenges and resistance have they encountered**; how did they address and overcome these
  - Capacity and resourcing barriers
  - Commitment barriers
  - Other barriers

- How (if at all) do they **monitor the success and track outcomes** of the activities they deliver
- How are young people, parents and other professionals involved in the review process
- Whether they gather feedback from parents children and young people about their MH provision
  - (Where they do this) How do they collect feedback from children, young people and parents

5. Supporting the school college workforce
School College Lead: Ask all questions
Head/Deputy: Ask questions according to their level of involvement

- What **support and skills development have staff needed** to support MH needs effectively
  - Who receives this training (e.g. for the whole school – CPD/Inset day or for specific teachers with responsibility for mental health)
  - How is it delivered
  - How are they supervised and supported
  - What (if any) training did they need to equip them to support the MH needs of children
- What **other training do individuals**; all staff need

- Which **health professionals are employed** (either part or full time in a school or college) to support children (e.g. a school nurse, school counsellor; other people)
  - How many hours per week do they work
  - Who manages these people
  - How are they supervised and supported
  - What (if any) training did they need to equip them to deliver these activities

- How well do these **school and health professionals work together**
  - What have been the challenges for working together to support the MH needs of pupils

6. Use of external services

- What if **any provision is outsourced**; to whom; what role/service are providers commissioned to deliver (e.g. deliver a service, be a named point of contact in targeted or specialist mental health services)
  - Which voluntary and community sector (VCS) providers are involved in delivering in-school provision (e.g. delivering counselling, drop-in advice sessions, anti-stigma work and initiatives to promote resilience and coping skills)
  - Which other specialist mental health providers are involved in delivering provision (e.g. CAMHS workers, clinical and educational psychologists, individual and group therapists, mental health nurses and specialist practitioners)

- How is **any external provision accessed, organised and funded**; who leads on this within the school/college
  - Can the school refer directly to CAMHs or adult mental health services
- Is there a named point of contact in CAMHs or other specialist services; how does this role work

- What has **worked well/less well with any outsourcing/commissioning** arrangements they set up
  - What have the main challenges been; how have they addressed these
  - How well do they work with CAMHS /adult mental health services and other specialist services work
- How do they **support joint working**; how embedded are the external specialist or other professionals in the school/college approach
- What is **key to successful working with CAMHs** or other specialist provision

- How is **(external) provision quality assured** (in terms of delivery staff qualifications and training)

- **SPECIAL SCHOOLS AND PRUS:** How did they **build and maintain the links with specialist services**
  - How if at all their links are extended to/exploited by other schools; how well does this work (e.g. mainstream schools using the links made to facilitate access to CAMHs or special schools or PRUs being a lead or link between a wider group of schools and CAMHs).

7. Reflections on MH provision

- How well is their approach/practice to supporting the MH needs of children/young people working; **what is working well; less well;** who for; **how do they know this**
- What **works best for identifying and assessing** needs
- What **approaches work best for pupils** (e.g. whole school, universal interventions, group, individual, peer led, teacher led, professional led)
- How, if at all, would they like to **expand or develop the provision** they deliver
  - Their approach and the tools you use
  - The way they identify and engage children and young people
  - The range of provision they offer
  - The support and training of staff
  - The way they work together with health practitioners and CAMHs
- Is there a **need for more information, advice** about how to support the MH needs of children/young people
  - How would they want this information provided
- What **best practice and innovative tips** or advice would they pass on to other other schools and health professionals working in a school/college
- What would be the **best way for us to carry out research with children, young people and parents** to explore their views about the provision that schools/colleges deliver
  - How **feasible** would it be to speak to children and young people who have engaged in specific interventions to support their MH
- **What feedback** would it be helpful to collect from children and young people and their parents

8. Closing

- Is there anything we have not covered which they think is important
- Reiterate confidentiality assurance.
- **Tell them about the workshops which will be held in the w/c 16 January 2017**

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The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.

Any enquiries regarding this publication should be sent to us at: catherine.newsome@education.gov.uk or www.education.gov.uk/contactus

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