Presidential Roundtables

Wellbeing – Schools and pupil mental health: do we fix the child or do we fix the school?
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Position Paper

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BERA Roundtable on Wellbeing and Mental Health: Position paper

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There is an understandable eagerness to engage schools in supporting the wellbeing and mental health of their students. 'Children spend more time in school than in any other formal institutional structure' (Rutter, Maughan, Mortimore & Outsen, 1979 in Fazel, Hoagwood, Stephan & Ford, 2014). From a social/environmental perspective it is to therefore be expected that schools should influence child and adolescent development and indeed, factors such as experiencing bullying in school have been shown to heighten mental ill-health risk (Arango et al., 2018; Bonell et al., 2019)). Student wellbeing and mental health have consistently been found to be associated with school connectedness, which measures individual student perspectives (Kidger, Araya, Donovan, & Gunnell, 2012; Shochet, Dadds, Ham & Montague, 2006), and with school climate (Aldridge & McChesney, 2018; Govorova, Benítez & Muñiz, 2020, Modin & Ostberg, 2009; Patalay, O'Neil, Deighton & Fink, 2020; Wang, Degol, Amemiya, Parr & Guo, 2020). From a medical perspective schools may offer an opportunity for 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 (Durlak, Weissberg, Dymnicki, Taylor & Schellinger, 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 for providing this support. School focus is on an academic curriculum, reinforced by expectations from parents and monitoring from government. Addressing wellbeing and mental health is more variable and school staff largely untrained in these areas. An alternative is to invite mental health professionals into schools. This approach was supported in England through the Green Paper, Transforming Children and Young People's Mental Health Provision (DoH & DfE, 2017), which proposed that Mental Health Support Teams would be set up to provide just such mental health expertise for schools. Whilst this can address individuals with mental health difficulties, external mental health professionals are not well-placed to change school environments.

The purpose of this paper is to promote debate from different perspectives on ways forward. We review the theoretical and empirical evidence base on school approaches to student wellbeing and mental health considering if and how schools and mental health professionals can reliably and consistently support students in their contexts. The implications of social and medical models of intervention will be foregrounded, exploring the extent to which approaches adopt a 'deficit' model and the extent to which the adults in charge of the institutional space address wider environmental factors.

Fix what?

Wellbeing and mental health Whilst there is a clear link between wellbeing and mental health there are some important differences. The World Health Organisation (WHO) refer to wellbeing as "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 refers to mental health as comprising "a broad range of problems with different symptoms… generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others." (WHO, 2004). Wellbeing and mental health are associated but they do not always go hand in hand, Patalay & Fitzsimmons (2018) report a fairly small correlation (r = 0.2) between the two. Treatment approaches refer to substantially different theoretical frameworks. There are overlaps, in particular around emotional awareness and regulation, but wellbeing frameworks relate to social and emotional development, mental health frameworks to specific symptom clusters

and typically including medication and/or specific psychosocial therapies. Managing emotional regulation and social behaviour is an element of a teacher's role but the standard teacher is neither trained in, nor tasked with, managing mental health, that is the domain of mental health professionals. Thus managing wellbeing and mental health in schools draws on different theoretical frameworks and the different professional domains of education and health.

School performance There are good reasons to include school performance, typically academic attainment and engagement, in both the underpinnings and measured outcomes of interventions addressing either wellbeing or mental health. 1) Students with psychological disorders are at risk of underachievement over a range of school subjects (Campbell, Bowman-Perrott, Burke & Sallese, 2018; Hurry, Flouri & Sylva, 2018) 2) Secondary students are at risk of absenteeism, exclusion, leaving school early and without qualifications (depression and school drop out,Dupéré, Dion, Nault-Brière, Archambault, Leventhal & Lesage, 2018; and absenteeism, Lereya, Patel, Dos Santos & Deighton; self-harm and low qualifications, Storey, Hurry, Jowitt, Owens & House, 2005; diagnoses of ADHD and Conduct Disorder are associated with school exclusion and lack of qualifications. The fact that adolescence is a critical moment in education and subsequent career opportunities makes a strong case for the importance of damage limitation around schooling for students with problems with mental health. 3) One aspect of wellbeing is being able to work effectively, which in the school context includes academic attainment and engagement (Caprara, Barbaranelli, Pastorelli, Bandura & Zimbardo, 2000). 4) The prospect of improving school performance is salient to teachers. School performance is firmly in the educational professional domain but teachers often lack confidence about strategies for managing pupils with specific mental health issues schools (DfE, 2016).

Changing the child – the individual level

It is common and useful to adopt a three tiered approach to intervention where Tier 1 universal provision is designed for use with all pupils and Tiers 2 and 3 focus on children at risk (Tier 2, typically small group provision) or experiencing problems (Tier 3, typically individual provision). Given that there is good evidence that both wellbeing and mental health are associated with individual factors ranging from genetic vulnerabilities through temperament and personality, and that all relevant theories address individual characteristics, it is unsurprising that the interventions at every tier involve supporting the child to change.

Tier 1. Universal provision addresses both wellbeing, broadly described as social and emotional learning (Durlak, et al., 2011) and mental health. Of the three tiers, Tier 1 interventions are the most likely to be managed by teachers, particularly interventions focusing on wellbeing. They are also the most commonly reported form of intervention in schools (Vostanis, Humphrey, Fitzgerald, Deighton, & Wolpert, 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 with a broad coverage of social skills and emotional regulation, some more focused on bullying, substance misuse, school connectedness, externalising behaviour problems or anxiety. In the UK, curriculum elements of SEAL (Humphrey, Lendrum & Wigelsworth, 2013) and INCLUSIVE (Bonell et al, 2019) are examples of this approach. Mindfulness techniques, also taught in schools (Zenner, Hernnleben-Kurtz & Walach, 2014), relate broadly to self-awareness and self-management but with a particular methodology focusing on the present with an accepting, non-judgemental attitude. Behaviourist theories underpin a further group of interventions

which emphasise rewards and sanctions and are a common feature of classroom practice (Kendall, 2015).

For mental health, Cognitive Behaviour Therapy (CBT) is by far the most widely evaluated intervention, addressing disorders such as depression and anxiety, both for 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 shape our behaviour and emotions: The Process Model of Emotion Generation (Gross & Thompson, 2007) and Social Information Processing (SIP Crick & Dodge, 1994). It 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, Peterman & Cummings, 2015).

Universal intervention to improve academic performance and engagement is essentially good classroom practice, at the heart of the job of the teacher, not possible to cover here. 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, Bunford, Evans & Owens, 2013).

Tier 2 interventions. Whilst the role of social/environmental factors in mental health are generally acknowledged, supporting the child is the primary perspective of Tier 2 interventions, sometimes managed by teachers, sometimes by external specialists from 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, Deighton, Patalay & Edbrooke-Childs, 2020) and for behaviour disorders, Behaviour Therapy (BT) programmes such as Check in Check Out (Bruhn, Lane & Hirsch, 2014; Carroll & Hurry, 2018), and these therefore share theoretical underpinnings with Tier 1 interventions. Whilst 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 been commonly evaluated (Cheney, Schlosser & Nash, 2014).

In terms of school performance, 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, Harrison, Temple-Harvey, Ramsey &. Parkerl, 2011), choice making, fast paced instruction and shortened task length (Harrison et al., 2013), peer-mediated, teacher-directed and self-regulation strategies (Campbell, Bowman-Perrott, Burke & Sallese, 2018). It seems likely however that specific instructional interventions may not be prioritised (Webster & Blatchford, 2013; Webster & Blatchford, 2018).

Tier 3 interventions This is the domain of mental health specialists. Lack of availability of referral options to mental health specialists has been identified as a problem by English schools (Sharpe et al., 2016) and this finding influenced government action resulting in Mental Health Support Teams (DoH & DfE, 2017).

Changing the school – the environmental level

At the social/ environmental level the aim is to create psychologically healthy and supportive school spaces. This requires a whole school approach (WSA) and a belief that schools themselves are a factor in pupils' wellbeing and mental health. Whilst teachers acknowledge

the relevance of the environment for student mental health they may look to family influences and avoid examining the school (Moore et al., 2019). What constitutes a psychological healthy space is not cut and dried given the breadth of wellbeing and mental health of interest. As with interventions addressing the child, WSAs are heterogeneous. Ecological theory outlines the various influences (Bronfenbrenner & Morris, 2006) and social learning theories are influential (Bandura, 2001) but more specific theories relate to target areas. A potentially powerful theory or health promoting schools with a coverage of 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, teachers and pupils, pupils and pupils and promoting strong cross-curricular connections. It requires empirical testing but it is a reminder that school ethos is complex and deep-rooted. Anti-bullying programmes are probably the most widely researched whole school approach (Ttofi & Farrington, 2011). Goldberg et al (2019) outline three components of WSA: curriculum, teaching and learning; school ethos and environment; family and community partnerships.

Ideally, in addition to shaping school climate, whole school approaches promote: consistency between curriculum messages and school experiences outside the classroom; provide a structure for the selection of interventions with the best fit to the school; create an environment for sustainable intervention and; support teachers to communicate, to learn and to change (Goldberg et al., 2019). An example of a recent successful WSA in secondary school that illustrates these affordances is INCLUSIVE which modified the school environment to reduce bullying and aggression (Bonell et al., 2019). In terms of school environment, the intervention was underpinned by a specific theoretical framework of restorative practices.

A potential strength of implementing a WSA is that it includes a review of student needs and measures easiest to implement and most acceptable in the setting. However this requires substantial planning and support with an infrastructure to support system-wide implementation, often found to be missing (Goldberg et al., 2019; Spoth et al., 2013). A WSA can be challenging when schools are not completely committed, particularly when the topic in question is not yet considered a key priority. 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 both the most important and feasible were: on-going, dynamic training; on-going consultation/coaching and; monitoring implementation progress. Thus education and mental health professionals both have complementary roles in school change. The educators understand the school context and must implement school action but they lack they expertise in the wellbeing/mental health domains and need training, consultation and advice on what to monitor from mental health folks.

The usual suspects threaten sustainability of WSAs to wellbeing and mental health: 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 and changing contexts (Herlitz, MacIntyre, Osborn & Bonell 2020).

Teacher development and wellbeing

To sustainably change the environment for pupils requires supporting teachers, not only with training and expert consultancy, but also acknowledging that working with students who are depressed or anxious or with challenging behaviour is difficult, and may elicit responses harmful to the teachers and their students. Good teacher-pupil relations have been found to be particularly important for pupils with problems (Sabol & Pianta, 2012). Studies have demonstrated, at least an association, if not causality, between teacher and student wellbeing and the importance of positive working relationships between professionals within school and externally with parents and partners are integral to the purpose of this paper (Klusman, Richter & Lüdtke, 2016). A recent cross-sectional study that collected data from 3216 year 8 (aged 12-13 years) students and from 1182 teachers in 25 secondary schools in England and Wales found that better teacher wellbeing was associated with i) better student wellbeing (standardised effect = 0·07, 95% CI = 0·02 to 0·12) and ii) lower student psychological distress (standardised effect = -0·10, 95% CI = -0·16 to -0·04). The findings, were partially explained by the quality of relationships between teachers and students and teacher presenteeism (Harding et al., 2019).

Some of the most reported approaches to practitioner wellbeing in schools include: the role of senior leadership; whole school approaches and support through mentoring, coaching and/or supervision. Research with school and college staff has established the fundamental role of senior leaders in cultivating practitioner wellbeing through, for example, communicating and embedding a clear vision and strategies related to wellbeing and role modelling positive wellbeing behaviours (Gu & Day, 2013). Wellbeing approaches with an emphasis on peer support (coaching and mentoring) and supervision are increasingly implemented in schools. 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, Cowell & Field, 2017).

The evidence

<u>Overall</u> The evidence across a number of well-conducted meta-analyses typically reports small to moderate effects for school programmes/interventions both universal and targeted on outcome measures relating to wellbeing and mental health (Table 1). In this standardised measure of the impact of intervention, effect sizes of 0.2 are considered small, 0.5 medium and 0.8 large. These effects tend to be short term with a shortage of long term outcome studies and a tendency for effects to disappear over a year or two. Studies tend to have mainly been conducted in the US, the majority covering the primary/elementary stage rather than secondary.

Study	Primary/ secondary	Universal/ Targeted	Outcome	Effect size Cohen's *d* or Hedges *g*	Intervention/ Long term
Bonell et al., 2019	secondary	universal	bullying misbehaviour/ delinquency quality of life wellbeing SDQ	-0.08 not significant 0.14 0.07 -0.14	Intervention INCLUSIVE assessed 36 months after inception
Caldwell et al., 2019	secondary secondary primary	universal universal universal	anxiety anxiety anxiety	*-0.65 **-0.15 **-0.07	*mindfulness **CBT **CBT

	both both	targeted both	anxiety depression	not significant not significant	all types all types
Durlak et al., 2011	both	universal	SEL skills attitudes positive.social. behaviour conduct problem emotional distress academic perf.	0.57 0.23 0.24 -0.22 -0.24 0.27	
Ford et al, 2019	primary	universal	SDQ (9m) immediately post intervention SDQ (18m) 9m post intervention SDQ (30m) 9m post intervention	statistically significant (p=0.03) not significant (p=0.85) not statistically significant (p=0.23)	Incredible Years Teacher Classroom Management
Gee et al., 2020	10-19	targeted	depression anxiety	-0.34 -0.49	
Goldberg et al., 2019	both	universal WSA	social & emotional adjust behavioural adjustment internalising symptoms academic achievement	0.22 0.13 -0.11 not significant	
Moltrecht et al., 2020	6-24	targeted	emotional regulation decrease dysregulation	0.36 -0.46	interventions addressing emotional regulation
Wang et al., 2020	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	both	most universal (N= 46 of 52), some both (N = 14).	internalsing wellbeing/SEL externalising (violence, bullying, anger)	small to modest small to moderate small	Effects tended to be stronger for at risk children

Effect sizes: small 0.2, medium 0.5, large 0.8

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. (e.g. Fazel et al., 2014; Moltrecht et al., 2020; Moore et al., 2019; Weare & Nind, 2011). One example of this is the Good Behaviour Game, positively evaluated in the US and beyond (Nolan, Houlihan, Wanzek & Jenson, 2014) but failing to significantly improve behaviour in UK schools (Humphrey et al, 2018). Similarly, anti-bullying programmes which have been widely and positively evaluated vary in effectiveness internationally, with the transferability from the original culture to other contexts being promoted as an explanation (Gaffney, Farrington & Ttofi, 2019). Fidelity of implementation is another culprit, discussed below.

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. Even the quality of Randomised Controlled Trials (RCTs) is reported as low (Gee et al., 2020) and the evidence base for Tier 2 interventions in the UK is weak (Banerjee, Weare & Farr, 2014; Cheney et al., 2014) and a number of are based on single case studies.

Child (individual) v school (WSA) focus

Overall, although the rationale for WSA over a focus on individual children's risk factors is theoretically persuasive, the evidence fails to provide strong support, at least in the area of SEL. Kidger et al., (2012) in their systematic review of the effect of the school environment on the emotional health of adolescents found no strong evidence of effectiveness of WSA in four of the five intervention studies reviewed. One found some evidence of a positive effect but was judged methodological flawed with a nonrandomised design, no baseline measurement and no control for clustering at school level. In line with Kidger, Langford et al., (2015) found WSA ineffective for a range of mental health outcomes, though being bullied was 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, with five reviews concluding that WSAs were effective and two (including Durlak et al., 2011) that they were not. In the most recent review Goldberg et al., (2019) found WSAs to effectively enhance social and emotional adjustment, behaviour and internalising symptoms, but not academic performance (see Table 1). Anti-bullying programmes, frequently applying WSAs, have been consistently found to reduce bullying (Ttofi & Farrington, 2011). Relevant to this, the evaluation of INCLUSIVE, presented at this Roundtable, 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, Humphrey, & Wiglesworth, 2013; Humphrey, Lendrum & Wigelsworth, 2013).

Education and health professionals – agents of transmission Teachers are often involved in delivering universal interventions and have been found to effective (Durlak et al., 2011), though this may involve initial training by external professionals. WSAs by definition are principally delivered by teachers. Tier 2 interventions have been found to be more effectively managed by external professionals (Gee et al., 2020).

School performance and engagement Evidence of the effect of wellbeing and mental health interventions on school performance is mixed. Durlak et al.,. (2011) & Farahmand et al,. (2011) in their reviews report small effects of SEL programmes, in their review of WSAs Goldberg et al (2018) fail to find any impact on academic activities, Hennessey, & Humphrey (2019) in a UK RCT of PATHS also report no impact on academic attainment. We argue above that the response of schools to students at risk of or experiencing mental health

problems should include action on educational outcomes. 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). Most approaches had some impact on improving outcomes from baseline but at secondary school, three of the most effective were corrective feedback, previewing and prompting. However, a more recent systematic review of educational accommodations reported more mixed findings (Harrison et al., 2013). Eighteen articles met robust inclusion criteria that evaluated 12 types of accommodations such as choice making, fast paced instruction and shortened task length. The authors of the review noted that many of the approaches evaluated were ones that might help all pupils as part of Universal Design for Learning[i] and that it was not possible to say with confidence that they specifically helped this group.

Teacher wellbeing Although a range of interventions have been implemented in schools to support teacher wellbeing, the sparse nature of the evidence available indicates that these practices may not yet be widespread across the sector. A review of the effectiveness of organisational interventions for improving teacher wellbeing found three cluster-randomised controlled trials and one stepped-wedge design and limited evidence for this approach (Naghieh, Montgomery, Bonell, Thompson, & Aber, 2015). Most of the research is based on self-report, such as, for example, the findings from small scale studies of supervision in schools for SENCOs and other professionals supporting vulnerable children. 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 in everyday real-world scenarios; time to consider and discuss the multitudes of possible avenues available for many complex problems faced by practitioners and opportunities to foster a greater sense of camaraderie between colleagues (Reid & Soan, 2018; Willis & Barnes, 2018).

Discussion and conclusion

We set out to explore the roles of teachers and mental health professionals in addressing the wellbeing and mental health of students and we argued that based on what is known about child and adolescent development, attention to both the school environment and individual risk factors would be useful.

The reported quantitative effects on both wellbeing and mental health outcomes tend to be small to moderate, with empirical evidence being more consistent for interventions addressing the individual child than the school environment. The size of effects is unsurprising, underscoring that schools are never the only solution but that nonetheless they should be a part of it. There is little disagreement that there should be support for the child but implementation is problematic. WSAs offer solutions relevant to implementation but there is inconsistent quantitative evidence of their effectiveness. This raises two points. The first is how we view evidence and the second how we implement it. With reference to the evidence, whilst WSAs do not clearly outperform individual focused programmes findings are difficult to interpret because WSAs are more frequently poorly implemented. Theoretical propositions, qualitative reports and implementation science provide persuasive reasons to promote WSAs. Also, even the effectiveness of positively evaluated approaches 'cannot be relied upon' (Weare & Nind, 2011, p31). This suggests the importance of contextual factors and that schools need to monitor the interventions they use. Also, contexts change, we are currently experiencing an example of that in the time of Covid. In terms of implementation, ideally, WSAs provide a framework for school-level decision making, organisation and staff buy-in which enables an exchange of knowledge between local educators and external professionals who are once removed from the school 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 and this would be typically part of the WSA. Another element would be to identify some key features of successful approaches and their underlying theoretical frameworks, not all approaches agree. Given the heterogeneity of these effects, even within one intervention, and the plethora of choices of intervention, providing practitioners with a theoretical map is seen as important to enable them to make choices and to synthesise approaches where useful. Key features for high quality implementation are: a sound theoretical base; direct focus on intended outcomes; giving priority to those interventions which are easiest to implement in the setting; explicit guidelines possibly manualised; complete and accurate implementation (Lyon et al., 2019; Herlitz et al., 2015; Weare and Nind, 2011). Thus we propose that WSAs are essentially necessary to good implementation but that the degree of flexibility around implementation needs to be constrained. Also, expectations should be tailored to school capacity, not all schools start from the same place.

Education and mental health professionals have very different contributions, with health being more advisory at Tier 1 but more directly involved in delivery at Tiers 2 and 3. There has been a greater focus on evidence relating to wellbeing/mental health than to school performance which is hardly surprising. However, SEL and more particularly mental health is associated with school performance and there is a need for attention to education of at risk children to keep them on track academically, with the associated need for teachers and health teams working together on the academic as well as the health dimensions of the child. As it is rolled out over the next four years the recent introduction of Mental Health Support Teams (MHSTs) in England (a joint venture between DoH and DfE) will provide specially trained Education Mental Health Practitioners (EMHPs) to go into schools. This is a promising innovation which offers an opportunity for more systematic, evidence based practice provided by suitably trained staff but benefits will only be realised if there is a close dialogue between school staff and mental health professionals. Perhaps a majority of UK schools do not use evidence based interventions (Vostanis et al., 2013; Wigelsworth et al., 2019). At Tier 1 EMHPs might take the role of consultant to teaching staff, assist with training and learn from teachers about the school context, what is seen as needed, what is more easily implemented. At Tier 2 the EMHPs would be more involved in delivering intervention and assisting in the referral process 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, both initial teacher training and continuing professional development in key principles of student wellbeing and mental health and its impact on teachers.

Conclusions

We conclude that every school should have a policy for Tier 1 & 2 approaches to student wellbeing and mental health. That this should include evidence informed approaches both to developing students' SEL and resilience to stress and WSAs to ensure consistent sustainable structures with a good fit to the school. Currently the research community is not well-aligned with the practical application of strategies to address student wellbeing and mental health. There has been important and useful work in trialling different approaches, creating a necessary evidence base, but there needs to be closer attention to synthesis of key theories and to methods of selecting suitable approaches for specific contexts. In practical terms, the Education Endowment Fund have produced useful practice guides which 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. We need evidence of how these are being used and whether or not they are subject to the same problems with overly flexible implementation as SEAL. Wigelsworth et al., (2019) conducted a survey of primary schools and SEL. Schools reported that SEL was becoming an increasingly important part of their curriculum but that SEAL was the most widely used programme, which is concerning given the evidence of its effectiveness. 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 (eg. the value exercise for mental health). 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 upskilling as well as their students, providing them with a clear structure for the process of change.

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