BERA

PRESIDENTIAL ROUNDTABLE REPORT

The role of schools in the mental health of children & young people

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For more about the series see https://www.bera.ac.uk/project/presidents-roundtable-seminar-series

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ABOUT THIS REPORT

This report arose from the BERA event, President Roundtable Seminar Series: Wellbeing – Schools and Pupil Mental Health: Do We Fix the Child or Do We Fix the School?, held online on 4 December 2020. It was chaired by Jane Hurry, with speakers Chris Bonell, Catherine Carroll and Jess Deighton (each of whom also coauthored this report). They were joined by discussants Matthew Hopkinson and Ann Keane-Maher.

A video recording of the event is available to BERA members at https://www.bera.ac.uk/media/president-roundtable-seminar-series-wellbeing-schools-and-pupil-mental-health-do-we-fix-the-child-or-do-we-fix-the-school.

Further details of the event can be viewed publicly at https://www.bera.ac.uk/event/president-roundtable-seminar-series-wellbeing.

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Summary

Young people spend many of their waking hours in school and form lasting social networks there. Making that environment mental healthy therefore seems like a good plan. Schools also offer opportunities for the early detection of mental health difficulties, and early treatment. However, schools focus primarily on an academic curriculum. Furthermore, while mental health professionals are good sources of expertise, especially for students experiencing problems, they are not necessarily knowledgeable about changing school environments.

This report reviews the evidence on school-based approaches to mental health, examining:

1. what is meant by mental health and wellbeing, and why this is important
2. the respective roles of school and mental health professionals
3. whether approaches should address individual 'deficits' and/or school environments
4. how schools and policymakers can act.

We clarify that mental health has two dimensions – wellbeing, and mental illness – and that while these dimensions are associated they are only weakly correlated. Theories about causes, intervention and treatment also differ between these two dimensions. Universal interventions (those aimed at all children and young people within a school, referred to in some contexts as 'tier 1') typically target wellbeing, focusing on social and emotional learning (SEL), and are the approaches most frequently managed by teachers though they are typically developed by mental health experts. Targeted interventions address pupils identified as being at risk, often in groups (tier 2), and pupils experiencing problems, typically individually (tier 3). These group interventions make greater use of the expertise of mental health professionals, applying mental illness frameworks to specific clusters of symptoms, though delivery may involve teachers. The role of schools in the treatment of individuals experiencing mental illness is generally confined to identification and referral.

The research evidence finds that these interventions have small-to-moderate effects on both wellbeing and mental illness outcomes, more consistently for interventions addressing the individual child than the school environment. The size of these effects is unsurprising, underscoring the fact that while schools are never the whole solution they nonetheless should be a part of it. While there is little disagreement that such support for children should be provided, implementation is problematic. The evidence for the effectiveness of whole-school approaches (WSAs) is more mixed and difficult to interpret than that for other interventions because they have frequently been poorly implemented. However, several key features of high quality implementation of WSAs can be identified:

- a sound theoretical base
- a focus on intended outcomes
- giving priority to interventions that are easiest to implement in the setting
- explicit guidelines, possibly manualised
- complete and accurate implementation.

WSAs can offer a mechanism to help schools and teachers adopt approaches and interventions, addressing the variety of mental health concerns they are likely to face, that are as well-linked as possible. It is clear from our review that there are a wide range of effective interventions on offer, both at the universal and targeted levels, which address social and emotional skills, bullying, aggression, depression, anxiety, substance misuse and more, and apply a range of different frameworks. They can also provide a vehicle for students to inform school policies and practices in this area, which is particularly important in the secondary phase.

We find that it is important to consider not only mental health outcomes but also academic ones, in two respects in particular. Firstly, there is some evidence that universal mental health programmes can not only improve mental health outcomes but also academic performance. Schools may be encouraged by this to expend some of their scarce resource – in terms of management, teacher time for training and timetabled teaching time – on such interventions. It has been proposed that addressing mental health both explicitly and through the hidden curriculum (that is, the unwritten, unofficial and

often unintended lessons, values, and perspectives that students learn in school) can improve students' school-connectedness and academic engagement and performance, particularly among students of lower socioeconomic status. However, it is likely that greater attention to students' mental health will require an acknowledgment of the resource implications, which is primarily a policy issue. Secondly, the educational outcomes of pupils with mental health difficulties are compromised and require particular attention. While we found a range of empirically tested methods of supporting these students' learning – covering, for example, provision of choice, corrective feedback, management of instructional time and assessment-led instructional programmes – the evidence base in this area is weak. This does not mean that we should ignore the research, but rather that we should use it alongside sound theoretical and professional understandings, and to monitor the effectiveness of interventions.

Finally, research indicates an association between teacher wellbeing and student wellbeing. Teachers can find themselves at the frontline of hearing about and responding to the mental health difficulties of pupils. This emotional labour can in turn cause anxiety, stress and ineffective responses to pupil needs, which highlights the need to support teachers as well as pupils. Although a range of interventions to support teacher wellbeing have been implemented in schools, evidence of their effectiveness is sparse and mainly reliant on self-report. Nonetheless these studies reported very positive findings from participants and 'tested' different models of supervision, with benefits such as providing a framework for discussing challenging situations, time to consider and discuss the problems faced by practitioners, and opportunities to foster a greater sense of camaraderie between colleagues.

As a result of our review of research evidence, and our understanding of the contexts of practice and education policy, we offer the following proposals.

1. Schools would benefit from having a policy for tier 1 and 2 approaches to mental health. The evidence is beginning to suggest that this should include evidence-informed approaches for SEL and WSAs to support the development of consistent sustainable structures with a good fit to the school.
2. Schools should monitor the efficacy of interventions.
3. Education and health professionals should work in partnership, constantly exchanging expertise in order to effect useful change.
4. Teachers should receive support to address the mental health of their students. This support should include opportunities for developing knowledge and skills, but also acknowledgement of the emotional labour involved and clear structures for any proposed school-wide changes.

1. Introduction

This report, drafted for a BERA presidential roundtable event on wellbeing, schools and pupil mental health (Hurry, 2020), identifies a key topic for schools and explores the major positions based on the best research evidence. It has been enriched by the roundtable itself, where researchers, teachers, policymakers and mental health professionals expanded the debate. While the implications of the Covid-19 pandemic and the resultant closure of schools across the UK could not be covered in this report due to insufficient evidence at the time of writing (in early 2021), it was expected that mental health in schools would be an area of increased focus due to reportedly heightened levels of student mental health problems (Newlove-Delgado et al. 2021; Sama et al., 2020; Waite et al., 2020).

There is an understandable eagerness to engage schools in supporting the mental health of their students. 'Children spend more time in school than in any other formal institutional structure' (Rutter et al., 1979, in Fazel et al., 2014). From a social/environmental perspective, it is to be expected that elements such as school ethos and relationships with teachers and peers will influence child and adolescent mental health development. Indeed, factors such as experiencing bullying in school have been shown to heighten the risk of mental illness (Arango et al., 2018; Bonell et al., 2019; Clarke & Lovewell, 2021). Student mental health has consistently been found to be quite strongly associated with school connectedness, which measures individual student perspectives on the quality of their relationships with staff and pupils, school inclusion and the value of their school in their lives (Kidger et al., 2012; Shochet et al., 2006). There is also evidence of an association between mental health and school climate (a measure of school-level features such as physical and psychosocial environment and the quality of teaching and learning), but to a lesser extent than for school connectedness in terms of both size of effect (3-4 per cent of variance, for example, in Govorova et al., 2020) and amount of evidence (Aldridge & McChesney, 2018; Govorova et al., 2020; Modin & Östberg, 2009; Kidger et al., 2012; Patalay, et al., 2020; Wang et al., 2020).

From a medical perspective, schools may offer an opportunity for the early detection of individual young people with mental health difficulties, and potentially early treatment (Humphrey & Wigelsworth, 2016). There is evidence that intervention in school can improve wellbeing (Bonell et al., 2019; Durlak et al., 2011; Goldberg et al., 2019) and reduce mental health difficulties (Caldwell et al., 2019). However, the fact that schools are primarily educational institutions creates a fundamental challenge to providing this support. Schools' focus on academic attainment is reinforced by expectations from parents and monitoring from government. Addressing mental health is more variable in terms of schools' responses: curriculum time dedicated to it is more limited, and school staff are largely untrained in mental health. That being the case, one approach is to invite mental health professionals into schools – an approach supported in England by the green paper *Transforming Children and Young People's Mental Health Provision* (DHSC & DfE, 2017), which was prepared as a response to calls for more concerted action to address mental health in schools in the face of apparently growing need. This green paper, the result of a collaboration between the Department of Health and Social Care and the Department of Education, set out a range of plans and actions that shape current school provision. It proposed that mental health support teams be set up to provide mental health expertise for schools. While such interventions can be effective for individuals with mental health difficulties, external mental health professionals are not well-placed to change school environments – a role that, in the green paper, is assigned to school staff with the role of 'designated mental health lead'.

1.1 THE PURPOSE OF THIS REPORT

Most research and intervention design concerning schools and mental health has been conducted by mental health specialists. Our intention is to review, from a more educational perspective, the current state of the evidence on how, working together, school and mental health professionals can practically, reliably and consistently support students in their contexts. This will include an examination of support and

provision for teachers as well as their students. We aim to provide an accessible overview that speaks to practitioners and policymakers, and challenges researchers. Consistent with our focus on the role of schools, the implications of social and medical models of intervention will be explored, examining the extent to which a given approach addresses the individual 'deficits' of children and young people, and the extent to which the adults responsible for the institutional space address wider environmental factors. Specifically, we will

- define what is meant by mental health and wellbeing, and why this is important
- clarify the personnel, structures and services at tiers 1, 2 and 3 of provision
- examine the research evidence on effective provision of support for mental health and wellbeing in schools
- make recommendations for policy and practice.

2. What do we mean by mental health, why does it matter & what do interventions seek to change?

2.1 WELLBEING & MENTAL HEALTH

The terms 'wellbeing', 'mental health' and 'mental illness' require some clarification. Mental health is described as an overarching category by the World Health Organisation (WHO, 2004), one that comprises wellbeing and mental illness. The Office for National Statistics in England, on the other hand, deals with mental illness as a component of wellbeing (ONS, 2019). The term 'mental health' is frequently used to refer to mental illness, as it is in the *Transforming Children and Young People's Mental Health Provision* green paper (DHSC & DfE, 2017).

In this report we adopt the WHO definition, whereby mental health covers both wellbeing and mental illness. Wellbeing is the positive aspect of mental health, 'a state... in which an individual realises his or her own abilities, can cope with the normal stresses of everyday life, can work productively and is able to make a contribution to his or her community' (WHO, 2004). Mental illness comprises 'a broad range of problems with different symptoms... generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others' (WHO, 2004). While wellbeing and mental illness are associated, that association is not a straightforward one: Patalay & Fitzsimmons (2018) report a fairly small correlation ($r = 0.2$) between the two. Approaches to intervention and/or treatment for wellbeing and mental health refer to substantially different theoretical frameworks and outcomes. While there are overlaps, particularly around emotional awareness and regulation, wellbeing frameworks generally relate to social and emotional development whereas mental illness frameworks refer to specific symptom clusters, typically including medication and/or specific psychosocial therapies.

Managing emotional regulation and social behaviour is an element of a teacher's role, albeit a somewhat hidden one. However, the standard teacher is neither trained in nor tasked with managing mental illness: that is the domain of mental health professionals. Thus, the management of wellbeing and mental illness in schools needs to draw on different theoretical frameworks, and on the different professional domains of education and health.

2.2 SCHOOL PERFORMANCE

There are good reasons to include school performance – by which is typically meant academic attainment and engagement – in both the underpinnings and measured outcomes of interventions addressing either wellbeing or mental illness in schools.

1. Students with psychological disorders are at risk of underachievement over a range of school subjects (Campbell et al., 2018; Hurry et al., 2018).
2. Secondary students are at risk of absenteeism, exclusion, leaving school early and without qualifications (on depression and school drop-out, see Dupéré et al., 2018; on absenteeism, Lereya et al., 2019; on self-harm and low qualifications, Storey et al., 2005). Diagnoses of attention deficit and hyperactivity disorder and conduct disorder are associated with school exclusion and lack of qualifications (Loe & Feldman, 2007; Paget et al., 2018). The fact that adolescence is a critical moment in education and subsequent career opportunities

(Backes & Bonnie, 2019) means that damage limitation around schooling for students with problems with mental health is important.

3. One aspect of wellbeing is being able to work effectively, which in the school context includes academic attainment and engagement (Caprara et al., 2000).
4. The prospect of improving school performance is salient to teachers. School performance is firmly in the domain of education professionals, but teachers often lack confidence in their ability to implement strategies for managing pupils with specific mental health issues (DfE, 2016). There is a danger that addressing mental health and academic performance is seen as a zero-sum game: that is, if schools expend effort on mental health then they do so at the cost of attention to academic attainment. Yet there is evidence that interventions to improve mental health and social/emotional skills can also increase educational attainment (Bonell et al. 2014). It would be naive to suppose that attention to mental health does not have resource implications for schools – it most certainly does, in the form of teacher and management time on training, maintaining systems and delivering the curriculum. However, that resource has been shown to have a positive impact not only on students' mental health but on their learning.

2.3 BENEFITS FOR TEACHERS' WELLBEING & MENTAL HEALTH

Research is emerging that indicates at least an association, if not a causal link, between teacher and student wellbeing (Klusman et al., 2016; Harding et al., 2019). A national survey found that of children and young people with a diagnosed mental health difficulty, approximately half (48.5 per cent) reported that they would seek help from a teacher – the most cited source of support – versus only 25.2 per cent who would contact a mental health service (NHS Digital, 2018). Teachers can therefore find themselves at the front line of hearing about and responding to the mental health difficulties of pupils. As this emotional labour can in turn cause anxiety, stress and burnout among teachers (Alisic, 2012), teacher wellbeing also stands to benefit from improvements to student wellbeing and mental health support.

3. Changing the child

The individual level

It is common and useful to adopt a three-tiered approach to intervention, in which tier 1 provision is designed for use with all pupils, and tiers 2 and 3 focus on, respectively, at-risk children (typically through small group provision) and children experiencing problems (typically through individual provision). Given that there is good evidence that both wellbeing and mental illness are strongly associated with individual factors ranging from genetic vulnerabilities through temperament, personality and personal experiences, and that all relevant theories address individual characteristics, it is unsurprising that the interventions at every tier involve supporting the child to change. In this section, and in the following one on changing the school (section 4), typical provision is described. The evidence for these approaches is then examined.

TIER 1 INTERVENTIONS

Universal provision addresses both wellbeing – broadly described as social and emotional learning (SEL) (Durlak et al., 2011) – and mental illness. Of the three tiers, tier 1 interventions, particularly those focusing on wellbeing, are the most likely to be managed by teachers. They are also the most commonly reported form of intervention in schools (Vostanis et al., 2013). Individual, within-child explanations of pupils' social and emotional competencies and behaviours are typically addressed, underpinned by theories of emotional regulation and/or learning theories of behaviourism or social cognition. Interventions are varied: some include a broad coverage of social skills and emotional regulation, some are more focused on bullying, substance misuse, school connectedness, externalising behaviour problems and/or anxiety. In the UK, the curriculum elements of SEAL (social and emotional aspects of learning; Humphrey et al., 2013) and INCLUSIVE (initiating change locally in bullying and aggression through the school environment; Bonell et al., 2019) are examples of universal SEL approaches. Mindfulness techniques, also taught in schools (Zenner et al., 2014), relate broadly to self-awareness and self-management, but with a particular focus on the present with an accepting, non-judgemental attitude. Behaviourist theories underpin a further group of interventions that emphasise rewards and sanctions, which are a common feature of classroom practice (Kendall et al., 2015).

Cognitive behavioural therapy (CBT) is by far the most widely evaluated intervention for mental illness, addressing disorders such as depression and anxiety in both universal and targeted interventions (Caldwell et al., 2019). CBT has much in common with theories underpinning SEL that propose that the way we interpret and process situations shapes our behaviour and emotions, such as the process model of emotion generation (Gross & Thompson, 2007) and social information processing (Crick & Dodge, 1994). CBT applies these theories as mediators in the relationship between life stress and psychopathology, targeting rigid and negative beliefs about oneself and one's environment (Kendall et al., 2015).

Universal interventions to improve academic performance and engagement are essentially good classroom practice, at the heart of the job of the teacher. Despite their importance it is not possible to cover them in this report. However, it is worth noting that engaging and relevant teaching is linked with combating school disaffection, and that many of the approaches that help students with mental health difficulties are the same as those that help all students (Harrison et al., 2013).

TIER 2 INTERVENTIONS

While the role of social/environmental factors in mental health are generally acknowledged, supporting the child is the primary focus of tier 2 interventions, which are sometimes managed by teachers and sometimes by external specialists with mental health or psychology backgrounds. As for tier 1, CBT is the most commonly evaluated intervention for depression and anxiety (Caldwell et al., 2019; Gee et al., 2020; Moltrecht et al., 2020). The most commonly evaluated interventions for behaviour disorders are behaviour therapy programmes such as 'check in check out'

(Bruhn et al., 2014; Carroll & Hurry, 2018). They therefore share theoretical underpinnings with tier 1 interventions. While teachers may be familiar to an extent with behaviourist approaches, CBT requires input from health/psychology professionals. In the UK, nurture groups, based on attachment theory, have also been commonly evaluated (Cheney et al., 2014).

In terms of school performance, some instructional interventions have been found to be effective at improving the academic attainment and engagement of students with emotional or behavioural problems, adopting a wide range of pedagogical techniques and strategies, often subject specific. These include the use of corrective feedback, previewing and prompting (Vannest et al., 2011), choice-making, fast-paced instruction and shortened task length (Harrison et al., 2013), peer-mediated, teacher-directed and self-regulation strategies (Campbell et al., 2018). However, specific pedagogical interventions may not be prioritised in schools for pupils with special educational needs (Webster & Blatchford, 2013, 2018), and external mental health professionals are principally concerned with behaviour/mental illness. Also, as for mental health outcomes, interventions can vary depending on diagnosis or specific need.

TIER 3 INTERVENTIONS

This is the domain of mental health specialists. A lack of available options to make referrals to mental health specialists has been identified as a problem by schools in England (Sharpe et al., 2016); this finding influenced government action, resulting in the introduction mental health support teams (DHSC & DfE, 2017).

4. Changing the school

The environmental level

At the social/environmental level the aim of mental health interventions is to create psychologically healthy and supportive school spaces, and this requires a whole-school approach (WSA). Goldberg et al. (2019) outline three components of WSAs:

1. curriculum, teaching and learning
2. school ethos and environment
3. family and community partnerships.

Effective WSAs require schools' staff to see themselves as a factor in pupils' mental health. Teachers are typically very conscious of family influences on their pupils, but they may avoid examining the role of the school as another significant environmental context that they can potentially manage (Moore et al., 2019). Given the breadth of mental health issues, what constitutes a psychological healthy space is not cut and dried, and, as is true of interventions addressing the child (see section 3 above), WSAs are heterogeneous. Theories informing WSAs include ecological theory, which outlines the various environmental influences, (Bronfenbrenner & Morris, 2006) and social learning theories which identify a range of social factors relevant to mental health (Bandura, 2001), but more specific theories relate to target areas. A potentially powerful theory for health-promoting schools, which covers school organisation, relationships within the school and pedagogy, is proposed by Markham and Aveyard (2003). This theory is far-reaching, encompassing relationships between the school and the community, between teachers and pupils and between pupils and pupils, and promoting strong cross-curricular connections. While it requires empirical testing, it is a reminder that school ethos is complex and deep-rooted. Anti-bullying programmes are probably the most widely researched WSAs, and provide strong evidence of the potential of WSAs to have a positive impact on students' mental health by promoting healthy school spaces (Langford et al. 2015; Smith et al., 2004; Ttofi & Farrington, 2011; Vreeman & Carroll, 2007).

Ideally, in addition to shaping school climate, WSAs will also perform the following functions.

- Promote consistency between curriculum messages and school experiences outside the classroom in interactions between pupils and pupils, and between pupils and school staff.
- Provide a structure for the selection of interventions with the best fit to the school.
- Create an environment for sustainable intervention, which involves developing staff and student commitment, monitoring and ongoing training.
- Support teachers to communicate, to learn and to change (Goldberg et al., 2019; Culshaw & Maitland, 2021).

A recent successful WSA in secondary schools that illustrates these affordances is INCLUSIVE (initiating change locally in bullying and aggression through the school environment), which modified school environments to reduce bullying and aggression (Bonell et al., 2019). The intervention was underpinned by a theoretical framework informed by Markham and Aveyard's (2003) theory, which was in turn influenced by Basil Bernstein's (1975) work on eroding school boundaries and reframing school practices in order to build the commitment of students, particularly those of lower socioeconomic status. The inclusion of students in school action groups was, therefore, an important feature of the INCLUSIVE intervention.

A potential strength of implementing a WSA is that it can include a review of student needs in order to identify the activities that are most appropriate to implement in each school. It can also provide opportunities for students to have a say on school policies on mental health identification and provision, discipline and behaviour. However, this requires substantial planning and support, with an infrastructure to support system-wide implementation – something that is often found to be missing (Goldberg et al., 2019; Spoth et al., 2013). When a school is not completely committed to a WSA, and in particular when the topic in question is not considered a key priority by staff, implementing it can be challenging. Common implementation features of WSAs reviewed by Goldberg et al. (2019) included:

- guidance on implementing intervention principles
- a school committee tasked with managing implementation
- whole-staff meetings on the approach
- monitoring progress
- professional development.

Lyon et al. (2019) have investigated the dimensions of importance and feasibility in effecting school change in the area of mental health. Strategies identified by 200 US change-makers as the most important and feasible were:

- ongoing, dynamic training
- ongoing consultation/coaching
- monitoring implementation progress.

Thus education and mental health professionals both have complementary roles in school change: educators understand the school context and must implement school action, but they lack expertise in the mental health domain and need training, consultation and advice from mental health experts on what to monitor.

Threats to the sustainability of WSAs for wellbeing and mental health include:

- time and resource constraints
- insufficient funding/resources
- staff turnover and a lack of ongoing training.

Sustainability depends upon the development and retention of knowledgeable, skilled and motivated senior leaders, and adaptation of the intervention to existing routines, staff strengths and specific, changing contexts (Herlitz et al., 2020).

We found that there is insufficient research on the role of student voice, which is therefore underrepresented in this report.

4.1 TEACHER DEVELOPMENT & WELLBEING

Sustainably changing the school environment for pupils requires support for teachers – not only training and expert consultancy, but also acknowledgment that working with students who are depressed, anxious or behave in challenging ways is difficult and may elicit responses that are harmful to both teachers and their students. A recent review from the Department for Education (2019) identified six core themes in relation to supporting teacher wellbeing. Three of them are the engagement of senior leadership; whole-school approaches; and provision of support through mentoring, coaching and supervision (see also Gu & Day, 2013). It is becoming increasingly common for wellbeing approaches with an emphasis on peer support (coaching and mentoring) and supervision to be implemented in schools (Barnardo's Scotland, 2019). Integral to these approaches is the opportunity to develop more trusting relationships, practitioners feeling valued, and support for the emotional labour of educating students, particularly those who experience mental health difficulties (Rae et al., 2017).

5. Evaluating the evidence of these approaches' effectiveness

5.1 OVERALL FINDINGS

The evidence across a number of well-conducted studies and meta-analyses typically reports small-to-moderate effects for school programmes and interventions, both universal and targeted, on outcome measures relating to wellbeing and mental illness. Table 5.1 summarises the effect sizes from those of these studies that provide a standardised measure of the impact of intervention. Effect sizes of 0.2 are considered small, 0.5 medium and 0.8 large (Cohen, 1988). These effects tend to be short-term – there is a tendency for effects to disappear over a year or two – and there is a shortage of long-term studies. The majority of studies cover the primary/elementary stage rather than secondary, and they tend to have been conducted in the US.

5.2 WIDE RANGE OF EFFECTIVENESS

Most reviewers remark on the wide variation in effectiveness both between different interventions and between the same intervention in different circumstances (see for example Fazel et al., 2014; Moltrecht et al., 2020; Moore et al., 2019; Weare & Nind, 2011). One example of the latter is the Good Behaviour Game, positively evaluated in the US and beyond (Nolan et al., 2014) but failing to significantly improve behaviour in UK schools (Humphrey et al., 2018). Similarly, anti-bullying programmes that have been widely and positively evaluated nevertheless vary in effectiveness internationally, with the transferability from the original culture to other contexts being promoted as an explanation (Gaffney et al., 2019). Fidelity of implementation is another potential issue, discussed below.

5.3 DIFFICULTIES WITH EVIDENCE AT TIER 2

Researching tier 2 interventions is more challenging than researching universal tier 1 programmes because of sample size, heterogeneity of student groups, and ethical issues. The quality of randomised controlled trials (RCTs) in this area is reported to be low (Gee et al., 2020) and the evidence base relies heavily on single case studies (Banerjee et al., 2014; Cheney et al., 2014).

5.4 CHILD (INDIVIDUAL) VERSUS SCHOOL (WSA) FOCUS

Overall, although the rationale for WSAs over a focus on individual children's risk factors is theoretically persuasive, the evidence fails to provide strong support for it, at least in the area of SEL. Kidger et al. (2012), in their systematic review of the effect of school environment on the emotional health of adolescents, found no strong evidence of the effectiveness of WSAs in four of the five intervention studies reviewed. One such study found some evidence of a positive effect but was judged to be methodologically flawed, with a nonrandomised design, no baseline measurement and no control for clustering at school level. In line with Kidger et al. (2012), Langford et al. (2015) found WSA ineffective for a range of mental health outcomes, though reports of being bullied were reduced significantly. Against their expectations, Durlak et al. (2011) reported that WSA SEL programmes were effective, but not as effective as classroom-only programmes. Weare & Nind (2011) reported mixed evidence, citing five reviews concluding that WSAs were effective and two (including Durlak et al., 2011) that they were not. In a more recent review, Goldberg et al. (2019) found that WSAs are effective at enhancing social and emotional adjustment, behaviour and internalising symptoms, but not academic performance (see table 5.1).

Table 5.1

Effect sizes across recent well-conducted studies and meta-analyses that include a standardised measure of interventions' impacts

Study & methodology (& study location)	Primary/ secondary	Universal/ targeted	Outcome	Effect size Cohen's d or Hedges g	Intervention
Bonell et al., (2019) RCT (UK)	secondary	universal	36 months after inception: *primary outcomes*: bullying aggression *secondary outcomes* quality of life wellbeing mental health (strengths & difficulties questionnaire [SDQ])	 -0.08 not significant 0.14 0.07 -0.14	INCLUSIVE, WSA to bullying & aggression.
Caldwell et al. (2019) meta-analysis	secondary secondary primary both both	universal universal universal targeted both	anxiety anxiety anxiety anxiety depression	*-0.65 **-0.15 **-0.07 not significant not significant	*mindfulness **CBT **CBT all types all types
Durlak et al., (2011) meta-analysis	both	universal	SEL skills attitudes positive social behaviour conduct problem emotional distress academic performance	0.57 0.23 0.24 -0.22 -0.24 0.27	meta-analysis of a wide range of SEL programmes addressing e.g. substance use, bullying & emotion regulation
Ford et al., (2019) RCT (UK)	primary	universal	SDQ immediately post-intervention SDQ 9 months post-intervention SDQ 21 months post-intervention	Significant (p=0.03) Not significant (p=0.85) Not significant (p=0.23)	incredible years teacher classroom management
Gee et al., (2020) Meta-analysis	ages 10–19	targeted	depression anxiety	-0.34 -0.49	RCTs for young people with elevated symptoms of depression or anxiety
Goldberg et al. (2019) meta-analysis	both	universal WSA	social & emotional adjust behavioural adjustment internalising symptoms academic achievement	0.22 0.13 -0.11 not significant	WSAs to social & emotional development
Moltrecht et al. (2020) meta-analysis	ages 6–24	targeted	emotional regulation decrease dysregulation	0.36 -0.46	interventions addressing emotional regulation
Wang et al., (2020) meta-analysis	both	universal	social competence motivation & engagement academic achievement externalising behaviour social/emotional distress	0.18 0.25 0.12 -0.18 -0.14	interventions addressing classroom climate
Weare & Nind (2011) systematic review	both	most universal (N= 46 of 52), some both (N = 14).	internalising wellbeing/SEL externalising (violence, bullying, anger)	small to modest small to moderate small (effects tended to be stronger for at-risk children)	

Anti-bullying programmes, which frequently apply WSAs, have been consistently found to reduce bullying (Ttofi & Farrington, 2011). Relevant to this, the evaluation of the INCLUSIVE trial (Bonell et al., 2019), which had bullying as a key target, reports that the whole-school element was the most successful, and the curriculum element less so. The issue of implementation was raised in a number of these reviews, and draws attention to the tension between programmes that are flexible, enabling fit with context, and the danger of being so loosely implemented that they fail the fidelity test. A good UK example of this is the SEAL programme (Goldberg et al., 2019; Lendrum et al., 2013; Humphrey et al., 2013).

5.5 EDUCATION & HEALTH PROFESSIONALS: AGENTS OF TRANSMISSION

Teachers are often involved in delivering universal interventions that have been found to be effective (Durlak et al., 2011), though these interventions may involve initial training by external professionals. WSAs are, by definition, principally delivered by teachers. Tier 2 interventions, on the other hand, have been found to be more effectively managed by external professionals (Gee et al., 2020). The INCLUSIVE trial provides an insight into how schools and teachers can make a difference: Bonell et al. (2019) suggest that by carrying out their core business with attention to student belonging and commitment, and by using restorative practices, schools can reduce bullying and improve mental health without any specific classroom curriculum intervention.

5.6 SCHOOL PERFORMANCE

Evidence of the effect of mental health interventions on school performance is mixed. In their reviews, Durlak et al. (2011) and Farahmand et al. (2011) report tier 1 SEL programmes having small positive effects; in their review of WSAs, Goldberg et al. (2018) fail to find any impact on academic activities, and similarly Hennessey and Humphrey (2019), in a UK RCT of the PATHS (promoting alternative thinking strategies) curriculum, also report no impact on academic attainment.

In the above section on what we should be seeking to change (section 2) we argue that schools' response to students at risk of or experiencing mental health problems should include action on educational outcomes. However, the evidence base at tiers 2 and 3 is, again, weak. A 2011 meta-analysis of research on instructional interventions for primary and secondary pupils with emotional or behavioural disorders categorised 16 types of academic approaches based on 34 papers (Vannest et al., 2011). While most of these approaches – such as 'cover, copy, compare', corrective feedback, increase/modification of instructional time, mnemonics, and assessment to inform use of specific instructional techniques (functional assessment) – improved pupils' academic outcomes, they relied on single case studies and were rarely replicated. A more recent systematic review of educational accommodations dug deeper (Harrison et al., 2013). Eighteen articles met robust inclusion criteria that evaluated 12 types of specific modification for students with emotional or behavioural challenges. Consistent with the Vannest et al. study (2011), these included increasing choice-making, functional assessment, fast-paced instruction and shortened task length. However, also consistent with Vannest et al. (2011), the authors concluded that the evidence base was not of high quality. Of the 12 techniques reviewed, only four were evaluated in more than one study, and only five of the 12 included studies with more than 10 participants. Harrison and colleagues also remarked that many of the approaches evaluated were ones that might help all pupils as part of universal design for learning (see CAST, n.d.), and that it was not possible to say with confidence that they specifically helped those with mental health issues.

Thus, overall there is some evidence of wellbeing programmes improving academic attainment at tier 1, but this is not consistent. Furthermore, while there are indications of the potential effectiveness of academic interventions for students with emotional or behavioural difficulties at tiers 2 and 3, this evidence is weak.

5.6 TEACHER WELLBEING

Although a range of interventions have been implemented in schools to support teacher wellbeing, the sparse nature of the available evidence indicates that these practices may not yet be widespread across the sector. A review of the effectiveness of organisational interventions for improving teacher wellbeing (Naghieh et al., 2015) found three cluster-RCTs and one stepped-wedge design, but limited evidence for this approach otherwise. Most of the research is based on self-report – such as, for example, the findings from small-scale studies of supervision in schools for special educational needs co-ordinators (SENCOs) and other professionals

supporting vulnerable children. These studies (Reid & Soan, 2018; Willis & Baines, 2018) reported very positive findings from participants, and 'tested' different models of supervision, citing benefits such as:

- providing a framework for discussing challenging situations in everyday, real-world scenarios
- time to consider and discuss the multitudes of possible avenues available for many complex problems faced by practitioners
- opportunities to foster a greater sense of camaraderie between colleagues.

6. Discussion

In this report we set out to explore the roles of teachers and mental health professionals in addressing the wellbeing and mental health of students, and argued that based on what is known about child and adolescent development, attention to both the school environment, including teacher wellbeing and individual risk factors, should prove useful.

A consideration of the empirical evidence shows that the reported quantitative effects on both wellbeing and mental illness outcomes tend to be small-to-moderate, while evidence is more consistent for interventions that address the individual child than for those that address the school environment. The relatively small size of effects is unsurprising, and underscores the fact that schools are never the only solution but should be a part of it nonetheless. There is little disagreement that there should be support for the child, but implementation is problematic. WSAs offer solutions relevant to implementation but the quantitative evidence of their effectiveness is inconsistent and, on the whole, less persuasive than that for individual focused interventions. The fact that WSAs are more frequently poorly or loosely implemented than individual focussed programmes makes research findings on the former difficult to interpret. By contrast, theoretical propositions, qualitative reports and implementation science provide persuasive reasons to promote WSAs. In fact, even evidence of the effectiveness of specific approaches, either with an individual or WSA focus 'cannot be relied upon' (Weare & Nind, 2011, p. 31) because they vary from one study to another and from one child to another (which is particularly relevant at tiers 2 and 3). What is good for one child may be ineffective or even harmful to another. This suggests the importance of contextual factors, and that schools need to monitor the interventions they use – particularly since contexts can change, as during Covid for example. We therefore argue for an evidence informed approach – that is, one in which empirical evidence, or lack of it, is assessed critically, with reference to theoretical and empirically supported basic principles, and subjected to reassessment within novel contexts.

Implementation emerges as a major issue both from the evidence on mental health approaches across the board and from implementation science. For example, addressing contextual factors and monitoring interventions requires structures that go beyond simply applying a research-based approach. Ideally WSAs provide a framework for school-level decision-making, organisation, and staff and student buy-in that enable an exchange of knowledge between students, school staff and external professionals who are once-removed from the school's priorities and environment. There are many interventions for schools to choose from, and they differ in non-trivial ways. One method that has been applied to help schools select a focus is to conduct a school audit, including a survey of student need, to prioritise relevant areas; this would typically be part of a WSA. Another method would be to identify some key features of successful approaches and their underlying theoretical frameworks. It is important to remember that approaches may be based on different theories. Given the plethora of choices of intervention, providing practitioners with a theoretical map – one that includes the importance of teacher and student relationships – is critical to enable them to make choices and to, where appropriate, synthesise approaches. We need to help schools and teachers to adopt approaches and interventions that are as well-linked as possible across the range of mental health concerns they are likely to face.

The key features of high quality implementation are:

- a sound theoretical base
- direct focus on intended outcomes
- giving priority to those interventions that are easiest to implement in the setting
- explicit, possibly manualised guidelines
- complete and accurate implementation (Lyon et al., 2019; Herlitz et al., 2020; Weare & Nind, 2011).

Thus, we propose that WSAs are necessary to good, sustainable implementation, but that the degree of flexibility around their implementation needs to be constrained. Expectations should be tailored to school capacity: not all schools start from the same place, and what would be an easy target for one school could be a significant change for another.

Education and mental health professionals make very different contributions, with the latter playing a more advisory role at tier 1 but being more directly involved in delivery at tiers 2 and 3. Greater attention has been paid to evidence relating to mental health than to school performance, which is hardly surprising. However, SEL and particularly mental illness is associated with school performance. In the case of SEL this supports the case for integrating SEL into the academic curriculum, rather than confining it to PHSE. There is a need for more of a focus on the education of at-risk children in order to keep them on track academically. SENCOs, a mandated role within English schools, provide an example of school-based expertise in this area, but a more robust evidence base to inform their practice is needed; this should extend to enabling classroom teachers to support the learning of these pupils.

In the absence of clear evidence, monitoring the effects of promising approaches takes on greater importance. Teachers and health teams should work together on the academic as well as the health dimensions of the child. As the policy is rolled out over the next four years, the recent introduction of mental health support teams in England (DHSC & DfE, 2017) will provide specially trained education mental health practitioners (EMHPs) to go into schools. Most schools and colleges now have a designated mental health lead (DMHL) in place, as is recommended in the same green paper (DHSC & DfE, 2017). This is a promising innovation which offers an opportunity for more systematic, evidence-informed practice provided by suitably trained staff, but its benefits will only be realised if there is a close dialogue between school staff and mental health professionals.

It is likely that a majority of UK schools do not use evidence-based interventions (Vostanis et al., 2013; Wigelsworth et al., 2019), which is a shame because trialling promising approaches is likely to be the most efficient way forward and could potentially inform the evidence base. At tier 1, EMHPs might take the role of consultant to teaching staff, assist with training and monitoring, and learn from the DMHL about the school context: what is seen as needed, what can and can't be easily implemented. At tier 2, EMHPs would be more involved in delivering interventions and assisting in the process of referrals to tier 3. In this way the two professions would work together on joint projects, sharing their different knowledge bases. This should not detract from the need to attend to teacher training and support – specifically both initial teacher training and continuing professional development in key principles of student wellbeing and mental illness, and its impact on teachers.

7. Conclusions

Although schools are not required to have a standalone policy on mental health, we recommend that they should have a policy for tier 1 and 2 approaches. Such policies would benefit from including evidence-informed approaches both to developing students' SEL and resilience to stress (child focused elements) and to WSAs (school-focused elements) to support the monitoring of impacts and the development of consistent sustainable structures with a good fit to the school (though we acknowledge that current empirical evidence on WSAs is mixed). In 2020, the Anna Freud Centre surveyed more than 6,000 teachers about the sorts of policies and practices their schools and colleges had in place. Most teachers said their school or college had policies in place that referenced mental health, but only 12 per cent of primary schools and 16 per cent of secondaries had a practical framework to support a WSA to mental health (Anna Freud Centre, n.d.). Unfortunately, there is not a clear, well-evidenced roadmap for WSAs, but in section 4 of this report we have outlined some key principles for desirable and workable features of one.

We promote the use of evidence-informed approaches, which are better than 'knitting without a pattern' (Oakley, et al., 1995). However, the implication of the fact that what works in one place may not work in another, and that what works with one child may not work with another, is that schools should plan to monitor and evaluate their chosen strategies right from the outset and adapt their plans, where indicated, on the basis of this monitoring.

Currently the research community is not well-aligned with the practical application of strategies to address student mental health in the school context. Important and useful work has been done on trialling different approaches and creating the necessary evidence base, but closer attention needs to be paid to the synthesis of key theories and to methods of selecting suitable approaches for specific contexts. In practical terms, the Education Endowment Fund (n.d.) have produced useful learning behaviour practice guides that aim to do this work, on improving behaviour in schools, improving social and emotional learning in primary schools and a 'programme to practice' review of social and emotional learning. The Early Intervention Foundation (n.d.) have also published a guidebook reviewing a range of information for practice. We need evidence of how these are being used and whether or not they are subject to the problems observed with the overly flexible implementation of SEAL (Wigelsworth et al., 2019). This report aims to improve schools' access to the current state of evidence on school approaches, and to encourage researchers to sharpen their focus on contextual fit, replicability and longer-term effects.

We propose that an overview of the student's experience across the curriculum – including physical activity, the arts, citizenship and curriculum subjects, rather a narrow view of SEL – is indicated theoretically (Markham & Aveyard, 2003) and, to a degree, empirically (the value exercise for mental health, for example). There is currently limited research on student perspectives on school approaches to mental health but, certainly in the secondary phase, the involvement of students is likely critical for the success of interventions such as the INCLUSIVE programme.

We propose that education and health professionals need to work in partnership, constantly exchanging expertise to effect useful change.

Finally, we propose that for progress to be achieved teachers need support and opportunities for development in knowledge and skills as well as their students, providing them with a clear structure for the process of change.

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