EDUCATION, EDUCATION, MENTAL HEALTH

SUPPORTING SECONDARY SCHOOLS TO PLAY A CENTRAL ROLE IN EARLY INTERVENTION MENTAL HEALTH SERVICES

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IDEAS to
CHANGE LIVES

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SUMMARY

There is a crisis affecting children and young people's mental health in England, with three children in every classroom experiencing a clinically diagnosable condition. Despite the growing number who require help, cuts to the funding of both NHS and local authority 'early intervention' services, which can prevent emerging mental health problems from escalating further, mean that increasing numbers of children are unable to access appropriate and timely support.

Early intervention mental health services for children and young people must be rejuvenated – and secondary schools should play a central role in this, complementing wider community and NHS provision.

There is currently a great deal of variation in both the *availability* and *quality* of school-based early intervention provision. This is due to four major barriers:
*   schools' inability to access sufficient funding and resources
*   a lack of established mechanisms by which schools can influence commissioning decisions taken by clinical commissioning groups (CCGs)
*   the inconsistent quality of mental health support available to schools to buy in directly
*   a lack of external checks on the appropriateness and quality of the approaches taken by individual schools.

The government must find ways to overcome each of these four barriers if schools are to fulfil their substantial potential for meeting pupils' emerging mental health needs, and play a central role in the transformation of children and young people's mental health services. This should involve guaranteeing every secondary school access to a mental health professional who delivers targeted interventions on-site, and making school counselling a regulated profession.

Key findings
Secondary schools face a 'perfect storm'
*   Demand for access to child and adolescent mental health services (CAMHS) has accelerated since 2010. The number of hospital admissions of 0–17-year-olds who had self-harmed increased by more than 50 per cent between 2009/10 and 2014/15.
*   At the same time, mental health services have faced growing financial pressures. In 2012/13, just 6 per cent of the total NHS spend on mental health went to services for children and young people.
*   The erosion of NHS and local authority early intervention services means that local CAMHS systems have become trapped in a vicious cycle that is reducing their ability to meet the growing level of need. The value of the 'early intervention' allocation received by local authorities fell from £3.2 billion per year in 2010/11 to £1.4 billion in 2015/16, a reduction of 55 per cent.
*   A consequence of cuts to services combined with a rising tide of mental ill-health is that secondary schools are being forced to pick up the pieces. In 2016, 90 per cent of secondary school headteachers reported an increase in rates of mental health problems such as anxiety and depression among their pupils over the previous five years.

The current picture
- Secondary schools are well-placed to act as the hubs from which early intervention provision is delivered by health professionals, alongside wider provision elsewhere in the community. School-based services can:
  - improve accessibility
  - better address school-related stressors
  - significantly ease pressures on specialist CAMHS
  - facilitate a wider culture within schools that values mental health and wellbeing.
- There is, however, significant variation in the *availability* of school-based early intervention mental health provision. Furthermore, where pupils are able to access these services within their school, they are often lacking in *quality*.
- The government's planned 'transformation' of children and young people's mental health services has so far failed to give schools the central role that was envisaged. Some CCGs are failing to direct transformation funding to frontline services, and just half of secondary schools expect to contribute to the local transformation of services.

Four barriers to improvement

1. Funding
Schools largely lack the funding required to provide pupils with targeted mental health support. They have long been unable to access funding, or services paid for by health providers, that would allow early intervention services to be provided on-site.

2. Commissioning and representation
In an increasingly academised school system, schools often lack the internal expertise they need to commission mental health support effectively. Schools also lack established mechanisms through which to influence commissioning decisions at a CCG level.

3. Quality
The quality of mental health support (particularly school counselling) available to schools is inconsistent, and schools do not receive sufficient guarantees that the specialists they commission or purchase have suitable levels of training and experience.

4. Accountability
Ofsted inspectors are not routinely assessing schools' mental health provision, despite recent changes to that end. This means there are insufficient external checks on the appropriateness and quality of the particular 'professional mix' that individual schools bring together to meet their pupils' mental health needs. Just one third of a sample of Ofsted reports published since the changes were introduced make explicit reference to pupils' mental health and/or emotional wellbeing.

Key recommendations

Funding
- **By the end of the current parliament, all secondary schools should be guaranteed access to at least one day per week of on-site support from a CAMHS professional who is able to provide targeted mental health interventions to pupils, rising to two days per week by 2022/23.**
- By 2020/21, this should be funded from within CCG budgets but delivered on school sites. In the interim, this should be phased in gradually using transformation funding. NHS England should stipulate that transformation plans are updated accordingly, with a portion of non-CCG transformation

funding also set aside to enable schools to be granted the right to request outreach CAMHS support.

- As well as funding universal services, headteachers should top-up this 'basic minimum' in early intervention provision using their own budgets, on the basis of ongoing assessment of pupil need.

Commissioning and representation

- **Transformation funding allocated to CCGs should be ringfenced.**
- Local transformation plans should be subject to more rigorous processes of assurance in order to protect funding that should be directed towards children and young people's mental health services from being subsumed into other CCG expenditure.
- All CCGs should be required to convene a headteachers' mental health forum for the local area, to sit at regular intervals each year. This would ensure that secondary schools are able to influence funding decisions in a more systematic and meaningful way.
- All CCGs should be required to identify 'beacon schools', selected according to their pupils' ability to access high-quality mental health provision. These schools should be used as a means of spreading best practice within local areas.

Quality

- **The government should set out a roadmap towards making counselling a regulated profession, with a clear 'specialist' route for working with children and young people in school settings.** In the short-term, this should involve the following.
  - A national recruitment drive for school counsellors, to ensure that the spread of counselling provision to *all* schools is not held back by the number of counsellors available.
  - An assessment of available training courses, with a view to raising entry requirements in line with other professional qualifications regulated by the Health and Care Professions Council.
  - Introducing a new 'school-ready' kite mark that demonstrates counsellors' specific knowledge on, and experience of, working with children, young people and families in a school setting.

Accountability

- **Ofsted must ensure that inspectors actually assess schools' mental health provision according to the changes to the framework that were introduced in 2015/16.** Inspectors should be instructed to assess schools according to the presence or quality of the following key features:
  - processes for monitoring pupils' mental health and wellbeing, and identifying pupils who are at risk of emerging problems
  - an effective internal system of triage, conducted by professionals who have the appropriate level of mental health expertise
  - arrangements for the clinical supervision of mental health specialists
  - the strength of referral pathways to specialist services
  - an appropriate mix of expertise and professionals operating within the school
  - evidence of the effectiveness of school-based interventions
  - the strength of schools' links to CCGs.

- Ofsted should work with the Care Quality Commission to undertake 'joint targeted area inspections' for children and young people's mental health (as recommended in the Mental Health Taskforce's 2016 report, *The Five Year Forward View for Mental Health*).

1.
INTRODUCTION

There is a crisis in children and young people's mental health in England, and nowhere is this felt more acutely than in our secondary schools. Schools and their staff increasingly find themselves on the frontline of this crisis, dealing with a growing number of pupils who experience mental health problems.

The statistics are startling. Three children in every classroom are now thought to have a diagnosable mental health condition, with mental ill-health affecting roughly one in 10 children and young people (Layard 2011).[1] Facing these challenges at such an early age can cause young people's educational attainment, their ability to form healthy relationships with their peers, and the quality of their family life all to suffer. What's more, mental ill-health during childhood and adolescence can go on to dramatically impact outcomes later in life, affecting future earnings, physical health and even life expectancy.

There is, therefore, an urgent need to find ways to better protect the mental health of children and young people. We cannot expect to have a healthy, happy and economically productive society when so many young people are affected by emotional problems such as stress, anxiety and depression, and behavioural problems such as conduct disorder and severe attention deficit hyperactivity disorder (ADHD).

Meeting the challenge that this poses has been made considerably more difficult by the fact that the system for managing the mental health of children and young people – which involves the NHS, local authorities, Public Health England, the voluntary and independent sectors, schools and clinical commissioning groups – is unnecessarily complex and under severe strain. In recognition of this fact, and as the number of stories highlighting individual tragedies experienced by families has risen, children and young people's mental health has risen up the policy agenda.

NHS England, the Department of Health and the Department for Education are now working together to administer the 'transformation' of services, using an injection of £1.25 billion in government funding over the course of the current parliament. Central to this approach is the ambition that all local stakeholders will work together to understand the nature of local need and how best to meet it – with a particular focus on the rejuvenation of early intervention services based in the community. A gradual erosion of this layer of services over recent years has increased the pressure on more specialist services, as more and more children and young people are denied the early help they need in order to prevent emerging mental health problems from developing into more severe and complex conditions.

However, there remains considerable uncertainty about the role that schools should play in this agenda. There is significant variation in the extent to which children and young people are able to access 'early intervention' mental health services in schools; and where schools do make such services available, they are often of poor quality.

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1   See chapter 2, section 2.1 of this report for a fuller discussion of these figures.

While schools have been granted greater autonomy to find their own ways to meet the mental health needs of pupils, this autonomy has not been accompanied by measures to strengthen their capacity in this area, or by a commitment to improve and develop the resources in the community that schools can draw upon. Furthermore, schools are struggling to have their voices heard in the unfamiliar world of health commissioning, as academisation has diminished the 'brokerage' role played by local authorities. As a result, too many pupils continue to be denied the option to access high-quality, school-based early intervention services for emerging mental health problems.

Schools have the potential to become a key part of the mental health infrastructure for children and young people. If they are to fulfil this potential, it will be necessary to take the important step of recognising them as centres of both education *and* health. This report sets out why it is important that schools do take on a greater role, how that role should be conceived of in practice, and how government can build on the 'transformation' agenda to provide schools with the mix of resources and incentives they need to meet pupils' emerging mental health needs, and hold them to account for doing so.

About this report

The empirical research presented in this report was conducted between November 2015 and April 2016, and consisted of interviews, focus groups and case study visits with young people, teachers, headteachers, CAMHS professionals, voluntary sector providers of school-based mental health support, clinical commissioning groups, local authority representatives and leading experts from the worlds of mental health and education. The evidence and views thus collected were supplemented by an extensive literature review of secondary sources.

The report consists of three broadly distinct parts.

The first part comprises chapters 2, 3 and 4, and examines why England's secondary schools are facing a 'perfect storm' in terms of mental health issues among pupils, and how this situation came about. Chapter 2 considers the evidence that indicates a growth in the prevalence of mental ill-health among children and young people in recent years, and looks at which particular conditions have become more widespread. Chapter 3 examines the current financial and organisational, as well as demographic, pressures on child and adolescent mental health services. Chapter 4 then reviews how these two trends are impacting specifically upon secondary schools, which in many ways are left to 'pick up the pieces'.

The second part, chapters 5–9, makes the case for putting secondary schools at the heart of early intervention provision for children and young people with emerging, low-level mental health problems. Chapter 5 presents the case for the revitalisation of early intervention mental health services for children and young people, and chapter 6 sets out the four key arguments in favour of early intervention provision in secondary schools, as well as in traditional 'health' settings. Chapter 7 reviews how recent policy changes have affected school-based mental health provision, and chapter 8 gives an overview of the different ways in which such provision is delivered in schools, highlighting a number of distinct 'categories' of school-based mental health provision, different combinations of which have emerged as a result of schools being granted autonomy to design their own 'whole school approaches'. Given this varied picture, chapter 9 explores the roles, responsibilities and accountability of four broad groups of professionals who are involved in mental health provision in English secondary schools, and questions whether they have the resources they need to meet the needs of their pupils.

The final part, chapter 10, presents IPPR's conclusions and recommendations on how schools and services more generally can better meet the mental health needs of children and young people, based on the evidence and analysis presented in the preceding chapters.

2.
RISING LEVELS OF MENTAL ILL-HEALTH AMONG CHILDREN AND YOUNG PEOPLE

Three children in every classroom now have a diagnosable mental health condition, of which the majority are behavioural or emotional conditions. There has been a long-term trend of increased childhood morbidity related to mental ill-health since the 1970s, but this trend appears to have accelerated since 2010. This chapter explores the prevalence of the most common mental health conditions affecting children and young people, how this situation has changed both over the long term and since 2010, and the range of factors that are likely to be driving these changes.

2.1 Understanding the current picture

It is widely believed that there is a crisis in the mental health of children and young people. The scale of the problem is such that professionals have warned of a 'hidden epidemic' (RCPCH 2010), while a wide variety of other stakeholder groups, including young people themselves, have also voiced real concern. Consider the following findings.

- Mental health was selected as the fifth-most-important topic in the 2014 Make Your Mark youth referendum, in which 876,000 young people across the UK were balloted (Youth Parliament 2014).
- In a 2015 survey of 1,180 headteachers, two-thirds named the mental health of pupils as their top concern (The Key 2015).
- A 2015 survey of 2,000 parents found that 40 per cent worried about their children's mental health more than they did about any other health concern (Action for Children 2015).

Despite the consistency of these reports' findings, the absence of official data on the topic makes it difficult to arrive at a firm understanding of the current levels of mental ill-health among children and young people. Prevalence data used to be collected every five years, but the last study was published back in 2004.[2]

According to that 2004 study, 9.6 per cent of children and young people aged between 5 and 16 had a clinically diagnosable mental health condition. That translates into roughly three children in every classroom (Layard 2011).

That rate of prevalence rises from 7.7 per cent among 5–10-year-olds to 11.5 per cent among 11–16-year-olds, which indicates that mental health conditions become more common (or at least more commonly diagnosed) among young people as they reach and progress through adolescence. Among both age groups, boys are more likely to be affected than girls (Murphy and Fonagy 2013).

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2   However, an updated study is currently being conducted by NatCen, and is due to be published in 2018.

2.2 Understanding different conditions: What does mental ill-health among children and young people look like?

Children and young people can experience a wide range of mental health conditions, although the majority can together be described as either *emotional* or *behavioural* disorders.[3] Within these two distinct groups are a number of particular conditions that span spectrums of severity and complexity.

Behavioural disorders

The most common behavioural disorders are conduct disorders, which affect 5.7 per cent of 5–16-year-olds. Conduct disorders are more common among 11–16-year-olds than among 5–10-year-olds, and are twice as likely to affect boys as they are girls (Green et al 2005).

Different types of conduct disorder can present with different symptoms. For example, oppositional defiant disorder is characterised by argumentativeness, anger and disobedience, while socialised conduct disorder means that young people engage primarily in solitary, antisocial activities. To be diagnosed with conduct disorders, symptoms must be so severe as to cause distress or impairment in a young person's functioning.

Severe ADHD is another type of behavioural disorder (also described as a hyperkinetic disorder). This condition affects 1.5 per cent of children and young people, the vast majority of whom are boys. Children and young people with severe ADHD are typically hyperactive, impulsive and inattentive (Green et al 2005).

Studies have found evidence for a long-term increase in the prevalence of behavioural disorders in adolescents from studies dating back to 1974 (Collishaw et al 2004).

Care and treatment for conduct disorders typically include social skills groups, behavioural therapies and talking therapies. For moderate-to-severe ADHD, medications can play an important part in managing the condition by helping to reduce hyperactivity and improve concentration. However, medication must be accompanied by behavioural management strategies if it is to be fully effective. Such strategies can be used by teachers and parents, and parenting programmes are sometimes used to facilitate their use.

Emotional disorders

The most common emotional disorders among children and young people are anxiety and depression.

Anxiety can either be specific to certain situations or events, such as social anxiety which affects a young person's ability to meet new people and speak in front of large groups, or be more general and so affect a wide range of everyday life occurrences. Anxiety is often accompanied by physical symptoms such as restlessness, fatigue, poor concentration, irritability and or insomnia (Green et al 2005).

Depression in children and young people is characterised by feelings of sadness, irritability and a persistent, general loss of interest. Depression may also be associated with deliberate self-harm and/or suicidal thoughts.

Symptoms of emotional disorders in children and young people can sometimes be brought about by exposure to prolonged or acute 'stressor' situations or experiences, such as changing school, bereavement or parental separation.

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3   Other, less common conditions include eating disorders, for which there was an increase in hospital admissions of 89 per cent between 2010/11 and 2013/14 (Ward 2015); and psychosis, most commonly schizophrenia, which affects 0.4 per cent of children and young people and becomes more common after the age of 15 (NICE 2013).

Furthermore, adolescents are thought to face a number of particular and unique stressors brought about by increased independence and autonomy, the physical changes that come with puberty, and educational pressures (Hagell et al 2012a).

The 2004 prevalence study estimated that 3.7 per cent of children and young people have an emotional disorder. Around 0.9 per cent of children and young people were found to be seriously depressed, with anxiety affecting between 2 and 3 per cent of children and young people. The prevalence of emotional disorders among 11–16-year-olds is roughly twice that of 5–10-year-olds (Green et al 2005). Studies point to a long-term trend of increasing incidence of emotional problems among adolescents, with a significant increase between 1986 and 1999 (Collishaw et al 2004).

Talking therapies and counselling are the predominant forms of care treatment offered to children and young people with emotional disorders; medication is a less commonly used option. This care is often delivered outside of specialist child and adolescent mental health services (referred to by the acronym CAMHS). In 2004, just one-quarter of the parents of children and young people with a diagnosable emotional disorder had contacted, or been referred to, CAMHS (Green et al 2005).

2.3 How are things changing?

Despite the absence of up-to-date prevalence data, we do know that demand for children and young people's mental health services is increasing. This is likely to be explained, at least in part, by increased rates of morbidity for both emotional and behavioural disorders. There are a number of proxies, such as levels of self-harm, that suggest that an increasing number of children and young people are experiencing increasing levels of psychological distress.

Figure 2.1
The incidence of self-harm among children and young people has increased substantially in recent years
Number of admissions relating to self-harm for patients under 18 in England, 2009/10–2014/15
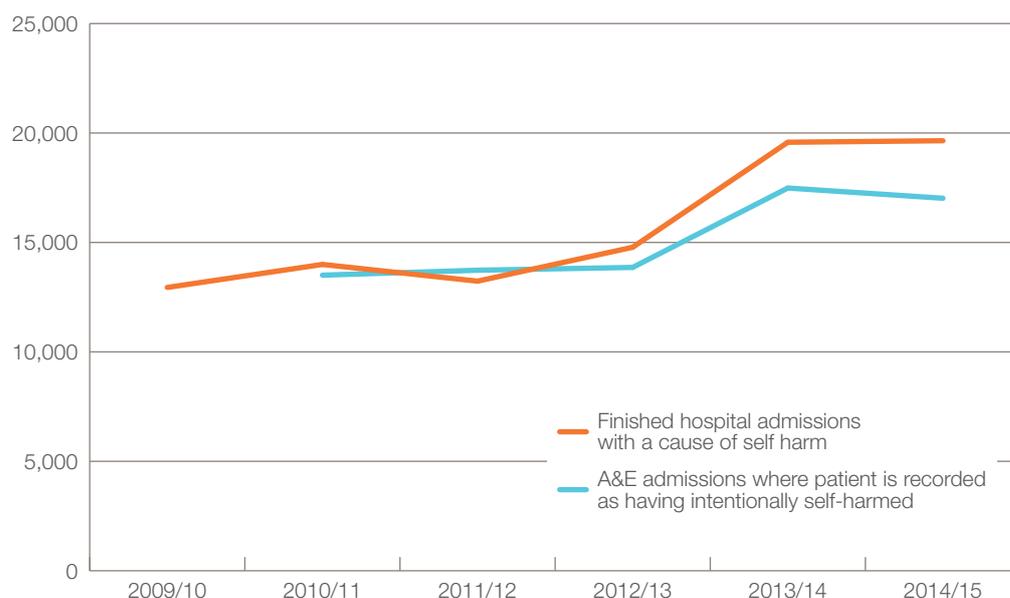

Source: Burt 2016a and 2016b

Figure 2.1 illustrates how, over the five-year period between 2009/10 and 2014/15, the number of finished hospital admissions of 0–17-year-olds due to self-harm increased by more than 50 per cent, reaching 19,647 in 2014/15 (Burt 2016a). Similarly, over the four-year period to 2014/15, the number of A&E admissions of 0–17 year olds for which intentional self-harm was recorded increased by 26 per cent, reaching 17,019 in 2014/15 (Burt 2016b).

While the Department of Health has argued that these increases can be explained by the issuance in 2013 of new guidance on how A&E staff should record instances of self-harm, mental health charities have argued instead that it is an accurate reflection of increased incidence (Wright 2016). In 2013, the children's helpline charity ChildLine reported that the number of calls they received that were related to self-harm had increased by 41 per cent since 2011 (NSPCC 2013). And in 2014, 43 per cent of the 15-year-olds who took part in a World Health Organisation survey said that they self-harm at least once a month.[4] Reports such as these indicate that the increase in admissions is likely to be predominantly the result of increased incidence rather than of changes to guidance.

A number of other indicators also suggest increases in rates of mental ill-health among children and young people in England, both over the long-term and since 2010.

• In 2011, twice as many adolescents were estimated to have emotional or behavioural problems than in the 1970s (Layard 2011).

• The number of 0–17-year-olds admitted to A&E with a diagnosed psychiatric condition more than doubled between 2010/11 and 2014/15, from 6,950 to 14,917 (a 114 per cent increase) (Burt 2016b).

• ChildLine reported a 33-per-cent increase in the number of children and young people who contacted them and talked about suicidal thoughts between 2011 and 2013 (NSPCC 2013).

2.3 Why are things changing?

The factors contributing to the increased prevalence of emotional and behavioural disorders among children and young people are multiple and complex. Some can contribute to accounting for the long-term trend of increased prevalence over the past 30 years; others can help explain the sharp rise in admissions observed since 2010. Many explanations involve children and young people becoming exposed to different types of stress and pressure. According to Collishaw (2012), 'if adolescents have been experiencing more stress, there is enough evidence to suggest that we could expect this to be related to rising trends in mental health problems too' (Hagell et al 2012a: 41). Considering the factors that may have increased the stresses that children and young people face can therefore help us to understand the increased prevalence of mental ill-health among them.

Parental mental ill-health, and changing levels of socioeconomic disadvantage

While mental ill-health can affect children and young people across different socioeconomic groups, prevalence is weighted disproportionately towards those in the poorest households, who are three times more likely to develop mental health conditions than those growing up in better-off homes (Green et al 2005). Part of the reason for this, according to Hagell et al (2012a: 34), is that 'stressful and unpredictable negative life events occur more often to young people in low versus high socioeconomic status contexts'.

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4   http://www.youngminds.org.uk/news/blog/2364_children_s_admissions_to_hospitals_for_self-harm_at_a_5-year_high

Relatedly, children and young people's wellbeing is often negatively affected by parents who experience mental ill-health. Almost two million adults were in contact with specialist mental health and learning disability services during 2014/15, while 75 per cent of people with mental health problems, including lower-level conditions such as depression and anxiety, received no support at all (NHS England 2016). Given that parental depression is considered the best-established risk factor for the development of emotional problems in children and young people (Gardner et al 2012: 86), it is no surprise that the current high levels of adult mental ill-health are occurring alongside similarly high levels among children and young people.

Depression in adults can often be caused by the stressors associated with social disadvantage. A number of trends in recent years indicate rising levels of social disadvantage which could, in turn, have had a negative effect on the mental health of both parents and children and young people.

- **Real wage stagnation:** Real wages rose consistently at around 2 per cent per year between 1980 and the early 2000s, before falling dramatically after the financial crisis in 2008. Between 2008 and 2014, median real wages fell by between 8 and 10 per cent, which corresponds to an almost 20 per cent drop relative to the trend growth seen between 1980 and the early 2000s (Machin 2015).

- **Child poverty:** Levels of child poverty in the UK fell from 4.4 million to 3.6 million between 1998/99 and 2010/11, meaning 800,000 children were lifted out of poverty. However, between 2010/11 and 2013/14, the number of children living in relative poverty remained relatively constant, having reached 3.7 million (or 28 per cent of all children) (DWP 2015). The Institute for Fiscal Studies has projected that this number will *increase* to 4.3 million by 2020 (meaning a return to levels not seen since 1999/00), and that this is a direct result of tax and benefit policies implemented since 2010.[5] Recent data published by NHS England shows a correlation between those regions with the highest prevalence of children and young people with mental health conditions and those with the highest levels of child poverty (NHS England 2016).

- **Foodbank referrals:** The number of three-day emergency food supplies that were issued by Trussell Trust food banks increased from 25,899 in 2008/09 to 1,084,604 in 2014/15 – an increase of over 4,000 per cent. Benefit delays, low incomes and changes to benefits have been identified as the primary reasons for referral to foodbanks.[6]

The impact of digital technologies
The 'digital age' is thought to pose a number of relatively new challenges to children and young people's mental health.

- **Cyberbullying:** ChildLine reported an 87 per cent increase in the number of counselling sessions it provided that were related to online cyberbullying between 2013 and 2014 alone (NSPCC 2014). Of the headteachers and deputy headteachers who responded to a survey in February 2016, 81 per cent identified an increase in the number of pupils experiencing cyberbullying (ASCL and NCB 2016).

- **'Screen time':** It is well known that today's children and young people spend more time on social media, playing video games and watching television than their predecessors. Excessive screen-time has been associated with lower wellbeing, higher levels of anxiety and depression, and attention difficulties (PHE 2013). In 2012/13, 56 per cent of children and young people were found to spend up to three hours per day using social media (ONS 2015). In a 2015 survey of independent schools' headteachers, problems related to social

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5   http://www.cpag.org.uk/child-poverty-facts-and-figures
6   https://www.trenselltrust.org/news-and-blog/latest-stats/

media and technology were the issues most frequently cited as the biggest cause of pressure on pupils (HMC 2015)

- **Websites that reinforce harmful behaviours:** A parliamentary report (HoC-HC 2014) highlighted the fact that websites and digital platforms that promote and reinforce harmful behaviours relating to self-harm and anorexia had raised 'sufficient concern… to warrant a more detailed consideration of the impact of the internet on children and young people's mental health'.

- **'Sexting':** Between 15 and 40 per cent of children and young people are thought to have engaged in sexting, which can be defined as 'creating, sharing and forwarding sexually suggestive nude or nearly nude images – through mobile phones and the internet' (NSPCC 2012). A 2014 survey of 2,988 10–16-year-olds found that 19 per cent of them knew someone who they felt 'were forced to post or send a personal or nude picture or video', while 4 per cent stated that they felt they personally had been involved. The dissemination of images and videos of this nature among peer groups and social networks causes significant pressures on young people.

Increased diagnosis

It has been found that between 1994 and 2003 there was deterioration in positive attitudes towards people with mental health conditions in England; this is thought to have been caused primarily by increased media coverage of high-profile cases linking mental health with violence (Mehta et al 2009). However, more recent studies have found evidence for significant improvements in public attitudes towards mental health. These have been linked to anti-stigma campaigns such as Time to Change, which launched in 2011.[7] The National Attitudes to Mental Illness study has recorded public attitudes towards mental health since 1993, and the 2.8 per cent improvement in attitudes recorded between 2012 and 2013 was the largest to have been recorded in any single year (Mind 2014).

The stigma associated with mental ill-health has been shown to be a factor in preventing people from accessing services (Mojtabai 2009). The erosion of stigma and improvements in positive public attitudes in recent years could, therefore, reasonably be expected to have contributed to an increased willingness among parents to seek help in relation to their children's mental health. There is, however, no evidence to demonstrate a causal link between reduced stigma and increased diagnoses of mental health conditions among children and young people.

Changes to family structure

There is a long-term trend of increasing rates of family breakdown in the UK, although there has been a reversal in recent years: the number of divorces increased by a third between 1972 and 2003, reaching 167,000, before falling back to 114,000 by 2009. Similarly, the number of children under the age of 16 experiencing divorce had, by the early 2000s, risen to just over a fifth of all children, although that proportion had peaked in the mid-1990s. The proportion of children living in lone-parent families tripled between 1972 and 2006, when it reached 25 per cent (Gardner et al 2012).

Studies suggest that there is a slight causal correlation between these trends and increased incidence of emotional and behavioural disorders in children and young people. It has been estimated that between 15 and 30 per cent of the change in emotional and behavioural problems observed between 1986 and 2006 could be attributed to changes in family structure (Gardner et al 2012).

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7   http://www.time-to-change.org.uk/

Educational pressures

There has over the last 30 years been a gradual increase in the number of children sitting 'high stakes' examinations. This started with the introduction of GCSEs in 1986, which led to all children sitting exams at age 16; it continued with the raising of the participation age and increasing numbers of children attending sixth forms and higher education. While these may have been positive moves in terms of expanding educational opportunity and social mobility, an unintended side-effect has been to expose more young people to the worry and stress that exams can bring (Hagell et al 2012b).

More recently, there has developed a sense that the pressure on schools to meet demanding accountability measures has led some schools to place unreasonable pressure on young people (Hutchings 2015). This looks set to be compounded in the coming years by more demanding exam content and a shift towards end-of-year assessments, although it is too early to tell what impact these changes will have on stress levels (Hagell et al 2012b).

It is not possible to make a causal link between increasing exam pressure and a rise in mental ill-health among young people. However, research has found that exam pressure is the most common worry among 10–16-year-olds, and as a result many commentators believe that it has played a part in the increasing incidence of mental ill-health among young people over the past 30 years (Chamberlain et al 2010). This being the case, it is important for schools to both promote educational success and fulfil their duty of care to young people's mental health, instead of seeing them as trade-off.

3.
PRESSURES ON CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

The effects of rising levels of mental ill-health among children and young people have been exacerbated by a simultaneous increase in the financial pressures that services have been put under in recent years. There is a long-term trend of chronic underinvestment in mental health services in England, and between 2009/10 and 2014/15 this underinvestment was particularly acute in children and young people's services. However, the current 'transformation agenda' in children and young people's mental health services is set to see them receive an additional £1.4 billion in investment by 2019/20.

This chapter explores this underinvestment, and how cuts to local authority budgets have caused an erosion of early intervention services in the community in England.

3.1 Chronic underinvestment in NHS mental health services

Relative to physical health services, there has been chronic, long-term underinvestment in mental health services in England. This is despite the fact that mental ill-health accounts for 38 per cent of all illness in under-65s (CEP-MHPG 2012). Mental ill-health accounts for 23 per cent of NHS activity, but spending on secondary mental health services is equivalent to just half that proportion (NHS England 2016). In recognition of this problem, the Coalition government enshrined 'parity of esteem' in law in the Health and Social Care Act 2012, requiring that equal priority be given to mental and physical health.

Despite the recognition of this disparity, there has been no tangible effort to correct it. Real-terms funding for NHS mental health trusts fell by more than 8 per cent over the course of the 2010–2015 parliament (McNicoll 2015). What's more, while mental health trusts' budgets fell by 2 per cent between 2013/14 and 2014/15, there was an increase in hospital trusts' budgets of 2.6 per cent over the same period (Bloch 2016). This suggests that the rhetoric on 'parity of esteem' has so far failed to translate into positive change, and that the gap between expenditure on physical and mental health services may, in fact, be widening.

The Five Year Forward View for Mental Health (Mental Health Taskforce 2016) recommended that government spend an additional £1 billion on mental health services each year to 2020/21, in order to improve services, help redress historic underfunding and enable one million more people to access high-quality care by 2020/21. This funding is to be found from within the additional £8 billion per year that was pledged to overall NHS spending following the publication in 2014 of the *NHS Five Year Forward View*.

This investment is unlikely to be sufficient to redress historic underfunding, given the scale of unmet demand. In England, one in four adults experience mental ill-health every year (Mental Health Taskforce 2016), which means that there are roughly 13 million who require some form of care or treatment. Davies (2013)

found that 75 per cent of this group currently receive no treatment whatsoever, which means that there are likely to be almost 10 million adults in need of support.[8] The government's promise to invest in services in order to reach one million more people by 2020/21 will therefore not be enough to significantly reduce underlying demand on a whole range of mental health services.

3.2 Particular underinvestment in children and young people's mental health services

Spending on mental health services has been particularly lacking in children and young people's services.

Spending on NHS mental health services increased by 36 per cent between 2006/07 and 2012/13, from £7.8 billion to £10.6 billion. Meanwhile, NHS spending on child and adolescent services increased by just 16 per cent between 2006/07 and 2009/10, from £610 million to £710 million, and then remained static at the latter level in 2010/11 and 2011/12, before falling to £700 million in 2012/13. This means that in 2012/13, expenditure on child and adolescent mental health services accounted for just 6 per cent of the total NHS spend on mental health, and 0.7 per cent of the total NHS spend across all services (DH and NHS England 2015).

What's more, the lack of funding for child and adolescent mental health services is not restricted to the NHS. Data obtained by YoungMinds showed that 60 per cent of local authorities either cut or froze their CAMHS budgets between 2010/11 and 2014/15, and 55 per cent either cut, froze, or increased at a rate below inflation their CAMHS budgets between 2013/14 and 2014/15 (McNicoll 2014).

These moves are symptomatic of reductions in overall local authority budgets over the course of the last parliament, which are projected to continue. Local government spending power is projected to fall by 10 per cent in real terms between 2015/16 and 2019/20.[9]

Models for organising children and young people's mental health services
The traditional model for organising children and young people's mental health services has been to separate different parts of the system into 'tiers'. This defines the system in terms of the services that organisations provide, which are understood according to the severity of need and the corresponding intensity of care and treatment offered. This model separates services into four tiers.

- **Tier 1** services are universal, and so provided to all children and young people. They are preventative, and aim to reduce the likelihood of mental health problems developing by promoting healthy behaviours and mitigating known risk factors. Tier 1 services are most often delivered in universal services such as schools, children's centres and GP surgeries, and are primarily delivered by non-mental-health specialists (often primary care workers such as school nurses and health visitors).

- **Tier 2** services are targeted at children and young people who have been identified as particularly vulnerable to developing more severe mental health conditions. They aim to intervene early in order to prevent 'emerging' or low-level mental health problems from worsening. These services can be delivered by a range of professionals in a number of both universal and targeted settings in the community, and usually involve primary mental health workers (PMHWs). Tier 2 services can sometimes involve CAMHS professionals working in 'outreach' in the community, or in liaison with non-mental health specialists.

- **Tier 3** services are targeted at children and young people with moderate-to-severe mental health needs, and are predominantly delivered by multidisciplinary teams of CAMHS professionals in clinical settings. These services will ordinarily follow a clinical

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8   IPPR analysis based on ONS population statistics for June 2015.
9   IPPR analysis of November 2015 spending review.

diagnosis of a mental health condition, and so deliver evidence-based interventions in partnership with children, young people and their families.

- **Tier 4** services are targeted at children and young people with the most severe and complex mental health needs, and are delivered in either day or inpatient settings by multidisciplinary teams of CAMHS professionals. These services deliver assessment and treatment in a more intensive setting with a view to the eventual relocation of care into the community.

Figure 3.1

The four tiers

The traditional model of organising children and young people's mental health services
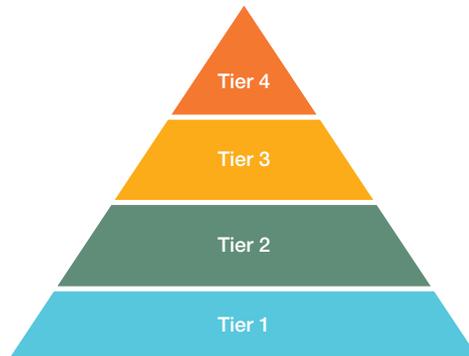
However, recently efforts have been made to move away from this tiered model, and towards an alternative one that is focussed on the needs of children, young people and their families. The THRIVE model, developed by the Anna Freud Centre and Tavistock and Portman NHS Foundation Trust, has emerged as the preferred alternative.

Figure 3.2

The THRIVE model of five needs-based groupings of equal importance

The input provided by services (left), and the corresponding 'state of being'
of the young person accessing those services (right)
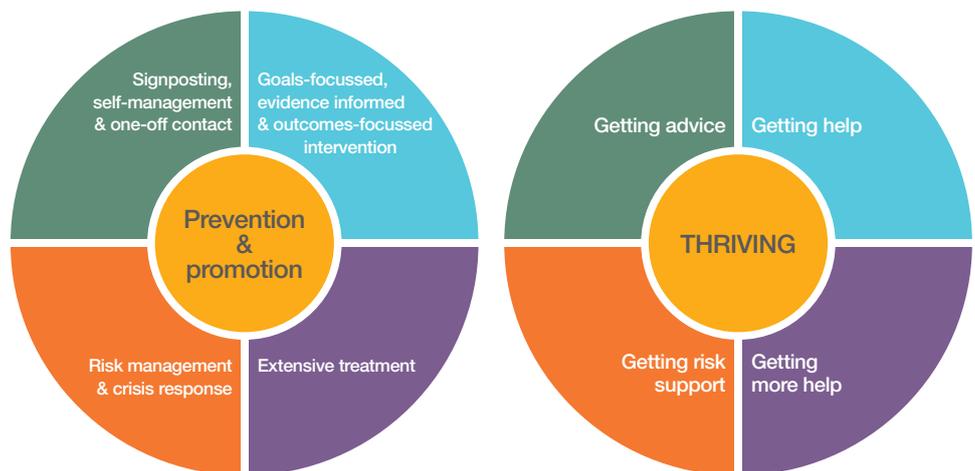
Source: adapted from Wolpert et al 2015

The THRIVE model represents a move away from understanding services in terms of tiers of severity or complexity: it shifts the framing of the system away from services and onto children, young people and their families, which it divides into five needs-based groupings. According to THRIVE, each grouping is to be understood in terms of different types of need that are equally important, and which should each be given equal priority and resource within the system. Figure 3.2 shows what are essentially two sides of the same coin. The left-hand image describes the input that services offer to each group, and the right-hand image describes the 'state of being' of the young person that necessitates the corresponding support and/or intervention (Wolpert et al 2015).

By framing services in a less rigid way, in practice the THRIVE model aims to create new opportunities to overcome traditional barriers between service providers, and move away from a siloed approach to delivery, thereby allowing for more integrated working across different parts of the system.

It is also hoped that framing services in this way will allow for more co-ordination when commissioning services, and so distribute funding more evenly across different parts of the system. Different services are currently commissioned both at different 'levels' (national and local) and by different bodies (clinical commissioning groups, local authorities, Public Health England, schools and so on). As with service provision, this separation can lead to siloed decision-making, which in turn leads to sub-optimal care.

3.3 An erosion of early intervention services in the community

During the 2010–2015 parliament, sizeable cuts were also made to a range of early intervention services that, when delivered effectively, are well-placed to prevent the escalation of a range of emotional and behavioural difficulties in children and young people.

A 2014 health select committee report heard evidence that tier-2 CAMHS early intervention services had become an 'easy target' for cuts by local authorities in the context of their overall budgetary pressures, and that in some places they had been 'cut altogether'. The committee found that 'in times of financial constraint, some local authorities do not consider CAMHS early intervention services as "core business"' (HoC-HC 2014).

Similarly, the committee found evidence that other early intervention services based in the community had been reduced as a result of financial pressures on local authorities. These services do not exist exclusively to meet mental health needs, but play an important role in preventing the escalation of behavioural and emotional difficulties which otherwise can increase demand for statutory mental health services. The committee heard testimony from voluntary sector providers of early intervention services, who attested to 'extremely fragile funding arrangements and increasing uncertainty about their future sustainability'. For example, the funding of youth information, advice and counselling services (YIACS) decreased in each year since 2010 (ibid).[10]

These findings were corroborated in 2015 by the National Children's Bureau, which found evidence of significant cuts to local-authority-funded early intervention services. The value of the early intervention allocation to local authorities fell by 55 per cent between 2010/11 and 2015/16, from around £3.2 billion to £1.4 billion per year. This translated into a fall in spending on children's centres, young people's services and family support services of 24 per cent between 2010/11 and 2014/15, from £3.0 billion to £2.3 billion per year. The difference between the fall in government allocation to local authorities and the actual level of spend on services suggests that local authorities found ways to mitigate, to some extent, the effects of reduced funding (NCB and TCS 2015).

However, local authorities' ability to continue to mitigate the effects of reduced budgets on early intervention services in this way has since been weakened by annual real-terms reductions of 3.9 per cent to their public health budgets in each year of the current spending review period, 2015/16–2020/21 (Nuffield Trust et al 2015). While Mind research has shown that just 1 per cent of the spend of these public health grants was directed towards mental health in 2015/16 (Mind 2015),

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10 YIACS support young people on issues such as mental health, sexual health, relationships, homelessness and benefits. Through interventions such as counselling and other psychological therapies, advice work, health clinics, community education and personal support, YIACS offer a unique combination of early intervention, prevention and crisis intervention for young people.

this represents an additional financial burden on local authority budgets which could otherwise be used to invest more heavily in early intervention services.

Figure 3.3
The value of the early intervention allocation to local authorities has fallen by 55 per cent over the last five years
The relative value (£bn) of the early intervention allocation to local authorities in 2010/11 (left) and 2015/16 (right)

2010/11:
£3.2 billion

2015/16:
£1.4 billion

4.
A PERFECT STORM
THE VIEW FROM SECONDARY SCHOOLS

Chapters 2 and 3 of this report showed that there is a growing prevalence of mental ill-health among children and young people, particularly for behavioural and emotional conditions such as anxiety, depression and conduct disorders; and that, at the same time, cuts to the funding of both NHS CAMHS and local authorities means that a range of early-intervention mental health services have been scaled back.

Given that the emergence of emotional and behavioural problems is more common among secondary-school-aged children and young people than among younger children, the effect of these dual phenomena has been to create a 'perfect storm' for English secondary schools, which are increasingly struggling to cope with the effects of mental ill-health among their pupils.

In a 2014 survey, headteachers reported high levels of both behavioural and emotional problems among their pupils, and that the growing prevalence of such problems were 'having an impact on pupil attainment, performance and ability to cope with everyday pressures' (Taggart et al 2014):

- 88 per cent reported self-harm as a concerning issue (a 57 per cent rise since 2010)
- 87 per cent reported depression as a concerning issue (an 85 per cent rise since 2010)
- 85 per cent reported eating disorders as a concerning issue (a 33 per cent rise since 2010) (ibid).

Finally, a 2016 survey of headteachers and deputy headteachers (ASCL and NCB 2016) provides further evidence of the extent of mental health problems among pupils in English secondary schools. Participants were asked to select the proportion of students who had demonstrated 'mental health and well-being issues' during the previous 12 months. The issues selected most frequently were:

- anxiety or stress (18 per cent)
- peer relationship issues (16 per cent)
- family relationship issues (12 per cent)
- low mood or depression (11 per cent) (ibid).

The survey also found those problems to have worsened over the last five years:

- 90 per cent of respondents reported an increase in levels of anxiety and stress
- 84 per cent reported an increase in low mood and depression
- 79 per cent reported an increase in self-harm or suicidal thoughts (ibid).

Similarly, a 2015 survey (HMC 2015) found that independent schools were also facing significant challenges. It is therefore clear that secondary schools are being forced to pick up the pieces as a result of cuts to community-based early intervention services, and a rising tide of mental ill-health.

5.
FALSE ECONOMIES
THE CASE FOR EARLY INTERVENTION

Seeking savings by eroding early-intervention mental health services for children and young people is a false economy. These services are uniquely well placed to prevent emerging emotional and behavioural problems from developing into more severe and complex mental health conditions. This chapter makes the case for the rejuvenation of early-intervention mental health services for children and young people, in terms of both the long-term economic benefits they deliver, and their more immediate ability and potential to relieve pressure on local CAMHS systems.

5.1 The economic benefits of early intervention

In addition to the health-related benefits it delivers for individuals, early intervention has been shown to deliver a range of economic benefits to society. Improved mental health in childhood and adolescence is associated with reductions in the use of a range of public services; with increases in earnings due to improved educational attainment; and, in the case of conduct disorder, with the benefits to society that result from reduced offending (DH and NHS England 2015). Despite this, between 60 and 70 per cent of children and young people who experience clinically significant mental health difficulties do not receive appropriate interventions at a sufficiently early age (Children's Society 2008). This has significant implications for public services and public spending, given that, for instance, the wider societal cost of severe conduct disorders during childhood is estimated to be £260,000 per child, much of which falls on the public purse (Parsonage et al 2014). In a 2004 report it was calculated that if services had intervened early for just one in 10 of the young people sentenced to prison each year, public services could have saved over £100 million annually (in 2003/04 prices) (Audit Commission 2004).

These cost implications are particularly important given the need to move towards a system of funding and delivering mental health care that is sustainable in the long term. The rates of mental ill-health within the population, the scale of historic underfunding in mental health services, and the political premium placed on 'balancing the books' with regards to expenditure on public services mean that, without a fundamental rethink, it will be impossible for government to invest the amounts necessary to meet demand. The size of the disconnect between the £1 billion annual investment recommended in the *Five Year Forward View for Mental Health* (Mental Health Taskforce 2016) and the current level of unmet need demonstrates the fact that the only way to achieve sustained, long-term improvements in mental health will be to invest more in early intervention and prevention in order to stem the flow of people who need access to more prolonged and expensive forms of treatment.

5.2 A vicious cycle

A reduced early intervention capacity in the community poses not only a long-term challenge to the public finances, but also an immediate problem for local CAMHS systems. Early-intervention services are particularly effective in preventing the escalation of a range of emotional and behavioural problems

that could otherwise develop into more severe mental health conditions. The scaling back of these services has therefore been identified as a contributing factor to the increased number of referrals to specialist CAMHS in recent years. For example, a 2014 House of Commons health committee investigation received the following two submissions, from a clinical commissioning group and a mental health trust respectively:

'Reductions in Tiers 1 and 2 provision largely as a result of budget reductions [were] leading to a lack of early intervention. Hence children and young people were tending to access services at too late a stage hence they required more complex and time consuming interventions to address their presenting challenges.'

'In order to manage demand, teams may be left in a position of turning an opportunity for preventative psychologically based work away. This means a young person and their family have been turned away from early help only to return when their condition has become more challenging to work with or, distressingly, requires admission to T4 [tier 4] in patient services.'
HoC-HC 2014

Figure 5.1
Cuts to early intervention services and the vicious cycle of increasing pressure on specialist CAMHS

NHS CAMHS spend fell from £710 million in 2010/11 to £700 million in 2012/13, while 60% of local authority CAMHS budgets were cut or frozen between 2010/11 and 2014/15.

Local authorities' 'early intervention allocations fell by 55% between 2010/11 and 2015/16, from £3.2 billion to £1.4 billion per year.

Scaling back of early intervention services

More resources focussed on specialist services

Fewer children & young people able to access early help

Reductions in NHS & LA CAMHS budgets

Reductions in LA early intervention budgets

Specialist services come under increased pressure

More low-level conditions allowed to deteriorate

Increased demand for specialist services

The number of hospital admissions of 0–17-year-olds who had self-harmed increased by more than 50% between 2009/10 and 2014/15.

On average, 23% of referrals are turned away by CAMHS, and average maximum waiting times have doubled since 2010/11.

Children and young people's mental health services have become trapped in a vicious cycle, with the result that CAMHS have become less able to meet the growing level of need. One consequence of this is a growing perception that only the most severe cases can obtain regular access to mental health professionals. Specialist CAMHS are, on average, turning away 23 per cent of children and young people who are referred to them, and the average maximum waiting time to access services has more than doubled since 2011/12 (Frith 2016). An immediate rejuvenation of early intervention services is, therefore, necessary in order to help the CAMHS system to escape from the current vicious cycle.

6.
PUTTING SECONDARY SCHOOLS AT THE HEART OF EARLY INTERVENTION PROVISION

Early intervention services have traditionally been based in the community, often in clinical NHS settings. However, pressures on both local authority and NHS budgets means they have been scaled back significantly over recent years, despite the benefits that early intervention is known to bring to the individual, to wider society, and to the sustainability of local CAMHS systems. There is, therefore, a need for providers and commissioners to work together to ensure that more funding is directed towards early intervention services in the coming years.

While early intervention services have traditionally been based in clinical NHS settings, this chapter makes the case that in future it should be made a priority for early intervention provision to be offered to pupils on-site in secondary schools. The rejuvenated system of early-intervention mental health services for children and young people that we need must have secondary schools at its heart.

6.1 Why secondary schools?
There are four key arguments in favour of having early intervention provision in secondary schools, as well as in traditional 'health' and community settings.

1. It would improve accessibility (especially for children and young people from hard-to-reach families)
Mental health support staff and CAMHS professionals based in schools can reach a large number of children with low-level mental health problems who might not otherwise receive the services they need, and who have traditionally had poor access to mental health services (National CAMHS Review 2009). They can ensure that children receive help in school-based, non-stigmatising and familiar environments, which can make children and young people feel more comfortable and so have a positive impact on the rate at which they attend scheduled appointments (Atkinson et al 2010). For example, in 2014/15 only 7 per cent of Place2Be[11] sessions were not attended due to the pupil being absent or unavailable.[12] This compares to an average non-attendance rate of 11 per cent for tier 1–3 CAMHS across England.[13] That children and young people voluntarily access Place2Be's services at such a high rate after referral, and prior to the emergence of moderate or severe mental health problems, suggests that schools are an appropriate and effective location at which to deliver early intervention services for those with emerging problems.

Headteachers often report that CAMHS only accept referrals if pupils and families are engaged and supportive of the process of receiving support (Taggart et al 2014). Schools are, therefore, well placed to make use of their pre-existing relationships with families to help direct children and young people into school-based mental health provision. Any subsequent referral to specialist CAMHS could then be aided by families having become more engaged during that early intervention phase.

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11   Place2Be is a voluntary sector organisation that provides school-based counselling services across the UK, operating in 222 primary schools and 40 secondary schools.
12   According to written evidence from Place2Be shared with IPPR.
13   http://www.rcpsych.ac.uk/pdf/CAMHS%20Report%20Dec%202013%20v1(1).pdf

2. It would better address school-related stressors that contribute to mental health problems

Many emerging emotional and behavioural problems in children and young people can be directly related to stressors associated with being at school, such as bullying or exam pressures. Delivering mental health interventions within schools would allow CAMHS professionals and others to more quickly and easily relay problems to school staff (when this would not constitute a breach of confidentiality). It would therefore offer greater opportunity and scope for aspects of school life that are having negative impacts on pupils' mental health to be identified and improved. What's more, recent research suggests that specialist CAMHS are actively refusing to see cases in which they believe mental health problems to be 'entirely school-related' (Frith 2016). This suggests that, when faced with rising demand, there is a growing sense that specialist settings may not always be the most appropriate place to unpick and begin to resolve the school-related causes of emerging mental health problems.

3. It would significantly ease pressures on specialist CAMHS

School-based early intervention provision can significantly ease the pressures on specialist CAMHS by reducing the number of referrals they receive, and ensuring that those cases that are referred to them are appropriate ones (Whitworth and Ball 2004). For example, the Newham local transformation plan[14] states,

> *'There was strong support for 1:1 CAMHS sessions to be held in school initially. It was recognised that specialist CAMHS resources could not support this for every child for the full length of an intervention, but it was felt that starting work in schools could reduce the DNA [did not attend] rate in central CAMHS and thus be more effective and efficient.'*
> Newham CCG and London Borough of Newham (no date)

4. It would help to facilitate other component parts of a whole-school approach

Facilitating early intervention within schools creates more opportunities for CAMHS professionals and/or mental health support staff to upskill teachers and other staff, and contribute to raising the prominence of mental health and wellbeing within school life. It has been shown that PMHWs have a positive influence in terms of helping other staff to identify problems early and to manage some emotional and behavioural issues in the classroom (Atkinson et al 2010).

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There is, therefore, a strong case for schools to be put at the heart of community-based CAMHS systems.

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14   See section 7.1 in the following chapter for a discussion of local transformation plans.

7.
HOW HAVE RECENT POLICY CHANGES AFFECTED SCHOOL-BASED MENTAL HEALTH PROVISION?

There is a need for a rejuvenation of early intervention services for children and young people with emerging mental health problems, and there is a strong case that schools should be at the heart of all local areas' early intervention offers. Schools should be equipped to offer these services to pupils on-site, to complement wider community and NHS provision.

But to what extent have recent policy changes affected schools' ability to meet pupils' mental health needs? This chapter explores several such changes, and their impact on the support and incentives for schools to become a more central part of mental health service provision for children and young people.

7.1 CAMHS transformation funding

The main policy governing children and young people's mental health services in recent years has been the 'transformation' agenda. This emerged from a joint Department of Health and NHS England taskforce assembled in 2014, and was first set out in its *Future in mind* report (DH and NHS England 2015). This transformation will be resourced by a government commitment to spend an additional £1.25 billion on services up to 2019/20 (excluding an additional £150 million investment in community-based eating disorder services).

This funding is to be delivered directly to local areas each year, and aims to enable them to 'develop additional capacity and a collaborative approach across health, education and children's services' (Burt 2015a). The national funding allocation was set at £143 million in 2015/16 (Burt 2015a) and £250 million for 2016/17 (Buchanan 2016), with allocations for subsequent years yet to be confirmed.

It is intended that this investment will add capacity and capability across the system, rather than be used to paper over existing cracks by, for example, covering existing costs, back-payments or deficits. The ambition is that, by 2020, the investment will have helped an additional 70,000 children and young people to access high-quality mental health care at an appropriately early stage.

In order for local areas to receive their share of this new investment, they were required to submit 'local transformation plans' to NHS England. Clinical commissioning groups (CCGs) were asked to work with local authorities and other local stakeholders to set out their plans for transforming the local offer for children and young people's mental health.

Local transformation plans were required to cover the full range of services and interventions, including prevention, early intervention for children and young people with emerging conditions, support and care in the community for established conditions, and inpatient care for the most severe and complex conditions. It was a requirement of plans that they reflect the ambitions for the future of services set out in the *Future in mind* report*,* and set out a 'shared action plan' for how all local

stakeholders involved in delivering and commissioning services would work together over the five-year period in question to review, monitor and track progress.[15]

By the deadline of October 2015, 137 plans had been submitted to NHS England, covering all 209 CCGs. Once plans are approved, funding is to be released to CCGs up to 2019/20.

The transformation agenda has given commissioners, providers and other partners a financial incentive (the receipt of a share of the £1.25 billion national funding allocation) to work together to improve the ways in which they commission and deliver local CAMHS systems, including by focussing on early intervention. However, research has identified two problems with the implementation of this approach which cast real doubt on whether it will have the desired effect.

First, fears have been raised regarding the extent to which CCGs are actually directing their share of transformation funding towards children and young people's mental health services. The NHS Confederation Mental Health Network has suggested that mental health trusts are yet to receive substantial investment through CCGs following the approval of transformation plans, and that some of the funding may instead have gone to pay for other, unrelated services. The Mental Health Commissioners Network, part of the NHS Clinical Commissioners organisation, has acknowledged that CCGs may have failed to allocate funding in accordance with the aspirations of the transformation agenda, due to the large number of competing budgets they allocate simultaneously (Buchanan 2016).

Second, schools have not been properly included in helping to design and deliver the local transformation of services in many parts of the country. This is despite the fact that the *Future in mind* report explicitly recognised the important role that schools ought to play within local CAMHS systems, and set out a requirement that they be involved in local transformation decisions (DH and NHS England 2015). A recent survey found that just one-quarter of schools were aware of the local transformation plan developed in their area. Of those that were aware of the plan, just 39 per cent had input into it, and half identified themselves as having a role in its delivery (ASCL and NCB 2016). This is symptomatic of a wider disconnect between health commissioners and the education system.

This evidence suggests that the transformation agenda has yet to translate into a significant improvement in schools' involvement in the planning and delivery of mental health services to children and young people in collaboration with other commissioners, providers and partners.

Problem
Despite the 'transformation agenda', too little funding is finding its way to children and young people's mental health services. Where funding *is* being directed towards these services, too little of it is finding its way to schools, which lack established mechanisms by which they can influence commissioning and funding decisions at a CCG level.

7.2 Academies commissioning services

There has been a rapid expansion in the number of English secondary schools that are classified as academies since the passing of the Academies Act 2010. Between 2010 and 2015, the number of primary and secondary schools classed as academies increased from 200 to 5,068. In May 2015, 61 per cent of English secondary schools were academies (DfE 2014). This increase is set to

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15   https://www.england.nhs.uk/mentalhealth/cyp/transformation/

continue, particularly now that it is government policy that all schools will become academies by 2022, with local authorities running schools to become 'a thing of the past' (HMT and Osborne 2015).

Compared to schools maintained by local authorities, academies have greater freedom to commission a range of services according to their particular preferences and the nature of their pupils' needs. Consequently, government has very little control over the approach that individual academies take to this issue, and few levers through which to influence exactly what mental health support schools choose to commission for their pupils.

In practice, local authorities' role in co-ordinating mental health provision across *all* local schools, and providing a link to health providers and commissioners, has been considerably scaled back. In some areas, this has created a void in which schools can find it difficult to have any influence over commissioning and funding decisions taken at a local level. On top of this, the increasing fragmentation of the schools system can mean that individual schools lack the internal commissioning expertise required to design effective school-based mental health provision.

Problem
In an increasingly fragmented schools system, schools can lack the internal commissioning expertise required to design effective school-based mental health provision.

7.3 Changing incentives for schools

The Ofsted framework has a very strong ability to influence school behaviour, and has changed over recent years in terms of the extent to which it incentivises schools to prioritise mental health provision for pupils as well as their educational attainment. In 2005, Ofsted inspection criteria were mapped against the outcomes of the government's Every Child Matters framework, which included an obligation on schools to work with local authorities and health services to improve the 'physical and mental wellbeing' of pupils. During this time, the Ofsted framework contained numerous references to health and emotional wellbeing (NCB 2014).

However, during the 2010–2015 parliament, in line with the Coalition government's movement away from the Every Child Matters framework as signalled by the Education Act 2011, references to children's wellbeing were removed from the Ofsted framework. Over this period, schools policy also became more heavily focussed on academic outcomes and educational rigour: the value of league tables was heightened, the curriculum narrowed, and the balance between exams and coursework shifted in favour of the former.

The use of accountability measures such as league tables and the Ofsted framework has been shown to have a dramatic impact on school behaviour.[16] But while incentives to achieve certain types of educational outcome increased between 2010 and 2015, incentives for mental health and wellbeing objectives fell away. There is a strong view within the teaching profession that this shifting policy and accountability landscape created a set of perverse incentives that impeded schools' ability to meet the needs of pupils with emerging mental health problems. For example, 84 per cent of teachers who responded to one survey agreed that 'the focus on academic targets means that social and emotional aspects of education tend to be neglected', while 93 per cent agreed that 'my stress levels sometimes impact on the way I interact with pupils' – drawing a direct link to pressures caused by changes to how schools were held

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16 For example, research by Parameshwaran and Thomson (2015) showed how changes in the extent to which league tables recognised vocational qualifications during the last parliament led to a drop in the average number of pupils schools entered for such qualifications at key stage 4.

accountable (Hutchings 2015). This view was supported by many of the headteachers and teachers whom we spoke to in the course of this research.

> 'Unless there's anything that really gives us any sense of credit for doing that work around mental health, it'll be very difficult to find time in the curriculum, very difficult to find time in the pastoral system, to do that. With the best will in the world, with the most altruistic headteachers saying 'this is what our students really need', if they then have Ofsted coming knocking on the door and saying, "We're not going to take any context from that, we'll take no consideration of that, we're just going to look at exam results", then you can see where the pressures, and the time, and the funding are going to go.'
> Headteacher (February 2016)

However, there have recently been some indications that this imbalance in schools policy, which disincentivises the diversion of resources into mental health provision by schools, is being softened. For example, in September 2015 the Ofsted framework as set out in the *School Inspection Handbook* was updated, and now contains a number of new references to pupils' emotional wellbeing (Ofsted 2015). One criterion for an outstanding school is now that,

> 'Pupils can explain accurately and confidently how to keep themselves healthy. They make informed choices about healthy eating, fitness and their emotional and mental well-being. They have an age-appropriate understanding of healthy relationships and are confident in staying safe from abuse and exploitation.'
> Ofsted 2015

Another is that,

> 'The school's open culture promotes all aspects of pupils' welfare. Pupils are safe and feel safe. They have opportunities to learn how to keep themselves safe. They enjoy learning about how to stay healthy and about emotional and mental health, safe and positive relationships and how to prevent misuse of technology.'
> Ofsted 2015

Ofsted's framework now states that inspectors will:

> 'evaluate the experience of particular individuals and groups, such as pupils for whom referrals have been made to the local authority (checking how the referral was made and the thoroughness of the follow-up), disabled pupils and those who have special educational needs, looked after children, those with medical needs and those with mental health needs. Inspectors must look at a small sample of case studies about the experience of these pupils.'
> Ofsted 2015

It remains to be seen what impact the reinsertion of references to pupils' emotional wellbeing in the above passages will have on how far schools are incentivised to divert more of their limited resources towards mental health provision.

However, IPPR's analysis of Ofsted inspection reports published after September 2015 reveals a significant problem in terms of the extent to which inspectors are actually assessing schools' mental health provision according to the new criteria described above.

Considerations related to the extent to which secondary schools promote the mental health and wellbeing of pupils, and ensure that appropriate services are made available to those with identified needs, should be listed in the 'personal development, behaviour and welfare' section of inspection reports. However,

our analysis of a sample of 50 Ofsted reports of inspections that took place after September 2015 show that just one-third (32 per cent) include an explicit reference to pupils' mental health and/or emotional wellbeing. Similarly, one third (32 per cent) make explicit reference to the school's pastoral system of care; 70 per cent reference the school's approach to building pupils' awareness of risky behaviours that could impact on mental health (such as safe use of the internet and social media); and 82 per cent reference the school's approach to tackling bullying.

Figure 7.1
Just one-third of recent Ofsted inspection reports reference mental health
Percentage of Ofsted inspection reports published after September 2015 referencing mental health and associated factors (sample size: 50 English secondary schools)
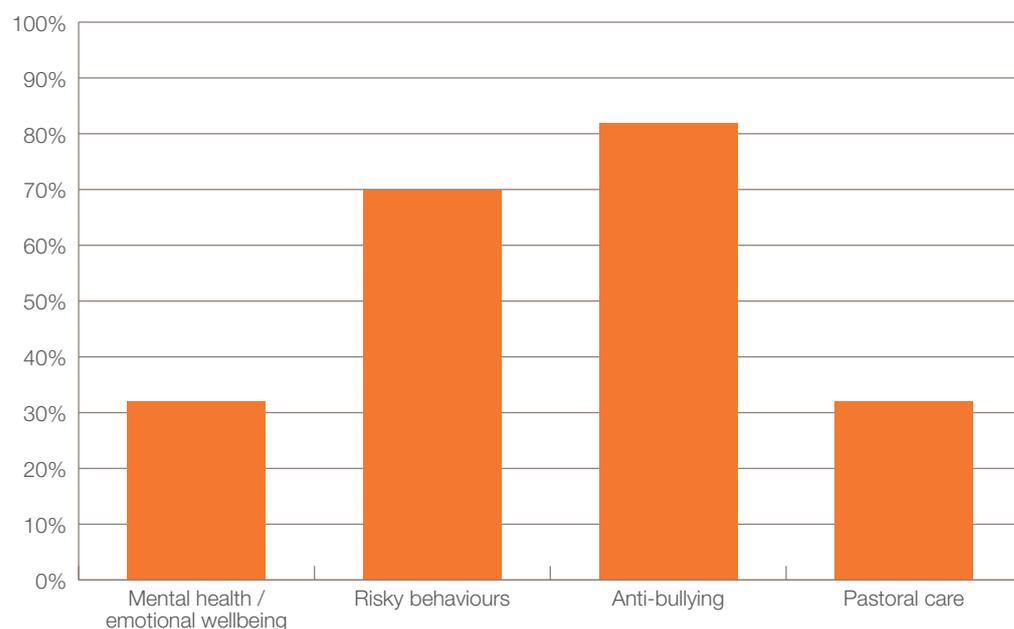
Source: IPPR analysis of Ofsted inspection reports.

That just one-third of reports sampled make direct reference to mental health and emotional wellbeing supports a view expressed during our interviews with experts: that many Ofsted inspectors are not routinely assessing schools' mental health provision, despite the recent changes to the framework.

Problem
During the last parliament, schools policy and accountability mechanisms were explicitly weighted in favour of educational outcomes, to the detriment of those relating to mental health and wellbeing; there was an intentional move away from schools being considered as part of a wider infrastructure of community-based health services. As a consequence, schools are being incentivised to direct their limited resources towards those areas for which they are most robustly held to account (educational outcomes), at the expense of further integration with health provision.

Problem
Despite the inclusion of new criteria for assessing schools' mental health provision in the Ofsted framework from September 2015, Ofsted inspectors are not routinely assessing and reporting on pupils' mental health and emotional wellbeing, or the steps taken by secondary schools to meet pupils' needs.

8.
CATEGORIES OF SCHOOL-BASED MENTAL HEALTH PROVISION

Secondary schools are responding to the growing crisis in children's mental health in a number of ways. This chapter gives an overview of the different roles that schools currently play in mental health services, highlighting significant variation in the 'whole-school approach' that schools adopt towards mental health.

This report distinguishes between three broad categories of school-based provision that exist in practice:
- schools as providers of prevention and promotion services
- schools as a point of early identification, triage and referral
- schools as a either a 'provider' of early intervention services, or the 'hub' from which they are delivered.

However, as our case studies of schools, focus groups held with young people, and interviews with headteachers made clear, the precise nature of provision and the extent to which each of these categories of provision are delivered varies significantly from school to school, and the overall picture may indeed have become more complex and less cohesive in recent years.

> '*Some schools… have a certain level of specialist service within them, in partnership with CAMHS, health and commissioning [while others do not]. Then it varies across different schools in terms of how they approach mental health and wellbeing, even at that 'tier 1' level, in terms of the curriculum, and the inputs, the staff involvement and so on. And so you have got a very varied picture. I think historically… you're coming from a point where there was [previously] a bit more of a unified approach to it. I think recently what's happened is things have fragmented a little bit, maybe just because of changes to services and provision and so on. So it feels, at the moment, a little bit more scattered than it perhaps traditionally wanted to be, or aspired to be.'*
> Headteacher (February 2016)

The remainder of this chapter will explore each of these three categories, what they look like in practice and how commonly they are implemented by schools, in turn.

8.1 Prevention and promotion
The first category of school-based mental health provision is the facilitation and delivery of prevention and promotion services. This is what has traditionally been understood as 'tier 1' provision within the tiered model (see figure 2.1), and is primarily aimed at children and young people who are 'thriving' and 'coping' according to the THRIVE model (see figure 3.2).

This category of provision is largely skills-based, and so focusses on the teaching and development of skills, strategies and behaviours that could help protect pupils from developing mental health problems. For example, much of the Department for Education's recent policy focus has been to emphasise the need for schools to

promote resilience in pupils through character education.[17] Prevention services can be either universal among all pupils, or targeted at those who are thought to be particularly vulnerable or at-risk but who may not yet have experienced a noticeable deterioration in their emotional wellbeing or behaviour.

Prevention and promotion should also ensure that schools create the conditions for positive wellbeing among pupils. Creating a 'culture' that values wellbeing can involve ensuring, for example, that pupils have access to green spaces, exercise, and a range of creative outlets through the curriculum.

If schools are providing high-quality provision in this category, the following should be evident.

- Learning on mental health is embedded in the curriculum (for example, about risk factors and the symptoms of specific conditions).
- Awareness-raising activities (such as assemblies, posters and campaigns).
- Anti-stigma work (for example, through initiatives such as the Time to Change campaign).
- A school ethos that places high value on mental health and wellbeing.
- The absence of teaching or other practices that might contribute to the development or exacerbation of mental health problems.
- Signposting towards support in the community.
- The provision of opportunities for peer support.

Schools are exceptionally well-placed to deliver mental health support within this category: they come into contact with children and young people more than any other service, and have the potential to seamlessly merge learning on mental health with the wider curriculum. This type of provision is widespread: for example, 81 per cent of secondary school headteachers reported that their school actively delivers mental health awareness-raising activities; 93 per cent dedicate personal, social, health and economic (PSHE) lessons to mental health; 95 per cent promote wellbeing through other lessons; and 75 per cent dedicate the content of some assemblies to issues associated with mental health (Taggart et al 2014).

It is local authorities that have ultimate responsibility for funding resilience and wellbeing services within schools, and for commissioning them together with schools themselves.

8.2 Early identification, triage and referral

This second category of school-based provision requires schools to perform two key functions in addition to prevention and promotion: first, the early identification of emotional and behavioural problems, and second, on-site triage to understand and differentiate between different levels of need, in order to direct pupils towards appropriate external services. These functions do not relate to the delivery of services, but are a form of screening. Within the THRIVE model, these functions are necessary in order for schools to be able to effectively identify children and young people who are not 'thriving', and so require some form of additional support.

Schools often act as the 'front end' of a local CAMHS system – as the place where problems can be identified. There are three main ways in which this can happen:

- schools are approached by parents with concerns over their child's mental health or wellbeing
- school staff can identify signs of problems among pupils as a result of their behaviour in school

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17   In this context, 'resilience' is understood as the personal quality that protects some children from developing mental health problems, while others who are faced with identical stresses and pressures do go on to develop conditions.

- pupils can approach school staff to raise any concerns they might have about their own wellbeing.

The presence of strong relationships between children and young people and their families and school staff is almost always a precondition for early identification.

Schools can choose to enhance their capacity for the early identification of emerging emotional and behavioural problems by using monitoring or screening tools, such as the Strengths and Difficulties Questionnaire (SDQ),[18] which can be used by teachers and other staff to help identify pupils who may be falling outside of the range of normal development. It has been estimated that approximately half of secondary schools use screening tools to identify mental health problems in pupils (Taggart et al 2014). These tools were thought to be effective in the majority of cases, according to a survey of headteachers, who were also largely confident in the ability of school staff to use such techniques (ibid).

However, while systems for the early identification of problems within schools are relatively widespread, systems of effective *triage* are less so. Just one-third of those schools that use screening tools are able to differentiate between different severities of need, and so to determine whether a pupil is experiencing a mild, moderate or severe mental illness (ibid). The absence of an effective means of triage impairs schools' ability to refer their pupils effectively to both internal and external provision. Where the broad nature of their need is insufficiently understood, young people and their families cannot rely on schools to signpost and refer them effectively.

Effective external referral also depends on the presence of strong relationships between schools and other services, particularly specialist CAMHS, and established pathways from one to the other. While 85 per cent of secondary schools report the presence of an external referral pathway of this kind, they are deemed to be effective in just over half of cases. This problem is linked to reports of schools having difficulties in helping pupils to access specialist CAMHS (ibid). While this is in part due to the pressures facing CAMHS explored in chapter 3, the absence of effective systems of triage and referral within schools can also mean that referrals to CAMHS and other services are inappropriate or too slow, which can deny or delay children and young people's receipt of the type of support they need.

A common practice among schools is to advise parents to go to their GP to try to access mental health services. This can sometimes be a consequence of a lack of triage capacity in schools – of a need being identified but not understood. A pathway directly from schools to specialist CAMHS and a range of other voluntary services in the community can, when effective, help to ensure quicker access to appropriate services.

> '[Schools] need to know where to look from the beginning, because what can happen is they can go to one service and find out that's the wrong one, and that can happen again, and it takes 20 services before they find the right one.'
> Young person with experience of mental health services (February 2016)

8.3 Early intervention
The provision of this third category of services requires schools to also be providing those in both categories one and two. It means that, after the early identification and triage of an emerging mental health problem affecting a pupil, that pupil has the opportunity to access, or be directed towards, school-based early intervention support. This requires schools to have regular access to staff

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18 http://www.sdqinfo.com/

members or commissioned support that possess mental health expertise, and to have structures and systems in place that to allow them to deliver interventions on-site. This would traditionally be categorised as 'tier 2' support within the tiered model, and under the THRIVE model can be aimed at children who require support in the 'getting help' category (see figure 2.2).

Early intervention involves targeted, evidence-based interventions directed towards children and young people with emerging mental health problems, who may or may not have a formal diagnosis. The decision over whether a child or young person should engage with this kind of service in school, rather than in a clinical CAMHS setting, is one that should be made jointly by mental health specialists, the young person and their family.

This report identifies two models for the way in which schools should perform this role: the school as a 'provider', and the school as a 'hub'.

• Schools following the 'provider' model either directly employ mental health specialists, or else contract them on an individual basis from some external agency (from the voluntary sector, local authority or NHS); schools assume management and supervisory responsibilities for these professionals while they are on site.

• The 'hub' model involves schools purchasing additional mental health expertise from an external agency, which delivers early intervention services on site and retains a degree of independence from the school's management.

According to the THRIVE model, provision that is targeted at reaching children and young people who should be 'getting help' should have health services as the lead provider and should use 'health language', although these requirements are not incompatible with such provision being delivered in a school setting (Wolpert et al 2015).

The 'transformation agenda' makes clear the requirement that schools play a role, along with local authorities and CCGs, in the commissioning of this category of mental health services. However, the results of a survey published in 2014 found that one-quarter of mainstream secondary schools do not commission mental health specialists that pupils can access on-site (Taggart et al 2014). In practice, schools have different levels of responsibility for commissioning different types of mental health specialists who can deliver early intervention services on site: they have sole responsibility for commissioning school counsellors; a joint responsibility alongside CCGs to commission CAMHS professionals who perform outreach work in schools; and a joint-responsibility, alongside local authorities, to commission educational psychologists (ibid). However, increased academisation has shifted more of the responsibility for commissioning and purchasing services and support onto academies – despite the fact that they often lack the commissioning expertise to be able to design effective school-based mental health provision.

Problem
There is significant variation in how secondary schools are putting a 'whole-school approach' to mental health provision into practice. School-based early intervention provision is not as widely available as it should be, because too many schools fail to provide pupils with the opportunity to access these services on-site – despite the fact that they are known to play an important role in helping to manage emerging mental health problems in a safe and accessible environment. In an increasingly fragmented school system, many schools lack the commissioning expertise required to commission early intervention support effectively.

9.
A WHOLE-SCHOOL APPROACH TO MENTAL HEALTH
ROLES AND RESPONSIBILITIES

The previous chapter described the wide variation in terms of how schools design and implement 'whole-school approaches' to mental health, with different schools offering different categories of provision. This variation causes dramatic differences in the extent to which children and young people can access school-based early intervention services.

As a result, children and young people often express concern about the lack of mental health support available in schools. A report by YoungMinds (2014) found that many children and young people who had interacted with mental health services felt that schools do not typically have enough of the right people in place to help. However, there is real confusion among schools about who the 'right people' are.

As the previous chapter discussed, schools have been granted the autonomy to design their own unique approaches to mental health provision in response to the particular levels and types of need among their pupils. This is reflective of the government's wider approach of granting schools the freedom to develop innovative solutions to boost pupils' performance. While it is important for schools to have autonomy in this area, moves to increase that autonomy have not been accompanied by measures to boost their capacity to meet pupils' mental health needs, or by any robust means of holding schools to account for the particular 'professional mix' they bring in to support pupils. The upshot of this is that even where school-based provision is *available*, its *quality* can be lacking.

This chapter explores the four broad groups of staff who are involved in mental health provision in English secondary schools: teachers, pastoral staff, mental health specialists and CAMHS professionals. It presents analysis of the variation in the quality of mental health support available to schools that illustrates both how government has failed to provide them with the capacity to meet their pupils' mental health needs, and how a more rigorous system of accountability would help to ensure that schools bring in an appropriate 'professional mix'.

9.1 Teachers
Teachers play a significant role in school-based mental health provision, and are integral to efforts to ensure that both of the first two categories of provision (prevention and promotion and early identification, triage and referral) are implemented effectively.

Prevention and promotion
Within this category, teachers are well placed to do the following.
- Deliver mental health education through the curriculum (using resources such as the non-statutory guidance and lesson plans on teaching mental health and emotional wellbeing produced by the PSHE Association).[19]

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19 https://www.pshe-association.org.uk/curriculum-and-resources/resources/guidance-preparing-teach-about-mental-health-and?ResourceId=570&Keyword=&SubjectID=0&LevelID=0&ResourceTypeID=3&SuggestedUseID=0

- Promote mental health and resilience among pupils through character education.
- Contribute to an ethos and culture within the school that is conducive to high levels of wellbeing.
- Avoid teaching practices that might contribute to the development or exacerbation of emotional or behavioural conditions among pupils.
- Help facilitate preventative activities such as mindfulness.

Case Study: School 21

School 21 is a comprehensive school based in East London.

Two-and-a-half hours per week are dedicated to providing pupils with teaching and learning on wellbeing, using a specially designed curriculum that aims to improve pupils' 'grit' and resilience. The wellbeing curriculum uses interactive assemblies and daily group and one-to-one coaching sessions. It covers learning on areas such as identifying strengths and aspirations, understanding healthy relationships and friendships, developing strategies for self-control in different situations, remaining optimistic and bouncing back from setbacks, and developing good learning habits.

Every member of staff is trained as a one-to-one coach, which enhances their ability to engage in meaningful, one-to-one conversations that can help support pupils to identify problems and find solutions. The school has a ratio of one one-to-one coach to every 12 secondary school pupils.

Early identification, triage and referral

Within this category, teachers should have responsibility for performing the early identification function. Given that they spend so much time with children and young people, and so are able to develop relationships with them over time, they are well placed to notice subtle emotional or behavioural changes that could, without the appropriate support, develop into more serious mental health problems.

Teachers are well placed to do the following.

- Identify early signs of trouble, and have the confidence to act where necessary.
- Use online learning tools such as MindEd and other resources to increase their awareness and understanding of different mental health problems.[20]
- Understand internal processes for referrals in instances in which they suspect a pupil may be experiencing emotional or behavioural difficulties that could be linked to mental ill-health (including who the case should be referred to).
- Maintain relationships with other parts of the internal school system in order that information can be shared where appropriate (while accepting that pupils' preferences for confidentiality might mean that not all information is shared with teachers all of the time).

However, teachers are not well placed to play a leading role in the performance of triage and referral functions: teachers should not attempt to diagnose, or provide any clinical or medical advice to, pupils.

'Teachers can only do a certain amount: they can't be a personal carer for all the children in the class, [and] there does come a time when they need to know where to refer to so that they can get support.'
Young person with experience of mental health services (February 2016)

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20   MindEd is a free online training tool to help school staff learn about specific mental health problems.

Teacher training on mental health

To enable teachers to perform their roles within school-based mental health provision effectively, they need appropriate training. However, there is ongoing concern about the level of training in this area that teachers receive in practice.

According to a recent survey of primary and secondary schools (Harland et al 2015), over one-third (38 per cent) of teachers and senior leaders in schools do not feel equipped to identify pupil behaviour that may be linked to a mental health issue, and just under half (54 per cent) feel that they do not know how to help pupils with mental health issues to access appropriate support.

Parents' views echo these findings. They often feel that teachers are ignorant of issues surrounding mental health, and can too easily fail to identify and act upon worrying signs. It has been shown that parents strongly believe that teachers should receive more training on mental health, particularly training that helps them to identify potential problems as early as possible. Indeed, parents have expressed concerns about teachers who have not received training becoming involved in their childen's mental health in any way (YoungMinds 2014).

Similarly, a focus group that we conducted with young people who have experience of mental health services identified the lack of training for teachers on mental health as a real problem. Without such training, participants expressed the fear that teachers could act in inappropriate ways, and were particularly concerned that teachers might not act with sensitivity towards or awareness of the need to maintain confidentiality. Most widely expressed among these latter concerns were the fears that teachers would alert other children to a child's problems by treating them differently; that they would speak to a young person's parents without that young person's consent; or discuss the issue with other teachers. One participant told us that,

> *'Anything that's going to make people notice is just going to make the situation worse… I know from personal experience that they did [make my mental health problem obvious], and it was a big mistake. People just made very negative assumptions, and the school should never even have done it.'*
> Young person with experience of mental health services (February 2016)

It is therefore vital that schools ensure that teachers receive appropriate training. Evaluations of Place2Be's Talented Teacher Programme, for instance, have demonstrated that it increased teachers' levels of ability and confidence in identifying and supporting pupils with mental health needs, which indicates the value of meaningful and well-designed continuing professional development focussed on mental health (Haywood et al 2016).

There have also been calls for training on mental health to be included in initial teacher training; this proposal is currently being reviewed by an independent expert group reporting to the Department for Education (DfE 2016). It is also important that teachers undergo training in internal processes for referral, which must be provided by the school itself.

9.2 Pastoral staff

Pastoral staff play a significant role in school-based mental health provision. Schools can choose to construct a pastoral system involving a variety of different staff members with different roles. All schools are required to have a nominated special and educational needs co-ordinator, and will have form tutors with pastoral obligations to pupils. They may also choose to employ additional non-teaching staff, such as 'pastoral managers', with responsibilities of this kind.

Pastoral staff are necessary to ensure that provision in the first two of the three categories of a whole-school-approach to mental health provision[21] is implemented effectively, and can also play a 'co-ordination' role that oversees provision across all three categories.

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21 That is, prevention and promotion, and early identification, triage and referral, with the third being schools acting as 'providers' of early intervention services, or 'hubs' from which they are delivered. See chapter 8.

Prevention and promotion

Within this first category, pastoral staff are in a position to promote behaviours relating to positive mental health and wellbeing, and signpost pupils to universal services available in the community.

Early identification, triage and referral

In this second category, pastoral staff are well placed to perform the early identification function. In a survey, headteachers singled out pastoral staff as the actors who are most important to supporting the early identification of pupils with emerging mental health problems (Taggart et al 2014). They are also well placed to contribute to triage and referral within schools, drawing on a range of internal and external mental health specialists and CAMHS professionals.

Case study: The Grange School
The Grange is an independent school based in Northwich, Cheshire.

The school employs a 'head of pupil support', whose role includes oversight of the school's approach to mental health. This person is described as having the trust of both the pupils and the staff, and has had some success in disassociating the head of pupil support role from the stigma that continues to surround mental health, by building trust with pupils over time.

The head of pupil support plays an important role in facilitating the training of other staff members in initiatives such as Mental Health First Aid,[22] and monitoring students' wellbeing using the AS Tracking tool that seeks to predict which pupils might be particularly vulnerable to or at risk of developing emotional and/or behavioural problems linked to mental health, thereby enhancing opportunities for early intervention.[23]

Pastoral staff as co-ordinators of a 'whole-school approach' to mental health

For a 'whole-school approach' to mental health to be fully effective, schools must ensure that the system has a central point of co-ordination, and that there are strong and transparent relationships between the various staff members and commissioned support involved in it. Pastoral staff are particularly well placed to perform this role.

As pastoral systems within schools have responsibility for the wider welfare of pupils, pastoral staff are likely to have experience of managing pathways into different services, and overseeing the school-based care of pupils with special educational needs; they are therefore likely to also be adept at performing a similar role for pupils with mental health needs. The pastoral system will generally include staff who are full-time in that capacity, and so can act as the link between teachers and the mental health specialists and CAMHS professionals operating within the school.

As co-ordinators of a school's system of mental health care provision, pastoral staff must foster strong relationships with, and between, teachers, mental health specialists and CAMHS professionals. This will allow them to work together in established and effective ways, and for everyone's different responsibilities to be clear and fully understood, which is important for both internal and external referrals. Schools must ensure that there are effective and established means by which the internal system can draw on and refer to external services, particularly specialist CAMHS.

22 http://mhfaengland.org/
23 http://mind.world/education/as-tracking/

In summary, pastoral staff are well placed to perform the following tasks.

- Assume the role of 'mental health lead' within the school (see boxed text below).
- Ensure the maintenance of appropriate levels of confidentiality between staff with mental health expertise and teachers.
- Feed back on the general mental health and wellbeing of pupils to the school's senior leadership.
- Assume line-management responsibilities for counsellors.
- Oversee the collection and analysis of data regarding pupil outcomes and the effectiveness of counselling interventions through tools such as the SDQ or the Young Person's CORE questionnaire.[24]
- Oversee processes for triage and referral (although where a 'hub' model is used, they might cede lead responsibilities to the external agencies operating within the school, while remaining an active partner in these processes).

Mental Health Services and Schools Link Pilots
The Department of Health and NHS England's *Future in mind* report (2015) proposed that a specific individual should be responsible for mental health in every school. The Mental Health Services and Schools Link Pilots are currently being rolled out in order to test this approach. There is now a named single point of contact for mental health in 255 schools across 22 local areas, in collaboration with 27 CCGs (NHS England 2015). NHS England and the Department for Education have jointly made £3 million of funding available for the pilot, with up to £85,000 going to each local area (ibid).

The approach has been designed with a view to ensuring more joined up working between schools and specialist CAMHS, and is expected to provide children and young people with more accessible pathways from the former to the latter, with the ultimate aim of developing more seamless and consistent support across health and education providers.

Each participating school has a 'single point of contact' who is responsible for developing closer relationships with a named counterpart in the local specialist CAMHS, in order to improve knowledge and understanding of mental health issues within the school and help ensure that referrals are timely and appropriate. The pilot involves staff from both the school and the local CAMHS undertaking a series of training days.

The pilot is subject to a national evaluation, which commenced in October 2015 and is due to run until November 2016 (Burt 2015b).

9.3 Mental health specialists

While teachers and pastoral staff both play an important role in effective school-based mental health provision, schools should also host a range of mental health specialists as part of a whole-school approach. Research suggests that parents express a strong preference for schools to increase the number of dedicated staff with specific mental health expertise (YoungMinds 2014). There are three types of mental health specialists that currently operate in schools on a significant scale: counsellors, school nurses and psychologists.

1. Counsellors

School counsellors provide a service that pupils can voluntarily enter into should they wish to receive help on any of a wide range of issues relating to their emotional wellbeing or behaviour. They should be used by schools to perform a role focussed on the second and third of the three categories discussed above.

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24   Young Person's CORE is a short questionnaire that can be used in every counselling session so that assessments can be compared over time.

Early identification, triage and referral
Within this category, school counsellors can play an important role in the early identification of emotional and behavioural problems relating to mental health. Research suggests that children and young people are slightly more likely to report having spoken to a counsellor about their mental health (42 per cent) than to a teacher (39 per cent) (YoungMinds 2014). Some school counselling services offer a drop-in service, whereby counsellors can be the first point of contact at which pupils' issues are raised. School counsellors often also play a role in triage and referral in collaboration with other staff.

Early intervention
Within the third category, school counsellors provide opportunities for children and young people to explore, understand and overcome issues in their lives which may be causing them difficulty, distress or confusion, and which may be symptomatic of emerging mental health problems (DfE 2016). In this context, school-based counselling is used as a form of early intervention in order to reduce the likelihood that children and young people with identified emotional or behavioural problems will go on to develop more serious mental health conditions. As a result, school counsellors often work with children and young people who have not received any clinical diagnosis relating to mental health.

School counsellors can deliver targeted, one-to-one interventions and, if they are appropriately trained, targeted group work with these pupils. Counselling sessions provide pupils with an opportunity to talk through their problems in a safe environment in which both parties are subject to an 'agreed' contract which sets out mutually agreed boundaries and goals.

The evidence shows that counselling in secondary schools can bring short-term benefits to children and young people who are experiencing psychological distress (Cooper 2013). What's more, it is generally approved of by children and young people. Research suggests that, where it is known to exist, 55 per cent of children and young people consider it to be helpful, and where it is absent, 91 per cent think that it would be helpful (YoungMinds 2014). Similarly, school staff generally approve of the service provided by counsellors, including the guidance that they can provide on managing emerging emotional and behavioural problems in school (DfE 2016).

In order for them to be effective, it is important that counsellors are integrated into the wider school system. This requires that the service is visible, that pupils' right to confidentiality is respected, and that the processes for referral from other school staff are well established. For example, where children and young people have not been involved in accessing mental health services, they often report being unaware of the presence of an on-site counsellor, or of how to access them if they should need to (YoungMinds 2014). This came through during our discussion group with young people. One participant told us,

> *'She was… hidden from view, you only saw her if you asked for the counsellor. There was no open door policy of "this person is here if you need support".'*
> Young person with experience of mental health services (February 2016)

The departmental advice on school-based counselling produced by the Department for Education (DfE 2016) sets out a number of best practice guidelines for how schools can ensure that counsellors are integrated into the wider school system. These include directions that:
• counsellors seek permission from children and young people, or their parents/carers where appropriate, to share information that would identify them as using the service

- schools ensure the presence of strong relationships between counsellors' school-based line-managers and external clinical supervisors, in order that issues regarding performance and practice can be raised and discussed
- schools ensure that staff and pupils are aware of appointment systems and procedures
- schools select a senior member of staff to act as the 'link person' to the counselling service (ibid).

Schools have sole responsibility for purchasing or commissioning school counselling services, and, as discussed above, they can do so according to either a 'provider' or a 'hub' model. Under the former, schools either directly employ counsellors who then become salaried members of staff, or establish individual contracts with self-employed counsellors. Under the latter, schools buy-in resources from an existing, external counselling service, ordinarily within the voluntary sector, which then operates within, and in partnership with, the school.

The financial cost to the school of providing counselling services varies depending on both the chosen delivery model ('provider' or 'hub') and the intensity of the service they receive. For example, an individual counsellor spending two days per week in school is estimated to cost £14,500 per annum, while a whole-school mental health service integrated with the school's internal pastoral, safeguarding and support systems is estimated at around £40,000 per annum (DfE 2016). Place2Be, when based in the school for two days per week, comes at a cost to the school of £27,000.[25] The most common means by which schools pay for this resource are thought to be the dedicated schools grant and the pupil premium. The boxed text below sets out an example of each model in practice, while table 9.1 sets out some generalisable strengths and weaknesses both.

We have identified three problems with the way in which counselling services are currently provided in schools.

Problem 1: Too many schools do not offer a counselling service
It has been estimated that 70 per cent of secondary schools offer counselling services to pupils (Harland et al 2015), and the level of provision is thought to have increased over time – largely as a response to growing need among pupils. While the trend towards greater provision is to be welcome, this 70 per cent figure means that pupils in the remaining 30 percent of secondary schools are denied access to school counsellors. Without this important means of early intervention in all schools, local CAMHS systems cannot achieve their full potential.

The Department for Education's has set out a 'strong expectation' that all schools will, over time, make counselling services available to all pupils in England (DfE 2016). There is, however, no statutory requirement that they do so, as there is in both Northern Ireland and Wales (see the boxed text below).

School counselling provision in Wales
In 2008, Welsh local authorities were given a statutory duty to provide school-based counselling services for all secondary school pupils. Since 2013, this was widened to impose a legislative duty on local authorities to ensure that counselling provision is available to all 11–18-year-olds, including in schools, with funding provided to local authorities via the revenue support grant.

A 2011 evaluation of this strategy reported widespread satisfaction with counselling provision among teachers, pupils, headteachers and parents. The amount of positive change experienced by young people receiving counselling was found to

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25 According to evidence from Place2Be shared with IPPR.

be higher than that experienced by those who had accessed other similar services elsewhere in the UK. The introduction of school counselling also eased the pressure on teachers and other staff, rather than adding to their workloads. By 2011, all counsellors operating in Welsh secondary schools were found to be professionally qualified, although not all were able to operate within a designated safe space within the school (Welsh Government 2011).

However, the evaluation identified some areas for improvement: for example, the degree to which counselling provision was integrated with schools' wider pastoral systems varied; there was also variation in the extent to which local authorities had collected outcome data; BME pupils and those with SEN were underrepresented among those accessing counselling; and some difficulties were pointed out in terms of young people's ability to directly refer themselves to the service (ibid).

Problem 2: Even in those schools that do have counselling provision, its quantity is often not sufficient to meet pupil demand

School counsellors are estimated to be available to pupils on a daily basis in just 28 per cent of English secondary schools, compared to once or twice a week in 43 per cent of schools, and once or twice a month in 13 per cent of schools (Taggart et al 2014). This problem also came through strongly in our discussion group with young people. One participant told us,

> 'we had one [counsellor] who was in once a week, but [this] meant she could only see six pupils out of a school of 1,000, and there were more than six pupils who needed her support'.
> Young person with experience of mental health services (February 2016)

Problem 3: There is significant variation in the quality of the counselling services available to schools

A qualified counsellor is a professional practitioner who has typically completed a two-year part-time or one-year full-time diploma. While most school counselling services use qualified counsellors, this is not always the case. For example, Place2Be uses a mix of qualified and trainee counsellors; the latter are nearing the end of their counselling training, and are at a point in it at which they are required to undertake a supervised counselling 'placement' in order to qualify. The trainees are overseen by a 'school project manager' who is a qualified counsellor (see the section on Fulwood Academy in the boxed text below).

Qualified school counsellors can opt to become accredited through being recognised on a voluntary register. The largest of these is administered by the British Association of Counsellors and Psychotherapists' (BACP). It is a public record of counsellors who have met the BACP's standards of registration – which cover training, supervision, continuing professional development, and a commitment to a specific ethical framework – and is accredited by the Professional Standards Authority for Health and Social Care. Accreditation is intended to provide both a broad framework of quality assurance for the growing number of practicing counsellors, and a quality kite-mark to assure potential employers of a counsellor's fitness to practice. Despite counselling in schools technically remaining an unregistered profession, the rise of accreditation has led to claims that it is 'increasingly viewed as a profession' (DfE 2016).

While this accreditation process does provide schools with some assurances, there are two significant gaps that were identified in the course of the research presented in this report, and which contribute to ongoing concerns about schools' ability to purchase or commission high-quality counselling provision. First, we heard how accreditation does not give any assurances about practicing in specific contexts or with specific groups of clients. School counsellors can therefore often have little or no experience of working specifically with children and young people, and so have little or no understanding of the particular issues and challenges that can commonly present within a school setting. Second, once a counsellor

has received accreditation, there is no requirement for ongoing validation, which makes it difficult for schools to be assured that individual counsellors' practice is maintained at a sufficient level.

Ideally, school counsellors will have obtained accreditation before they start working with pupils. However, where this is not the case, school counsellors are required to demonstrate that they have conducted 450 hours of practice, with at least 1.5 hours of clinical supervision per month, in order to receive accreditation should they wish to obtain it (DfE 2016).[26] Counsellors seeking accreditation therefore have good reason to work with the school to ensure that clinical supervision is in place. However, where a counsellor is not seeking accreditation, or has already been accredited, there may be less incentive to ensure that clinical supervision occurs.

It is not known how many counsellors operating in schools are qualified, how many are accredited, how many are working towards accreditation, and how many have substantial experience of working with children and young people within a school setting.

The 'provider' and 'hub' models of school-based counselling provision: two case studies

'Provider': Manchester Communication Academy
The school buys-in a full-time counsellor to work with children and young people and their families, as part of its wider approach to mental health and wellbeing.

As an academy, it has used its autonomy to develop a long-term strategy for mental health and wellbeing, and to take the sole lead for organising their offer to pupils and families independently of the local authority or any particular voluntary sector provider. Instead, the school's pastoral leaders have taken responsibility for shaping the offer, and have commissioned or directly employed a number of individual mental health specialists to provide support to pupils and their families on the school premises.

For example, the counsellor works alongside a commissioned educational psychologist who is on-site for 40 days over the course of an academic year, and a full-time nurse employed directly by the school. The school has opted not to commission any services directly from the local authority.

The school selects the individual mental health specialists that it employs, or commissions them, on the basis of their:
- 'local intelligence' and understanding of the particular types of need faced by pupils and their families in the area
- adherence to the school's particular ethos and approach
- ability to influence gatekeepers to other services, such as specialist CAMHS, and so ensure that pupils are able to receive appropriate, timely support.

The school's overarching approach to mental health and wellbeing for pupils is defined in its 'early help, risk and response framework', designed by the school's pastoral leaders. This sets out three levels of response to pupils with identified needs and/or vulnerability.
- Level 1: Universal provision
- Level 2: Targeted response
- Level 3: Specialist response.

Under Manchester Communication Academy's specific approach, the counsellor is commissioned in order to provide support within level 2 only, and does not have responsibilities for levels 1 or 3.

The service was praised by the school's leaders, pastoral staff and teachers. Its effectiveness was thought to be based on:

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26 Clinical supervision is separate from line management. While the latter can be carried out by staff from within the school or an external counselling service who are not themselves qualified counsellors, the former should be carried out by experienced, qualified counsellors operating within the community.

- the control the school has over the particular roles and personalities brought in as part of its mental health and wellbeing offer
- the freedom it has to easily remove or replace individual commissioned mental health specialists where problems are identified
- the ability of the school's pastoral leaders to shape the school's offer, given their unique knowledge and understanding of local need (which it was felt could not be replicated by any voluntary sector organisation).

Source: case study visit to Manchester Communication Academy, including interviews with the headteacher, the head of pastoral care, and a small number of teachers.

'Hub': Fulwood Academy, Preston
The school receives counselling services for 2.5 days per week from Place2Be.

The service is co-ordinated by a school project manager (SPM) – a qualified counsellor with experience of working with children and young people. The SPM's role is largely one of co-ordination, with counselling sessions themselves delivered by volunteer, trainee counsellors.

Counsellors receive training from Place2Be in a broad approach to child-centred therapy. The majority of counselling sessions are designed around the use of one-to-one talking therapy, and service as a whole is largely framed using the language of 'wellbeing' rather than 'mental health'.

Pupils can access the service by a number of means: drop-in (Place2Talk) sessions; referral from teachers and other staff; or parental referral. After a young person is referred, the SPM performs an initial assessment before allocating them to a trainee counsellor. The young person then undertakes weekly, hour-long counselling sessions for up to an academic year.

Trainee counsellors share issues raised during sessions with the SPM. Where safeguarding issues arise, or where counsellors feel that a pupil would benefit from more specialist provision, the SPM can liaise with the school's internal pastoral system and the pupil's family in order to make an effective referral. The SPM can also liaise with teachers to share the broad themes that emerge from counselling sessions, without going into the specifics of particular issues raised by particular pupils.

Central to this model is a twin emphasis on both the 'separateness' of the service from the school, and the need for strong links between the SPM and the school's internal pastoral system. Place2Be is described to pupils as being 'outside' of the school; counsellors are referred to by their first names, and sessions take place in a separate, safe space away from classrooms. Fulwood Academy's SPM told us:

> *'They see me as non-threatening… I do a lot of presentations in forms, and I'm very open and say that, "I'm not a teacher. I won't tell you what to do. I'm here for you".'*

At the same time, the SPM works closely with the special and educational needs co-ordinator and other pastoral staff as part of a cohesive unit behind-the-scenes. This co-operation was described as '[blending] really well, because we're all working towards the same goal of promoting the wellbeing of that student'.

The responsibilities of the SPM are, then, to:
- line-manage and provide clinical supervision to the trainee counsellors
- raise awareness of mental health and wellbeing, and help reduce the stigma surrounding it (through assemblies, assisting in PSHE lessons and so on)
- up-skill school staff on issues related to mental health and wellbeing
- engage with parents and families
- work together with the school's internal pastoral system
- monitor and evaluate the effectiveness of the service using the SDQ
- maintain strong links with Place2Be's central office.

The service was universally praised by staff and pupils at Fulwood Academy, and its effectiveness was thought to be based on:
- the strong relationships between Place2Be staff and the school's teaching and pastoral staff

- the 'co-ordination' role that the SPM fulfils, alongside those of individual counsellors
- the trust that pupils and their families have in the service
- the quality assurance, monitoring and evaluation provided by Place2Be.

Source: case study visit to Fulwood Academy, including interviews with the headteacher, assistant SEN co-ordinator and SPM, and a series of focus groups: two groups of pupils, one group of teachers, and a group of trainee counsellors.

Table 9.1
Strengths and weaknesses of the 'provider' and 'hub' models for school-based counselling provision

Provider model		Hub model	
Strengths	**Weaknesses**	**Strengths**	**Weaknesses**
Schools retain control over the appointment and line-management of individual counsellors.	An absence of mental health expertise elsewhere in the school can mean that problems with the quality of counselling are not identified.	An external provider can provide assurance that counsellors are sufficiently trained, and that they receive appropriate clinical supervision.	It is incumbent on schools to ensure that the counselling service is effectively integrated with other parts of the school's mental health provision.
Relatively low cost.	It is incumbent on schools to ensure that mechanisms are in place for effective clinical supervision.	Can provide a mechanism for quality assurance and evaluation.	Relatively high cost.
	It falls to schools to ensure that counsellors have sufficiently strong relationships with teaching and pastoral staff, and with external services.	Pupils prefer counsellors who are more obviously independent from the school and its staff, and so are perceived to have a more rigid system of confidentiality.	Headteachers can be reluctant to surrender a degree of control over the provision, line management and appointment of individual counsellors to an external agency.
	Schools themselves must ensure that counsellors are appropriately trained and have relevant experience.	Can include an on-site 'co-ordinator' who can oversee individual counsellors and facilitate links to pastoral staff.	
	Schools have full responsibility for ensuring that counsellors do not go 'under the radar' and lack visibility to pupils; schools also cannot draw on the enhanced visibility that might come with an external provider operating within the school.	Can provide mechanism through which issues and complaints can be raised.	
		Can improve visibility of counsellors to pupils.	

In the course of this research we heard many testimonies from teachers and other experts about the widespread lack of understanding within schools of the best means of guaranteeing the quality of individual school counsellors. This lack of understanding is a major contributing factor to the significant variation in the quality of counselling provision between schools.

> *'It's individual schools buying in individual counsellors. It's not an organisation, so they're not under the same scrutiny. There isn't the same auditing, there isn't the same evaluation. It's just different schools buying in different services, and people with different qualifications and different experiences, and often from an adult counselling service rather than a young person's counselling service.'*
> Headteacher (February 2016)

'The difficulty is sometimes you might buy from a service, but actually the quality you get from that isn't necessarily as good as buying form an individual, or vice versa. So most schools will go out to procure the best; however that [depends] on what's available.'
Headteacher (February 2016)

'There isn't that sense [of there being] some level of uniformity that says, actually, there's a base standard that [all counsellors] should meet… That element has been missing a little bit. So you can't always just trust when someone says, "I'm qualified and our charity is really good at providing this work". Because a lot of the time you can get someone from a service and, depending on the actual person that you get on the day, that service can obviously vary from time to time and person to person. [There lacks] some form of standardisation… that says, "Actually, this is the baseline of what these types of services provide".'
Headteacher (February 2016)

Problem
In too many schools, counselling provision is not sufficient to meet pupil need. What's more, the quality of school counselling services is inconsistent, and quality assurance insufficient.

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2. School nurses
School nurses lead and deliver the Healthy Child Programme for 5–19-year-olds, and work together with schools and a wide range of health services based in the community. They are qualified nurses with specialist training in public health for children, young people and families, and are registered with the Nursing and Midwifery Council. School nurses' main role is to identify health problems and concerns as early as possible by conducting health needs assessments, and to promote healthy lifestyles. Public Health England has set out six 'high impact areas' for school nurses:

- building resilience and improving emotional health and wellbeing
- keeping pupils safe, managing risk and reducing harm
- improving lifestyles
- maximising learning and achievement
- supporting additional health and wellbeing needs
- seamless transition into, and preparing for, adulthood (PHE 2016).

The majority (85 per cent) of secondary schools report that they have a school nurse available. In mainstream secondary schools, nurses are most commonly available for one or two days per week, although it has been estimated that in 25 per cent of schools they are available for just one or two days per month (Taggart et al 2014). There are currently around 1,500 school nurses in England, and they are commissioned through local authorities and Public Health England, with individual schools receiving an allocation of days at no cost.

School nurses have the potential to play an important role in school-based mental health provision, and the *Future in mind* report specifically set out the need for them to build resilience and improve emotional health and wellbeing among pupils (DH and NHS England 2015). They are well placed to take on responsibilities in the first two categories of provision.

Promotion and prevention
Within the first category, school nurses are can effectively fulfil a number of responsibilities with regards to prevention and promotion. These responsibilities are detailed in the guidance issued by the Department of Health and Public

Health England on school nurses' role in promoting emotional wellbeing and positive mental health, and they include:

- recognising and utilising opportunities to promote emotional health and wellbeing
- de-stigmatising mental illness and normalising emotional health and wellbeing
- providing non-judgemental support (DH and PHE 2014).

Early identification, triage and referral
Within the second category, school nurses are well placed to perform the early identification, triage and referral functions. Taggart et al (2014) found that pupils with possible mental health problems are referred to school nurses by other school staff in 84 per cent of secondary schools, followed by pupil referral (in 67 per cent of secondary schools), and pupil drop-in (64 per cent).[27] This suggests that it is often preferred that school nurses identify issues in the first instance *after* they are approached by pupils, and that they 'take on' cases from teachers and pastoral staff who have themselves identified issues. In the workshop that we held, headteachers also indicated that schools often prefer to use school nurses, along with GPs, as mediators through which referrals are made to specialist CAMHS and other services in the community.

Training school nurses in mental health
School nurses can sometimes be barred from taking a leading role in a whole-school approach to mental health due to insufficient training. While 'emotional health and wellbeing' does form part of school nurses' initial training, there is currently no statutory requirement for school nurses to receive *mental health* training, either as part of their initial training or once they are qualified and operating within schools (Brown 2015). Where schools or commissioners choose not to upskill school nurses using tools such as MindEd, they can sometimes not be fully equipped to fulfil responsibilities relating to mental health – despite the fact that many schools give them a central role in triage and referral. Where schools rely on school nurses who lack sufficient training to perform these important functions, children and young people may not receive appropriate and timely care.

In 2012, the Institute of Psychiatry at King's College London and Rethink piloted a new project – QUEST – with the objective of improving school nurses' knowledge, professional confidence and clinical behaviour with regards to pupils' mental health (Ling et al 2012). It identified school nurses as the key to improving the identification of children experiencing emerging mental health problems, and so provided school nurses across 13 primary care trusts and 169 secondary schools with a specially designed training package. The project trained school nurses to be better at recognising and assessing mental health problems and at knowing when to refer them on, to be able to manage pupils' mental health needs themselves when appropriate. Results showed the project had a positive effect on nurses' knowledge, attitudes and skills, with a significant improvement in their ability to identify and work with pupils with depression (ibid).

Many service providers do recognise the importance of developing school nurses' skills and capacity with regards to mental health, and take steps to do so. In Tower Hamlets, the social enterprise Compass Wellbeing operates school nursing provision, having taken on nurses' contracts from Barts Health NHS Trust in 2015. As well as administering the allocation of nurses to schools – with each school receiving an allocation of one day per week – the service also provides nurses with additional training on how to integrate physical and mental health within a school setting. This training intended to enable them to better meet the needs of pupils with emerging mental health problems, to differentiate between different types of behaviour that may or may not be related to mental ill-health, and to start conversations with pupils on the issue of mental health.

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27   Schools often have more than one means of referral.

3. Psychologists

Children and young people are often able to access a child psychologist and/or an educational psychologist within a school setting. Child psychologists specialise in children and young people's mental health, and can provide help and support to those who are experiencing difficulties. Educational psychologists, on the other hand, explore issues relating to emotion and behaviour, with a specific focus on how they might interfere with learning. Schools can often access a child psychologist from CAMHS, and/or an educational psychologist from their local authority; alternatively, schools can choose to commission a psychologist directly. However, while 86 per cent of mainstream schools report having access to a qualified psychologist, they also report that they are less likely to be in school as often as school nurses or counsellors: 69 per cent were said to be on-site for one or two days per month, 8 per cent on-site once or twice a week and 1 per cent on-site every day (Taggart et al 2014).

Psychologists are best placed to work within the third category of provision, early intervention.

Early intervention
Within this third category, psychologists can deliver targeted mental health interventions for emerging emotional or behavioural problems in a school setting. The national evaluation of the Targeted Mental Health in Schools (TaMHS) programme found psychologist-led interventions based in schools to have significant positive outcomes for pupils (DfE 2011).

9.4 CAMHS professionals

Mental health professionals from specialist CAMHS can also operate within schools. This often takes the form of primary mental health workers (PMHWs) either spending a certain number of days per week or month on 'outreach' in a school, or else being based more permanently in the school while retaining strong links to, and management from, CAMHS.

During a workshop with headteachers, several reported that their school received on-site support from CAMHS professionals, and that there was a strong feeling that this service was the most effective form of school-based mental health provision available to pupils.

Similarly, children and young people have also been found to prefer that mental health support in schools is provided by specialists in mental health (YoungMinds 2014). CAMHS professionals can perform roles across all three levels of provision.

Prevention and promotion

Within this first category, CAMHS professionals can provide training and support to teachers and other staff involved in prevention and promotion, improving their skills and confidence.

> *'They can be involved in further staff training and development, and the school can then grow in terms of providing good mental health provision in a totality, rather than trying to scrabble around, because you've got a professional working with you, and a backup resource [specialist CAMHS] that can be accessed.'*
> Headteacher (February 2016)

Early identification, triage and referral

With regards to this second category, CAMHS professionals can help to facilitate early identification, and play a leading role in triage and referral. Given their enhanced level of professional expertise, triage by professionals means that schools can often be more

confident that directing pupils toward services provided by mental health support staff (such as counselling) are the most appropriate option.

> *'The practitioners who work in the schools can provide a triage approach, so if it's something they can deal with they will deal with that. If it needs more clinical input then it can be directed there, and it's very effective.'*
> Headteacher

> *'[It is] a quality service that's driven by clinical, medical professionals who know what they're talking about.'*
> Headteacher

CAMHS professionals can also help to ensure that both the speed and quality of referrals into specialist CAMHS and other services are significantly enhanced. While the vast majority (94 per cent) of mainstream, maintained schools have access to an external referral pathway for pupils with more severe or complex mental health needs, headteachers deemed this pathway effective in less than half of cases (Taggart et al 2014). Research suggests that many schools consider the support that specialist CAMHS provide to be inadequate: the main complaints were that referrals take too long to be accepted, the threshold is too high, and that it is difficult for teachers to make a referral unless the pupil in question is in crisis. Furthermore, specialist CAMHS were perceived to be operating at capacity, with the time it took to access the service making it impossible to provide early intervention to children and young people (ibid).

The Mental Health Services and Schools Link Pilots is expected to lead to stronger relationships between participating schools and specialist CAMHS, and so to improve referral processes. However, headteachers were clear that having a CAMHS professional operating within the school further enhances these relationships and functions. They can act as an effective screening tool for CAMHS, leading to a reduction in referrals; they can also ensure that children and young people are directed immediately to the most appropriate early intervention services (Atkinson et al 2010).

> *'[Having CAMHS professionals working in schools] has been really powerful… because it's meant that the problems in terms of putting your referrals in and then just sitting and waiting – a lot of that problem has disappeared.'*
> Headteacher

> *'In the past we would have had to wait weeks, months, sometimes a year to get a child in [to specialist CAMHS] at 'assessment' level, whereas with the [CAMHS professionals] resource we've got at the moment, we don't have to do that.'*
> Headteacher

Early Intervention
Within this third category, CAMHS professionals based in schools can deliver specific therapeutic interventions to pupils with emerging mental health problems, although this is less widespread – CAMHS professionals based in schools will often be solely involved in categories one and two as described above (National CAMHS Review 2009). However, there is evidence that the presence of PMHWs and other CAMHS professionals who have a role in delivering early intervention services to pupils, in addition to category one and two functions, is valued by teachers and other school staff (MacDonald et al 2004).

'Having the professional in school allows [pupils' mental health] to be managed on home turf in an accessible environment for the child and the family, and it allows things to happen much quicker.'
Headteacher

The Emotional Health in Schools service

The Emotional Health in Schools service provides training, consultation and school-based mental health interventions in nine secondary schools across the Manchester city council area, targeting children and young people aged between 11 and 16. The service aims to deliver early interventions and improve communication and access to tier 2 and 3 specialist CAMHS provision.

The service is staffed by CAMHS professionals (clinical psychologists and school health advisors), with each participating school receiving 2.5 days per week of on-site support.

The service aims to cater to the full range of need among secondary-school-aged pupils, and aims to:

- provide training and consultation to school staff
- provide drop-in sessions for pupils
- provide timely, responsive assessments
- provide brief interventions for pupils with identifiable conditions
- provide targeted, evidence-based psychological interventions to pupils with emerging mental health problems within accessible educational settings
- facilitate strong communication with specialist CAMHS and other targeted mental health services based in the community
- allow for seamless transitions into specialist CAMHS for pupils with more complex and enduring conditions.

Source: a focus group conducted with headteachers with experience of involvement in the Emotional Health in Schools service.

The headteachers we spoke to also noted how CAMHS professionals working in schools can help to break down siloes between 'health' and 'education' professionals and institutions, thereby allowing improved sharing of information, ideas and expertise. They expressed a sense of ownership of the service, and felt that CAMHS recognised them as active and respected partners in efforts to meet pupils' mental health needs.

'There's something to be said… for the model of true partnership working, which is health and education working truly together, in terms of health professionals being based in the school setting [and] education professionals having an input into health. I think there's something about people having a foot in both camps definitely [bringing] added value to whatever you do. [Counselling and CAMHS] are two different provisions within a school and they have different purposes. When you're buying in CAMHS, my sense has always been you're not just getting that person, you're also getting a foot in the door to a wider range of other... pathways and options, and that's part of the added value of what you're doing.'
Headteacher (February 2016)

'The professional siloes are one of the greatest drawbacks to whatever we're doing. CAMHS work in schools, don't work in schools, schools don't understand CAMHS – and that's something that's a massive barrier to the whole [transformation] agenda.'
Headteacher (February 2016)

However, despite the popularity of schools-based CAMHS provision, it is not widespread in comparison with the availability of mental health specialists such as counsellors. Some local areas – such as Brighton and Hove – have set out an ambition in their local transformation plans for PMHWs to be made available to more schools, in part to provide early intervention services. However, many of these plans do not set out any such ambition. The headteachers we spoke to identified the financial cost to schools as being the biggest barrier to CAMHS professionals being based in more schools more often. This reflects a more general problem that schools face when looking to improve their mental health provision: during the course of the research undertaken for this project, headteachers and school leaders repeatedly told us that the absence of long-term funding prohibits them from being able to develop long-term strategies for mental health provision for pupils.

Problem
Schools are unable to access sufficient funding to provide high-quality early intervention provision – in the form of both counsellors and CAMHS professionals – for their pupils, and so are unable to plan for the long-term.

Table 9.2
Indicative delineation of roles and responsibilities within a whole-school approach to mental health, by category, function/outcome, staff type and role and type/level of responsibility

| Function | Category 1 | | Category 2 | | | Category 3 |
	Promotion	Prevention	Early identification	Triage	Referral	Early intervention
Teachers	X	X	X			
Pastoral staff	X	X	X	X	X	X
Counsellors		X	X	X	X	X
School nurses	X	X	X	X	X	
Psychologists				X	X	X
CAMHS professionals	X		X	X	X	X

(Rows Counsellors, School nurses, Psychologists, CAMHS professionals grouped under "Mental health specialists")

Key	
Primary responsibility	X
Secondary responsibility	X
Co-ordination responsibility	X

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This second part of the report (chapters 5–9) has demonstrated that there is significant variation in both the *availability* and *quality* of school-based mental health provision, particularly with regards to early intervention services. We have seen how although schools have been granted autonomy to design their own 'whole-school approach' to the issue, that autonomy has not been accompanied by any measures

to boost schools' capacity to meet pupil need. That this presents a problem is evident from ongoing concerns about the quality of services that schools can buy-in, and the lack of funding available for schools to allow them to prioritise pupils' mental health alongside their educational attainment. We have also seen how schools' increased autonomy has not been accompanied by any means of holding them to account for the shape they choose give to their mental health provision, which has led to variation in how school leaders organise their internal mental health expertise. A forthcoming survey of school and college provision for mental health and character education (tendered by the Department for Education) is likely to shine further light on the level of variation in the availability and quality of services to pupils.

At this point, however, we know that there are particular problems in the following areas.

- The training of school staff (particularly teachers and school nurses) to enable them to identify and refer emerging mental health problems effectively.
- The availability of high-quality school counsellors in *all* schools for enough days per week to meet the level of need among pupils.
- Schools' ability to guarantee access to high-quality counsellors, given the unregulated nature of the profession and the lack of a guarantee that counsellors have experience of working with children and young people in a school setting.
- The lack of sufficient funding to allow schools regular access to CAMHS professionals operating within the school premises.

10. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Secondary schools have great potential to do more to help meet pupils' mental health needs alongside other community-based NHS and voluntary sector provision. They have an important role to play in prevention and promotion; early identification, triage and referral; and early intervention targeted at pupils with emerging mental health problems.

However, there are two significant problems with how, and to what extent, schools are providing their pupils with access to targeted early intervention provision, alongside their universal offer. First, too few schools are currently offering early intervention provision to pupils. Second, even where pupils are able to access these services within school, they are often not of a sufficient quality.

These two problems have contributed to both schools' longstanding underdelivery of this kind of provision, and their more recent inability to play a leading role in the government's planned transformation of local CAMHS systems. Despite new government investment, the early signs suggest that the transformation agenda is not enabling schools to improve the *availability* and *quality* of their early intervention provision, and that schools are having too little say in the planning and delivery of services.

These problems mean that a significant number of schools are not fulfilling their potential in terms of meeting their pupils' emerging mental health needs as part of local CAMHS systems. There is not enough high-quality, school-based early intervention provision available to children and young people. The government must therefore take action to reinvigorate early-intervention mental health provision in schools.

This report has identified four major barriers to effective school-based early intervention mental health provision.

1. Funding
Schools largely lack the funding they require to provide pupils with targeted mental health support. They have long been unable to access sufficient 'health' funding, or services paid for by health providers, that would allow early intervention services to be provided on-site. Following the introduction of the transformation agenda, the effect of this inability to access 'health' funding is that schools are not being recognised fully within local CAMHS systems.

2. Commissioning and representation
In an increasingly academised school system, schools often lack the internal expertise they need to commission effective mental health specialists. They also lack established mechanisms by which they can influence commissioning decisions at a CCG level (despite the aspirations for joint working set out in the *Future in mind* report[28]).

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28   DH and NHS England (2015).

3. Quality
The quality of mental health support (particularly school counselling) available to schools is inconsistent, and schools are not receiving sufficient guarantees that all the staff they commission or purchase have suitable levels of training and experience.

4. Accountability
Given that schools are an important part of local CAMHS systems, they are not sufficiently held to account for ensuring that high-quality mental health provision is available to their pupils. There are insufficient external checks on the appropriateness and quality of the particular 'professional mix' that individual schools use as part of a whole-school approach to mental health, and Ofsted inspectors are not routinely reporting on schools' mental health provision despite the recent inclusion in the Ofsted framework of new criteria regarding pupils' mental health and emotional wellbeing.

Government must find ways to overcome each of these barriers if it is to enable schools to fulfil their potential as either 'providers' of early intervention services or the 'hubs' from which they can be delivered, and to play the role in the transformation of local CAMHS systems that is set out for them in *Future in mind.*

Recommendations

Funding
Mechanisms should be established to ensure that more 'health' funding is directed towards schools, so that a basic minimum level of school-based mental health provision is available to all pupils. Transformation funding should be used as a means of transferring more health funding to schools in the short term, so that more early intervention provision can be based within them. This should then facilitate more sustainable arrangements in the long term, whereby early intervention mental health provision in schools is incorporated as an ongoing part of CCGs' expenditure from 2020/21. Headteachers should then top-up this 'basic minimum' provision using their own budgets, on the basis of ongoing assessment of pupil need.

The burden of funding mental health provision in schools should be shared, and use both 'health' and schools' budgets. Schools should not be forced by limited budgets to choose between prioritising their pupils' mental health and their educational attainment.

1. By the end of the current parliament, all secondary schools should be guaranteed access to at least one day per week of on-site support from a CAMHS professional. This should rise to two days per week by 2022, in order to ensure that CAMHS professionals are able to deliver early intervention provision to pupils with emerging mental health needs, as well as triage and school development work, in all schools.[29] In the long term, this should be funded from within CCG budgets but delivered on school sites. Putting this provision in place is an important means of shifting the locus of early intervention care into schools, while ensuring that school-based interventions are backed up by the NHS's clinical infrastructure. This will provide greater assurances of the effectiveness of school-based interventions.

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29   IPPR estimates that this provision would cost £595 million over the 10 years from 2016/17 to 2025/26. This is calculated on the basis of the annual cost of a CAMHS professional being based in a school for one day per week – around £13,000 per year, as confirmed by CAMHS professionals interviewed in the course of this research. This figure was multiplied by the number of secondary schools in England (approximately 3,381). The calculation is based on the assumption that a CAMHS professional will be based in every school for one day per week up to 2021/22, and for two days per week between 2022/23 and 2025/26.

2. We realise that CCGs and CAHMS may not have the capacity to deliver this change immediately. We therefore recommend the following policies to help facilitate the transition to a system in which all schools have access to an on-site CAHMS professional.

   – All schools should be given the right to request a CAHMS professional to work on-site. This should be phased in gradually up to 2019/20 to give the CAMHS workforce time to adapt. Priority should be given to schools with higher needs.

   – While some CCGs have already set out plans to increase the number of CAMHS professionals working in schools, this is not yet widespread. Therefore, before CCGs make commissioning decisions for 2017/18, NHS England should stipulate that transformation plans are updated to prioritise the availability of CAMHS outreach in secondary schools.

   – In order to further facilitate this change, a portion of the non-CCG transformation funding allocation for the years 2017/18–2019/20 should be set aside for the express purpose of enabling more CAMHS professionals to be based in schools.[30]

3. As well as being able to access 'health' funding, schools must be able to contribute to early intervention provision from within their own budgets. With this in mind, the new national funding formula for schools should ensure that schools with high levels of mental health needs receive additional funding, and government should refrain from cutting the budgets of any schools.[31]

Commissioning and representation

Secondary schools should be at the heart of funding and commissioning decisions that concern the mental health of children and young people. The transformation of local CAMHS systems requires secondary schools to be involved in a more systematic and meaningful way – one that ensures their voices are heard when decisions are taken on how and where money is spent.

1. Transformation funding allocated to CCGs should be ringfenced to ensure that spend is allocated to children and young people's mental health provision. This is the best way to help correct the historic underfunding of these services relative to other parts of the health system.

   However, if the government chooses not to ringfence funding in this way, then the checks on CCGs' expenditure on children and young people's mental health services should be tightened. Local transformation plans should be subject to separate, rigorous processes of assurance from the forthcoming sustainability and transformation plans. This would protect funding that should be directed towards children and young people's mental health services from being subsumed into other CCG expenditure, thereby repeating the historic trend towards the underfunding of these services.[32]

2. All CCGs should be required by NHS England to convene and oversee a headteachers' mental health forum for the local area, which should sit at regular intervals each year. This would provide secondary school

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30   On the basis of data from Buchanan (2016), IPPR estimates that an average of £206 million will be available for non-CCG transformation spend for each year from 2017/18 to 2019/20. This estimate is based on the average of the total annual funding amount allocated for non-CCG spend for 2015/16 and 2016/17, applied to the remainder of the unspent portion of the £1.25 billion allocated for the years 2017/18–2019/20.

31   In the absence of adequate school-level data on levels of mental health problems among pupils, the national funding formula should take known risk-factors, such as area-level socioeconomic disadvantage, as a proxy for levels of mental ill-health in individual schools. NHS England (2016) analysis shows a correlation between levels of child poverty and the prevalence of children with mental health problems among English regions.

32   Local health and care systems are required to submit a sustainability and transformation plan covering the period October 2016 to March 2021, which must show how local services will work together to improve the quality of care across services, the local population's health and wellbeing, and NHS finances. Local transformation plans (for children and young people's mental health) will therefore be considered within this wider context for years to 2019/20.

headteachers a formal opportunity to influence funding decisions taken by CCGs, learn about opportunities for joint-commissioning with health providers, and discuss and learn from each another's experience of which commissioned services are most effective.

3. CCGs should be required by NHS England to identify 'beacon schools' in each CCG-area, which provide high-quality provision across all three categories in response to local need. These schools should receive an amount of annual funding for the academic years 2017/18–2019/20 from within the national transformation funding allocation, and be used as a means of spreading best practice and providing leadership across secondary schools within the local area.

    These beacon schools should be required to publish a 'whole-school strategy for mental health', and be able to demonstrate having taken active steps towards sharing this best practice locally in order to receive funding for years two and three. The DfE should publish all such strategies centrally.

Quality

The quality, and quality assurance, of the mental health specialists available to schools needs to be improved. Schools must have confidence that the support they choose to commission or purchase from within their limited budgets has the training and experience necessary to meet pupils' needs. While the DfE's departmental advice on school counselling will likely help to stimulate *demand* from schools, it will not address underlying concerns with the *supply* of highly-trained counsellors who have relevant experience of working with children and young people in a school setting.

The government should therefore set out a roadmap towards making counselling a regulated profession, with a clear 'specialist' route for working with children and young people in school settings. In the short-term, this should involve the following measures.

1. A national recruitment drive for school counsellors, to ensure that the spread of counselling provision to all schools is not held back by the number of available counsellors.

2. An assessment of available training courses, with a view to raising entry requirements in line with other professional qualifications regulated by the Health and Care Professions Council.

3. The introduction of a new 'school-ready' kite mark that demonstrates counsellors' specific knowledge on, and experience of, working with children, young people and families in a school setting. The DfE should facilitate the development of this new kite mark, building on initiatives such as the evidence-based curriculum for children and young people's counselling being developed by the BACP. Prior to counselling becoming a regulated profession, counsellors should be enabled to work towards this additional kite mark as part of the accreditation process.

Accountability

If steps are taken to ensure that schools have access to funding, are able to affect commissioning decisions, and can access high-quality mental health specialists, then schools should also be held to account for the quality and appropriateness of their mental health provision. There is no 'ideal' mix of professionals that holds true within all school settings, and schools should continue to have autonomy over their particular approaches. However, schools should be required to demonstrate that their approach is well considered, sufficiently resourced, and includes the provision of targeted early intervention support alongside prevention and promotion services.

1. Ofsted should continue to assess the educational offer provided to pupils with identified mental health needs in line with the changes made to its framework for the 2015/16 academic year.

2. In order to ensure that inspectors actually assess schools' mental health provision in line with these changes, the DfE should work with Ofsted to ensure that, during inspections, the quality of schools' mental health provision is interpreted according to the presence or quality of the following features.

    –   Processes for monitoring pupils' mental health and wellbeing, and for identifying pupils who are at risk of emerging problems.
    –   An effective internal system of triage, conducted by professionals who have the appropriate level of mental health expertise.
    –   Arrangements for the clinical supervision of mental health specialists.
    –   The strength of referral pathways to external providers (including specialist CAMHS).
    –   An appropriate mix of expertise and professionals operating within the school.
    –   Evidence of the effectiveness of school-based interventions.
    –   The strength of schools' links to CCGs.

3. We support the recommendation in the *Five Year Forward View for Mental Health* (Mental Health Taskforce 2016) that Ofsted should work with the Care Quality Commission (CQC) to undertake 'joint targeted area inspections' for children and young people's mental health. Ofsted's assessment of individual schools according to the above features should feed in to area-level inspections conducted in partnership with the CQC.

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