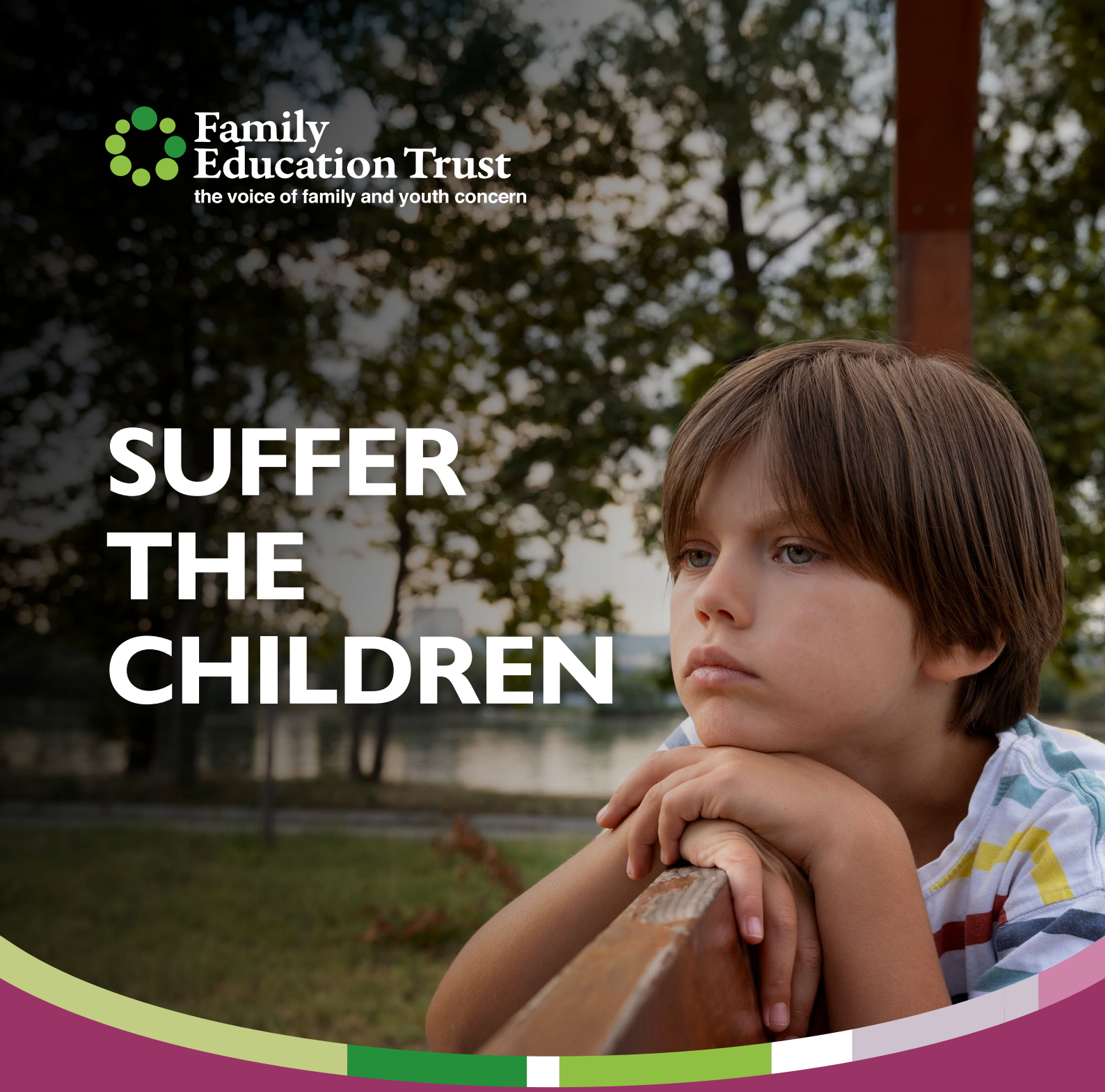

Family Education Trust
the voice of family and youth concern

SUFFER THE CHILDREN

Why having a 'mental health professional' in every school is not the answer

Lucy Beney

Foreword by **Baroness Fox of Buckley**

This paper is for all the children and young people who have taught me so much over many years. You deserve so much better.

'Most mental health difficulties are not about broken brains but broken hearts'. [1]

1 Sen, D, 'The revolution will not be pathologised', from *Drop the Disorder* (ed. Watson, J; 2019).

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ABOUT THE AUTHOR

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With a degree in History from the University of Bristol, Lucy worked first in journalism and publishing, becoming Head of Information and Analysis at a public affairs company in London. She then spent nearly two decades abroad, accompanying her husband, which is where she first worked with children in a voluntary capacity, in Malaysia, Oman, the Netherlands and finally with street children in Brazil, while also researching and writing about history and culture. On her return to the UK, she achieved a Masters in Archaeology and Heritage Management from the University of Exeter, before embarking on counselling training to try to play a small part in turning the tide of misery she saw among young people in the UK.

Lucy's interests include travel, culture, languages and food. She is married with two adult children.

FOREWORD

This paper is a refreshing, must-read antidote to orthodoxies associated with the enormous spike in numbers of young people who have mental health problems. Too often, shocking revelations, such as the fact that 20% of school-aged children in the UK have a diagnosis, can lead to knee-jerk 'something must be done' policies, nodded through with little scrutiny or challenge. The cross-party, near unanimous support for placing a mental health professional in every school is a pertinent example, and a worthy subject of Lucy Beney's interrogation, noting ironically that such assumed solutions may well make matters worse.

Challenges to well-meaning initiatives are often swatted away as evidence of a hard-nosed lack of sympathy for suffering children. What is invaluable about Beney's essay is that it is suffused with compassion, informed by her own clinical practice, but she does that rare service of dispassionately digging deeper beneath the stats and surface crisis. Readers are forced to look beyond the medical model of treating and managing "the symptoms of our children's distress", urged instead to be more curious about its social origins. The author advocates that we 'take a clear-eyed look at where **we** are going wrong, and not focus on what is allegedly 'wrong' with our children' (my emphasis). She concedes this can raise difficult and controversial issues. And what's deemed controversial can even be as little as asking questions about the prevailing narrative – as I know to my cost.

At the start of the year, I gave several speeches in the House of Lords in debates on the new Mental Health Bill, voicing my concerns about how ever greater numbers of especially young people are being encouraged – often by Government-backed policies – to view more the human condition itself, and more and more aspects of normal, if adverse or painful, life events through the prism of mental illness or neurodivergence. My modest aim was to probe if one of the unintended consequences of pathologising ever more aspects of life might reduce the time and resources available to those who desperately need professional help, by clogging up the system with inappropriate referrals and arguably over-diagnosed conditions. I quoted Tony Blair who recently warned that, 'You've got to be careful of encouraging people to think they've got some condition rather than simply confronting the challenges of life'. I cited Secretary of State for Health Wes Streeting who has queried whether over-diagnosis is adding to problems of worklessness and sick leave, sadly wasting the potential of those increasing numbers who remove themselves from productive work because of mental health-related problems.

In other words, what I argued was pretty mainstream, and yet… My speeches were picked up by the media, and led to an onslaught of abusive emails, attacks on social media, and an official complaint to the Lords standards body. I have made lots of speeches on far more contentious topics, so was taken aback by the howls of indignation from young people in

distress (and their parents). But this backlash taught me a lesson: in contemporary culture, conditions such as ADHD and mental illness go far beyond medical diagnosis or the need for expert pharmacological or therapeutic intervention – these labels have now been internalised as part of individuals' identities.

And as with other expressions of identity in the political realm, any challenge to the orthodoxy is treated as insensitive heresy and threatened with 'you can't say that' cancellation. This is not a cynical ruse. People take any objective critique personally, as affront to their 'lived experience' and they genuinely are hurting. But for this reason alone, we need more debate and it's precisely why we need to interrogate what is going on here, to ask tough questions: Why are so many young people perceive themselves in mental turmoil? Why has the old regressive stigma around psychiatric conditions been replaced by generations who now compete to have an official diagnosis, as an unquestioned right? And much more. In that context, *Suffer The Children* is invaluable as a contribution to opening up a richer and more nuanced debate.

The essay bravely tackles sacred cows, such as the 'mental health industrial complex'. The huge increase in classification in the psychological realm has moved the job of diagnosis far beyond the field of psychiatry. There's a veritable industry of counsellors, therapists and psychotherapeutic practitioners, private providers, online diagnostic toolkits and 'sickinfluencers', who now label an ever-expanding set of behaviours as mental ill-health. What's more, swathes of this unregulated sector have embraced ideological positions, tangling up critical social justice theory with medical terminology; adopting an affirmative approach to young people's demands, which as Beney points out has been so damaging (and clinically harmful) in relation to gender confusion.

This is all leading to an unintended but inevitable situation of making matters worse. As the number of labelled conditions has grown, 'the more people start to identify with the symptoms'. And arguably, as schools have become more proactive in promoting mental health awareness, and more staff are dedicated to pupils' emotional wellbeing, the more the rates of mental illness rise.

Heightened awareness seems as likely to embed the language and mores of mental health into how we socialise children and create a self-fulfilling prophecy. Primary school pupils can be heard using vocabulary usually associated with psychiatry rather than the playground, and describe themselves as anxious, depressed and traumatised. University students justify no-platforming for fear that hearing speakers they disagree with will induce PTSD; exams are traumatising; set texts require trigger warnings. Pathologies we obsessively make young people aware of are colonising their minds, so unsurprisingly, they will interpret all and every difficulty through the prism of mental disorder. Beney is especially convincing on what teachers should

be concentrating on in the classroom. If schools are focusing children on homing in narrowly on their own internal feelings, rather than more productively encouraging them to look outward beyond themselves, to the wonders, intellectual adventures and creative hemisphere that Knowledge (with a capital K) offers, they may well get stuck in a doom-loop.

One need not agree with all of Beney's explanation or solutions to appreciate, as I do, this essay's demand that 'Adults need to re-enter the room' to tackle what she rightly describes as 'a very large, complex and growing problem'. Every educator, policy maker, legislator, parent and indeed young person – should read this important and profound essay.

Claire Fox
Director, Academy of Ideas; Baroness Fox of Buckley, independent Peer, House of Lords

Executive Summary

- There is no doubt that currently, children and young people are failing to thrive as they should. In 2024, almost 20% of school-aged children in the UK had been diagnosed with a mental health condition, up from 10% twenty years ago;
- There has been almost unanimous agreement across the political spectrum and among representative bodies for mental health professionals, that placing a 'mental health professional' in every school may improve the situation;
- It is difficult to ascertain whether or not this is the right approach, without understanding what is meant by the terms 'mental health' and 'mental illness', and the challenges in diagnosing a growing number of conditions experienced entirely subjectively through feelings and observed behaviour;
- An abundance of information about mental wellbeing is freely available in a variety of different settings, but has done nothing to improve the situation for young people. Schools already have more staff and programmes dedicated to pupil wellbeing than ever before, even as rates of 'mental illness' continue to rise. The effects of 'social contagion' also need to be considered;
- Professional bodies have lobbied for the 'mental health professionals' to be fully qualified counsellors – there are, however, structural issues within the profession which suggest many interventions would, in fact, be carried out by unpaid volunteers, or professionals in training;
- The capture of mental health professional bodies by critical social justice theory and gender ideology – and the incorporation of these ideas in membership bodies' ethical frameworks – means that many professionals are likely to look at distress through the lens of systemic oppression and decolonisation, and a need to challenge 'heteronormativity', rather than addressing individual distress;
- A 'mental health industrial complex' has developed in recent years, and there is a lot of money being spent – and to be made – in connection with the 'mental health crisis';
- This paper stresses the need to look beneath the surface for answers, in order to find long-term solutions, principally at the importance of:
  - secure early attachment and the need to support the mother/child relationship in the early years;
  - family stability and unity for children's mental wellbeing;
  - addressing the 'disaster' narrative and nihilistic outlook fed to children.
- This paper recommends that in order to improve the mental, emotional and physical wellbeing of our children we need to encourage:
  - the healthy formation of a child's identity over time and within the context of family, community, personality and wider interests;
  - the building of strong communities, committed to children's wellbeing;
  - a return to a knowledge-based curriculum in school, and a school day structured to build resilience through relationships;
  - adults to take responsibility for leadership once more;
  - the equal – fair – treatment of boys and girls, while simultaneously their differences are acknowledged and suitable provision is made accordingly.

INTRODUCTION

As even professionals observe, 'it's hard to be a normal kid these days'.[2] Barely a day passes without a mention somewhere of the current 'mental health crisis' among young people. We are told that rates of mental illness among children in the UK have risen from one in ten[3] in 2004, to almost one in five now.[4] A National Health Service (NHS) survey in 2022 stated that 18% of children aged 7–16 were found to have a 'mental disorder'.[5] According to Mental Health UK, one in three young workers is currently taking sick leave because of mental health issues.[6] Mental health and behavioural conditions are cited as the primary reason for claiming disability benefits by 44% of claimants.[7]

To address this malaise, we appear collectively to be embracing the view that having a 'mental health professional' in every school might be part of the answer. Back in 2017, the government published a Green Paper, in which plans were set out to transform the mental health of children and young people, with a focus on providing additional support through schools and colleges.

At the UK General Election in 2024, there was consensus among the main political parties that more should be done to address children's mental health in educational settings. The Labour Party's manifesto committed the incoming Government to 'provide access to specialist mental health professionals in every school'.[8] The Liberal Democrats, likewise, promised to put a 'dedicated, qualified mental health professional in every primary and secondary school'.[9] The Conservatives opted for a variation on the theme, offering an expansion of the 'coverage of Mental Health Support Teams from 50% to 100% of schools and colleges in England by 2030'.[10] At a recent conference for family doctors, Government Minister Stephen Kinnock confirmed that the government is indeed committed to putting a 'mental health practitioner' into 'every school in the country'.[11]

As we might expect, those working in the sector agreed. The British Association for Counselling and Psychotherapy (BACP) is the largest professional body, with around 70,000 members across the UK. In their 'manifesto' for the 2024 General Election, the BACP called upon the new Government to 'ensure that there is a mental health professional in every school, and that the workforce includes counsellors and psychotherapists'.[12]

2 Timimi, S (2025), *Searching for Normal – A New Approach to Understanding Mental Health, Distress and Neurodiversity,* Fern Press.
3 Health Committee, Children's and adolescents mental health and CAMHS, UK Parliament (5 November 2014).
4 Gov.uk, *Special Educational Needs in England, Academic Year 2023-24* (20 June 2024).
5 NHS, *Mental Health of Children and Young People in England 2022 – wave 3 follow up to the 2017 survey*, (29 November 2022).
6 Mental Health UK, *The Burnout Report* (January 2025).
7 Latimer E *et al*, *The role of changing health in rising health-related benefits claims*, Institute for Fiscal Studies (12 March 2025).
8 Labour Party, *Change* (Manifesto 2024).
9 Liberal Democrats, *For a Fair Deal* (Manifesto 2024).
10 Conservative Party, *Clear Plan, Bold Action, Secure Future* (Manifesto 2024).
11 Kaffash, J, 'Minister announces crackdown on private sector therapists at Pulse conference', *Pulse* (19 March 2025).
12 BACP Manifesto, *Mental health matters: championing counselling and psychotherapy*, General Election 2024.

While the headlines are alarming, statistics only ever tell a part of the story. There are undoubtedly children and young people whose suffering is very real, and whose lives are severely impacted by a number of serious and complicating factors. As Abigail Shrier notes in her book, *Bad Therapy*, some conditions undoubtedly 'exile the afflicted from the locus of normal life'. [13] Likely to be under psychiatric care, very few of these children would be seen routinely by a mental health professional in school.

What about those who are in school? Some have not met the 'threshold' to access dedicated mental health services. Others face particular, but limited, challenges brought on by a specific set of circumstances. Yet more are affected by what could loosely be called *sociogenic* factors, often originating within their peer group and exacerbated by internet use and social media. But are all – or any – of these young people 'mentally ill'? Is school the best place to address their suffering? Or have we forgotten that to experience a full spectrum of emotions deeply is part of what it means to be human?

These questions cannot adequately be addressed without looking at the roots of the difficulties faced by so many children and young people today, and the pressures they face, and asking if there is perhaps a better way of addressing their emotional distress – a term I prefer to 'mental illness' – beyond offering additional 'mental health' support in school. Before arriving at an answer, it is also important to examine what currently happens in schools, and who the likely mental health professionals will be.

We also need to have a clear understanding of what is meant by 'mental health', and indeed 'mental illness'. Increasingly, distress is viewed through a diagnostic, 'medicalised' lens when frequently young people are in fact reacting normally to abnormal situations. It would be more unusual if they did not react when their lives fell apart, when they encountered life's challenges or when they suffered the consequences of early adverse experiences.

The one aspect on which we can all agree is that far too many of our children and young people are not thriving – physically, mentally or emotionally – in the way that they should be. [14]

13 Shrier, A, (2024), *Bad Therapy: Why the kids aren't growing up*, Swift.

14 Beney, L, *What's Going On?*, Save Mental Health.

WHAT DO WE MEAN BY MENTAL HEALTH?

'It's my mental health'

Every counsellor or therapist will have heard this very common response, when meeting a young person for the first time, and asking what has led them to seek help. Nailing down a meaningful definition is difficult. It is nonetheless vitally important that we find clear and unambiguous language to describe what is happening to so many young people.

Mental health organisations tell us that we all have 'mental health', and that it is increasingly under threat. A brief perusal of definitions provided by different organisations within the NHS in England offers various explanations, some as simple – and ultimately meaningless – as 'mental health is the way we think and feel'. [15] Leading charity Young Minds defines mental health as 'our emotional, psychological and social wellbeing'. [16] However, even here there is an acknowledgement that this '... is just one definition of mental health. We all have our own ways of understanding it'. This particular Young Minds definition came from 'activists', aged 14 to 25, who are volunteers with the charity and who are 'passionate about mental health or have experienced challenges related to mental health in their lives'.

Immediately, it is clear that there will be a different understanding of what 'mental health' means to different people. We also see the emphasis given to subjective 'lived experience', rather than to objective factors. Differences in definition can be particularly pronounced between different cultures and demographics, which partly accounts for the different rates of diagnosis of 'mental illness'. While the use of the term 'disorder' suggests that there is something 'wrong' with an individual, paradoxically the role played by external experience in individuals' wellbeing is also obvious from the outset.

Lack of objectivity in diagnosis

For some time now, campaigners have stressed the importance of treating mental health in the same way as physical health – but there is one crucial difference, which makes any agreed definition of the terms 'mental health' and the many 'disorders' identified as 'mental illness' particularly difficult.

Generally speaking, physical illness can be objectively diagnosed. For example, a broken bone will show up on an X-ray; a tumour will be visible on a scan; and infections can be identified through blood tests. When it comes to mental health – or mental illness – none of this is true. The increasing number of disorders with which people are being diagnosed have no objective, clinical or scientific tests. Diagnosis is based entirely on personal feelings or experience, and observed behaviour. The interpretation of feelings, experience and behaviour are highly subjective – and with young people, can often vary widely.

15 Oxford Health NHS Foundation Trust, *CAMHS: Good Advice – What is mental health?* (accessed 20 March 2025).

16 Young Minds (accessed 20 January 2025).

As ground-breaking NHS child and adolescent psychiatrist Sami Timimi explains in his book, *Insane Medicine*, [17] regarding psychiatric diagnoses, 'ranges of reliability have been found to be broad, and in some cases ranged the entire spectrum from chance to perfect agreement'. At the same time, the number of 'disorders' is growing exponentially.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), produced by the American Psychiatric Association, is regarded worldwide as the primary guide for mental health diagnoses. The first edition, produced in 1952, covered 106 mental 'disorders'. There are now over 450 variations in diagnosis. The most recent edition, DSM-V TR, which was published in 2022, was compiled by over two hundred experts. While fears of 'diagnostic inflation' have been voiced from various quarters, a meta analysis of changes in the stringency of diagnosis carried out in Australia in 2020 found these have been 'overstated'. However, 'notable examples of diagnostic inflation' include ADHD, autism, eating disorders and substance dependence, all of which are particularly relevant in connection with young people. [18]

While the publication's stated aim is to 'classify mental disorders with concise and explicit criteria intended to facilitate an objective assessment of symptom presentations', as already outlined, this is not actually possible. [19] To illustrate this, it is worth considering the validity of the condition 'unspecified mood disorder', which appears to offer a catch-all diagnosis for any emotional distress which does not meet the full criteria for any other disorder.

As Dr Timimi reminds us, many psychiatric diagnoses 'have been literally imagined into being' by a few influential experts. Professor Donald Klein, a leader in developing diagnostic criteria, quoted in the influential book, *The Power Threat Meaning Framework*, confirms 'we were forced to rely on clinical consensus, which admittedly is a very poor way to do things'. [20] Additionally, there is a degree of circularity involved in diagnosis – for example, the reason given for someone hearing voices is that they have schizophrenia; and we know that they have schizophrenia because they hear voices. As *The Power Threat Meaning Framework* goes on to explain, in its plea to treat mental health challenges differently, 'if we want to understand why someone might feel or behave as they do, we need to move away from a 'diagnostic model'. [21]

Neurology consultant Suzanne O'Sullivan adds, in her recent book, *The Age of Diagnosis*, that 'whenever a tightening of diagnostic criteria risks taking a diagnosis away from some people, a new diagnostic label is usually created'. She explains that this is what happened in DSM-V when the category of 'social (pragmatic) communication disorder' was developed, 'to account for people who might no longer qualify as having autism according to the newest criteria'.

17 Timimi, S (2021), *Insane Medicine: How the Mental Health Industry Creates Damaging Treatment Traps and How you can Escape Them.*

18 Fabiano F and Haslam N, *Diagnostic inflation in the DSM: A meta-analysis of changes in the stringency of psychiatric diagnosis from DSM-III to DSM-5,* Clinical Psychology Review, Vol 80, August 2020.

19 American Psychiatric Association, About DSM-V-TR (accessed 12 February 2025).

20 Boyle, M and Johnstone, L (2020), *The Power Threat Meaning Framework*, PCCS Books.

21 *Ibid.*

To the detriment of those most severely affected, the criteria for diagnosis of both autism and ADHD are now so wide as to be almost practically meaningless – to the extent that many children have bizarrely been diagnosed with both simultaneously. Suzanne O'Sullivan suggests that perhaps these disorders 'are so poorly defined that the same people are getting multiple diagnoses to explain the same difficulties'. [22]

Into the Mainstream

With the best of intentions, a concerted effort has been made over many years now to break the 'taboo' – or perceived silence – around emotional distress, or mental health. Unfortunately, an unintended consequence has seen the expansion of therapeutic terminology into everyday language. Words such as 'trauma', 'toxic', 'overwhelm' and 'narcissistic' crop up so frequently that their meaning has been diluted.

Too often, young people are encouraged to look at life primarily through the filter of their own feelings, which can be reliably unreliable, especially in the teenage years. As we have seen, subjectivity has superseded objectivity; and 'lived experience' matters more than expertise. Examining other interpretations of a problem is seldom encouraged. Instead of asking 'what has happened to you?', as we should, increasingly we ask, 'what is wrong with you?'.

Added to this is an inclination to 'medicalise' negative feelings and experiences. In 2022, a YouGov poll for Barnardo's discovered that 66% of young people reported feeling sad or anxious at least once a month. [23] In 2024, one in three adults reported having experienced at least one traumatic event. [24] Obviously, there are degrees of sadness and anxiety – and sometimes terrible things happen – but it is important not to forget that this is part of life and experiencing a range of emotions is an integral and important part of being human. Feeling sad or anxious is not indicative of mental ill-health – reacting to our experiences, environment and relationships is entirely normal. Too often, in a world of instant gratification and social media perfection, this is forgotten.

This approach is being encouraged by a proliferation of mental health advice, the clear implication being that anyone might need it at any time. There are leaflets on display everywhere from libraries to travel hubs. [25] Some of this advice itself carries 'trigger warnings', to alert readers that the content might be upsetting. Leading mental health charity Mind lists over twenty-five corporate partners from the world of banking (HSBC) to bicycles (Halfords) and everything in between. Clothing websites offer the opportunity to donate to Mind at checkout. [26] Clicking the Marks and Spencer logo on the Young Minds website takes customers straight through to the retailer's online store.

22 O'Sullivan, S (2025), *The Age of Diagnosis: Sickness, health and why medicine has gone too far*, Hodder Press.

23 Barnardo's, *It's Hard to Talk – Expanding Mental Health Support Teams in Education* (December 2022).

24 Mental Health Foundation, *The impact of traumatic events on mental health.*

25 Mind, *Opening up about your mental health et al*, Bristol Airport (February 2025).

26 Seasalt (accessed 03 April 2024).

Meanwhile some sufferers tour the country having turned their 'disorder' into a form of entertainment. One 'late-diagnosed' individual offers an 'interactive and dopamine filled evening where ADHD takes the stage' with her show *ADHD Unmasked* – which is 'perfect for those with ADHD, whether diagnosed or not, supportive friends and family, or those who want to learn more about ADHD brains'. She also promises to share her life 'as a mum and wife to two autistic/ADHD teenagers and her autistic/ADHD husband'. [27]

There is no doubt that 'mental health' is the *cause du jour* – but at what cost? As Sami Timimi writes in his most recent book, published this year, 'under the guise of anti-stigma, prevention, self-help, employee support, suicide prevention and education, mental health ideology, and its sibling the wellness industry, found favour and expanded markets this way and that'. [28] He believes, I think quite reasonably, that mental health ideology 'may be the biggest and most powerful cause of mental health problems today'.

Self-Diagnosis

The limitations of diagnosis, and the arbitrary nature of the labels attached to certain patterns of thinking and behaviour, are clear. Formal diagnosis, however, tells only a partial story. We are living primarily through an epidemic of self-diagnosis, which in turn puts pressure on mental health services as young people and their parents seek confirmation of their own beliefs about themselves or their children.

As we indulge in ever more assessment and box-ticking academically and developmentally, and as in-groups and out-groups become ever more rigidly defined through social media 'friends', 'followers' and 'group chats', increasing numbers of young people feel that they are 'different', that they 'don't belong' or that there must be 'something wrong' with them. Many lack the strong roots, perspective and reassurance a stable family can offer. They then seek help, advice and a sense of community elsewhere – usually online.

According to a paper published in April 2024, videos with the hashtag 'mental health' have amassed over 17 billion views on the social media platform TikTok alone. As platform users scroll, algorithms feed them further related content. 'Sickfluencers' have built 'communities' based on self-diagnosed labels which become an integral part – sometimes the defining aspect – of an isolated individual's identity. Here, 'lived experience' is everything and is unfiltered. There have also been numerous legal cases where the defendant has used 'mental health' issues as an explanation – and an excuse – for their actions.

27 Maple Tree Entertainment, ADHD Unmasked (accessed 01 April 2025).

28 *Op. cit.*, Timimi, S (2025), *Searching for Normal.*

The paper's authors explain how 'social media communities represent a cultural antithesis of the medical establishment by rejecting healthcare expertise and creating spaces whose membership is only afforded through a psychiatric diagnosis for individuals to participate in shared experiences'. [29] This is very arguably profoundly unhealthy, as we know that 'identifying strongly with a diagnosis has been shown to lead to a more negative health outcome'. [30] There is no incentive for young people to overcome any perceived difficulty or dysfunction. Often, being part of the 'in-group' rests on the continuation of performative symptoms and suffering.

There have even been cases of influencers being 'diagnosed' by their followers. Recently, a successful journalist wrote about how her 'so-called honesty' in exchanges on TikTok, led to speculation among her 80,000 followers about whether or not she is autistic. She then paid for a diagnosis based largely on traits which are in fact common to many people – not enjoying small talk, not liking overhead lighting and regularly eating the same meal – and believes this now explains why she has 'no friends'. [31] This is an incredibly superficial analysis, taking no account of wider life experience, and again plays into a 'them and us' approach to being human, which is entirely unrealistic.

In addition to ubiquitous mental health advice in the wider world, there are the posters and books, often prominently displayed in wellbeing hubs or 'safe spaces' in schools – books with catchy titles such as *All Dogs Have ADHD, All Cats have Asperger Syndrome* and *All Birds have Anxiety*. Not only does use of the word 'have' suggest an unnecessary degree of permanency about any difficulties a child may be facing, but yet again these struggles are simplified, and can reinforce in a child the idea that they have something 'different' about them – for which some will read 'wrong' with them – even if this is packaged playfully. This is significant because 'feeling different' is one of the primary reasons young people give for seeking help, not realising that we are all different.

It is very common, now, for a young person to arrive for a first counselling session and – when invited to tell the counsellor a little bit about themselves and their life – to describe themselves purely in terms of mental health acronyms, which they 'have'. Some may have an official diagnosis while others – when asked – will prevaricate, but assure the counsellor that they 'just know, they've done all the tests and quizzes'. They know that there is something 'wrong' with them.

29 Corzine, A and Roy, A, 'Inside the black mirror: current perspectives on the role of social media in mental illness self-diagnosis', *Discover Psychology* (15 April 2024).

30 *Op. cit.,* O'Sullivan, S (2025), *The Age of Diagnosis.*

31 Fenwick Elliott, A, 'I have autism and ADHD. Finally I understand why I have no friends', *Telegraph* (05 April 2025).

The SEND Bandwagon

As all this has unfolded, increasing cultural conformity has ensured that the tramlines of what is regarded as 'normal' have narrowed. The buzz word of the twenty-first century is 'neurodiversity' – which describes any divergence from a mythical 'neurotypical' ideal, and overlooks the wide variations in individual thinking patterns and behaviour which have, throughout history, made human beings so successful as a species. As a result, there has been a huge increase in the number of children identified as having Special Educational Needs and Disabilities (SEND).

The line between 'learning disabilities' and 'mental health issues' has also become increasingly blurred. According to the charity ADHD UK, [32] a diagnosis of ADHD, sometimes referred to as a 'learning difficulty', is listed as a 'mental health disability' under the Mental Health Act of 1990.

The National Autistic Society (NAS) tells us that 'being autistic means you may feel things and react to them differently to non-autistic people', which seems to suggest that there is a 'right' way and a 'wrong' way to react to events, without any mention of context – culture, time, place, mood or situation. It is perfectly normal for people, at times, to find socialising 'confusing and tiring', to have 'intense interests' and to prefer 'order and routine', but these are considered apparent markers for autism. At the same time, the NAS states, 'there is no single way to appear or be autistic because all autistic people are unique *[as indeed is every human being]*, and for this reason there is no sign or definitive list of signs that can tell you whether you, your child or another person is autistic'. This does not prevent the website declaring bluntly and without qualification that 'autistic people are disabled'. [33]

The addition of the D for 'disabilities' to 'special educational needs' (previously SEN) highlights the very short path down which many children now walk, from being 'different' – or failing to conform to an arbitrary developmental checklist – to being 'disabled'. The ethics of this, in terms of outcomes for children and their families – and the ensuing cost to taxpayers from government support to which they may then become entitled – are seldom discussed.

Aside from the ethics, diagnosing someone as disabled because they function differently is evidently absurd, as the following tale demonstrates:

32 ADHD UK, Access To Work (accessed 24 April 2025).

33 National Autistic Society, *What is autism?*, (accessed 02 April 2025).

> *'At the Battle of Ideas Festival in London in October 2024, I met a young man who recounted how – on moving from school in Latin America to the UK – teachers felt he must have ADHD. He was so lively, flitted from one thing to another, asked so many questions and expressed his feelings openly. On his return to school in Latin America several years later, it was assumed that he must be autistic – he repressed his feelings, would not speak openly, or make eye contact. This experience mirrors the experience of my own children, moving to a school in Latin America and then returning to school here. A huge number of careless assumptions are made in these diagnoses – personal, professional and cultural. This undermines any scientific validity.*

It is also alarming that these diagnoses disproportionately affect boys and young men. As Timimi suggests, have we forgotten that these boys 'are young, develop at different speeds, that they are more energetic, or curious, or just boys'? [34] Add in lower rates of literacy competence, concerns about 'toxic masculinity' and the concerted efforts of some to erase all differences between the sexes, plus endless online exposure to polished and perfect parenthood, is it a surprise that so many are concerned when boys behave differently? As one SEND coordinator recently told me, schools are becoming ever more like 'sausage machines' – and those machines need to keep running with as little disruption as possible.

Over 1.6 million pupils in England now have a 'special educational needs' diagnosis, up 24.9% since 2016, while the number of children with an Education, Health and Care Plan (EHCP) has risen by an astonishing 83.4% since 2016, and 11.6% in just the last year alone. [35] Children with an EHCP are deemed to need more support than is usually available through standard SEN provision, and frequently have multiple diagnoses. Together, just under 20% of school children in England currently have either have an EHCP or SEN support. In total, by November 2023, 445,000 people were in contact with children and young people's mental health services – just under twice the number in 2019. [36]

When one fifth of children are deemed to have a 'disorder', the term becomes meaningless, primarily to the disadvantage of a much smaller number living with serious, chronic and life-limiting conditions.

34 *Op. cit.,* Timimi, S (2020), *Insane Medicine.*

35 *Op. cit.,* Gov.uk, *Special Educational Needs in England, Academic Year 2023-24.*

36 Garratt K, Kirk-Wade E, Long R, *Children and young people's mental health: policy and services (England)*, House of Commons Library (26 January 2024).

WHAT HAPPENS IN SCHOOL NOW?

Before examining the ways in which schools currently address this situation – and whether or not it is effective – it is worth pausing for a moment to consider what education is for, and how our concept of the purpose of schools has changed over the last half century or so. What happens in school – both in terms of what is taught and how pupils and their learning are managed – has a significant impact on wellbeing.

The Purpose of School

As suggested by the word 'education' – derived from the Latin *educare*, meaning 'to lead out' – the original intention of schooling was to lead children from a state of ignorance, to one of understanding and knowledge upon which they could build skills for life. For generations, children were taught accumulated knowledge, drawn from the brightest and best minds which had preceded them across disciplines, along with practical skills and reasoning, all set within a moral code which underpinned the expected conduct of productive, law-abiding members of society. Faith was often an important framework for school life, each day beginning with a religiously-inspired assembly.

This is very different from the model of education experienced by many children today. 'Discovery', 'experience' and 'interpretation' are key words, along with the idea of young people 'directing their own learning'. Working collaboratively in groups and the social aspects of school have become more important, to the extent that some children see no point in going to school if they are unable to be in a lesson with their friends. There is an emphasis on skills and 'teaching children to think' rather than teaching them what to think, although as highly successful headmistress Katharine Birbalsingh has pointed out on numerous occasions, first children need a bank of knowledge from which to draw, if they are to be able to think independently and develop critical thinking skills. [37]

Schools have increasingly taken on responsibility for areas of a child's life beyond education – from the provision of breakfast clubs, to developing 'teachers' skills and confidence in supporting young people's mental health'. [38] Above all, the focus has shifted to moulding the 'right' kind of socially and politically aware citizens rather than enlightened and liberally educated individuals. Concepts such as 'critical social justice' and more recently 'critical race theory', environmental activism, 'not being judgemental', 'sex positivism' and gender ideology underpin much of what happens in school, especially in personal, social, health, citizenship and economic education (PSHCEE) lessons. In 2022, Professor Eric Kaufmann conducted research which discovered that 73% of British schoolchildren were being exposed to critical social justice-linked ideas. [39] A few years ago, National Education Union (NEU) – the UK's largest teaching union with just under half a million members – produced a document calling for 'activist training for teachers' and suggested 'critiquing the ideas and knowledge we perpetuate'. [40]

37 New Culture Forum, *Headteacher Katharine Birbalsingh: Kids need knowledge and discipline,* YouTube (6 July 2019).

38 Clarke A *et al*, *Adolescent mental health: A systematic review on the effectiveness of school-based interventions,* Early Intervention Foundation (21 July 2021).

39 Kaufmann E, 'Report: Critical Race Theory is Endemic in British Schools', *UnHerd,* 21 November 2022.

40 Somerville, E, 'Decolonise your desks, demands teaching union in 'sinister' new escalation of culture wars', *Telegraph* (3 July 2021).

Team Players

While the wellbeing of pupils has deteriorated, as outlined above, never have there been so many staff and volunteers in schools with a specific responsibility for the emotional wellbeing of pupils. A report produced jointly by school counselling charity Place2Be, together with teaching union the National Association of Head Teachers (NAHT), found that between 2016 and 2020, the number of schools commissioning support for mental health issues almost doubled. [41] From this year, all schools should now have a designated 'Senior Mental Health Lead' in place.

Educational psychologists visit schools to assess pupils and educate staff. Access to counselling is available in a majority of schools. The Department for Education (DfE) does not routinely collect data, but a survey conducted in 2017 suggested that around 85% of secondary schools offer counselling services, dropping to around 55% of primary schools. [42] These professionals are either employed by the school or contracted in, while others will be volunteers on placement, about which more later.

There are Mental Health Support Teams (MHSTs) which partner with schools, and bring in staff with varying qualifications to support students and deliver school-wide interventions. The first wave of these were commissioned in 2018–19, and as of early 2023, these covered 35% of pupils in England. There are ongoing plans to continue to expand coverage. [43] In May 2025, the government announced that the number of MHSTs would rise from 607 to 713 by March 2026, while at the same time announcing that there will be 'innovative new attendance and behaviour hubs' to tackle 'the root causes of issues resulting in disruption and chaos in classrooms'. [44]

Some within these MHSTs may be Education Mental Health Practitioners (EMHPs), a new role created in 2019; for over twenty years now, Emotional Literacy Support Assistants (ELSAs) have supported pupil wellbeing in school; and there are also school-based Parent Family Support Advisers (PFSAs) to assist and advise families going through tough times. There are Mental Health First Aiders (MHFAs) who offer initial support to those who are struggling and Psychological First Aiders (PFAs) who aim to reduce the impact of traumatic events.

The training required to hold these positions is very varied, from post-graduate clinically experienced psychologists and professionally-registered counsellors, to volunteers in training. EMHPs have 60 days of training spread across a year, plus work-based placements and self-study. [45] ELSAs receive six days of training with an educational psychologist. [46] Studying online for an hour a week for three weeks on a course produced by Public Health England qualifies staff as Psychological First Aiders to 'support children and young people's mental health after emergency and crisis situations'. [47]

41 NAHT and Place2Be, *Huge rise in number of school-based counsellors over past three years* (3 February 2020).
42 UK Parliament, *Provision of school-based counselling services*, House of Commons Library (05 November 2021).
43 NHS, *Mental Health* (accessed 30 January 2025).
44 Wood P, 'Children to be taught to show some grit', *Telegraph* (16 May 2025).
45 NHS, *Health Careers* (accessed 30 January 2025).
46 ELSA Network.
47 FutureLearn, *Psychological First Aid: Supporting Children and Young People* (accessed 20 March 2025).

Additionally, some schools have access to specialist services to address issues such as drug and alcohol abuse, while many charities and other campaign groups offer resources for lessons and assemblies.

It is fair to say that currently, there is no shortage of adults trained in various aspects of mental health care and wellbeing currently working within schools – even as rates of 'mental illness' continue to rise.

Accommodation and Alienation

In addition to specialist staff, a number of measures can be taken within schools, to accommodate children's difficulties and desires. While these are supposed to be implemented only in exceptional circumstances, they are increasingly commonplace.

Some pupils do not attend school full-time; some have a limited timetable; others have 'exit' passes, allowing them to leave a lesson without notice if they feel 'triggered' or overwhelmed in any way. Special provision is made at exam time, for those who feel that they cannot sit in the main exam hall. Arrangements can also be made for pupils to take exams at home if necessary, often involving multiple adults, if the young person also needs support in reading the questions or writing down the answers.

In these situations, the young people with whom I have worked have universally explained that they 'can't' do what is being required of them, and therefore they both need and expect special arrangements to be made for them. There is little willingness to try to overcome these limitations. The views of staff and parents are generally divided over these measures.

Some feel that they are very necessary, and the only way in which a child can attend school avoiding further disruption – both of the child's education and of other students. Others recognise that these measures are open to manipulation and believe that feelings and behaviour which should be challenged in order to build resilience, are instead being indulged. Many of the latter group highlight that in the 'real world' such accommodation will not necessarily be possible – although with the expansion of our understanding of disability, and protections against discrimination under the provisions of the Equality Act 2010, employers are finding this is in fact a requirement. One example recently brought to my attention concerned the requirement for colleagues to email a co-worker before ever addressing her in face-to-face conversation, or telephoning her, to avoid her suffering a panic attack.

BRINGING IN THE PROFESSIONALS

With so much support in place already, the demand for 'a mental health professional in every school' is widely understood to mean the imposition of a legal requirement for schools to employ a qualified counsellor (or use a counselling service), and for this to be fully funded by the Government. The BACP was specific about this in their 2024 election 'manifesto'. Currently, there is no legal requirement in England for schools to provide this, although such provision is made in Scotland, Wales and Northern Ireland.

The BACP recently offered two possible models for this: the commissioning of independent counselling services, via a local authority funding model (as happens in the other UK nations); or an extension of the MHST approach, which would include a 'step-up to counselling'. According to the BACP, 82% of parents with children aged four to seventeen 'believe counselling or psychotherapy should be freely available to all school children, throughout all schools'. [48]

Several points need to be considered in relation to this proposal.

Counselling in School – the Pros and Cons

While some young people are relieved and pleased to start counselling, and can undoubtedly benefit from it, for some it merely reinforces the erroneous idea that they are irretrievably 'broken'. Others are more cautious or hostile to the idea, not wanting to be 'forced' to talk. It is important never to underestimate how strange it is to be expected to talk on cue about difficult things with a complete stranger. There can also be concerns about confidentiality being maintained with other staff, and also about their friends – or enemies – knowing about sessions (for reasons of safeguarding, most doors in schools have glass panels). The absence of children from lessons is noted, and may need to be explained.

Demand to see a counsellor is likely to continue to outstrip supply. There is usually a waiting list in schools. The group 'identity' element involved in diagnoses, leads to a degree of competition between students over who is 'worse'. This is already the case where medication is concerned, and dosages are regularly compared in school corridors. I have also witnessed this in connection with therapy – seeing a counsellor can have kudos. Some studies have suggested focussing resources on more vulnerable groups, but have noted that this can lead to 'marginalising the vulnerable', which could also do more harm than good. [49]

To address demand, the number of sessions available to each student is limited – usually to somewhere between six and 10 sessions per student. While this can be helpful, where issues are deeper and more complex, it is barely possible to scratch the surface in such a time frame.

48 BACP, *School Counselling in England campaign* (14 February 2025).

49 *Op. cit.*, Clarke A *et al* (21 July 2021).

A relationship of trust is the key to successful therapy, and it is quite common to have established a degree of trust with a child – and to feel that some progress is being made – just as the standard number of sessions comes to an end. Rather than being helpful, this can feel like a betrayal and reinforce beliefs that adults don't actually care, but are merely 'going through the motions' in trying to help. This supports an argument for more targeted, long-term intervention, tailored to individual needs – and including provision during school holidays – rather than simply a 'mental health professional' in every school.

Practitioners working as part of a MHST are most likely to offer Cognitive Behavioural Therapy (CBT), 'which has emerged as the grand emperor of psychotherapies'. [50] The reason for this rests on the modality's emphasis on thinking patterns, its methodological approach and use of questionnaires, which can be easily assessed and evaluated. Again, it can be very helpful for addressing specific issues, but does not necessarily offer the depth of other modalities. Children experiencing the highest levels of emotional distress and turmoil in their lives require something more substantial than routine interventions in school for a few weeks.

As well as benefiting mental health, the BACP cites a long-term financial incentive to expand school counselling. The Association, together with Citizens UK, commissioned Public First to write a report on the economic benefits of investment in school counselling which found that for every £1 spent on school counselling there was a return of £8 in secondary schools and a return of £10 in primary schools. [51] This claim is extraordinarily hard to verify. I will expand on it below.

Who are the Counsellors?

If we propose to put a counsellor in every school, it is important to understand some basic facts about the counselling profession.

'Counsellor' and 'psychotherapist' are both titles which are currently unprotected in UK law. In other words, anyone can call themselves a counsellor or psychotherapist. Added to this, at the last count, there were over five hundred different modalities of therapy, with new approaches being developed all the time. Many of these are very similar, but use different terms; some are very different.

While the profession is unregulated, therapists have the option of joining a number of different membership bodies – some general, and some relating to a specific therapeutic approach. To join these organisations, practitioners must hold a recognised qualification (or be working towards one), as well as having insurance and regular supervision and a commitment to continuing professional development. Often, joining the membership body is a prerequisite for enrolling on a course, and some courses are accredited by a membership body.

50 *Op. cit.*, Timimi, S (2025), *Searching for Normal.*

51 Public First, *The Case for Counselling in Schools and Colleges – A socioeconomic impact assessment* (June 2024).

While not regulatory bodies, over time – in the absence of any other oversight – these membership organisations have become holders of registers of members for the Professional Standards Authority (PSA). This is a government-backed initiative that ensures professional bodies maintain 'rigorous standards of practice, ethics and public protection'. [52]

No doubt counsellors working in schools would be required to be registered, if not accredited – and would therefore be working in schools ethically and safely at all times, or face censure from their membership organisation. However, as has happened with so many other organisations and institutions, there has been an almost wholesale take-over of counselling and psychotherapy membership bodies by critical social justice theory. This encompasses critical race theory and gender ideology, both of which are already an issue within schools.

The Influence of Critical Social Justice Theory

Many counsellors today no longer see focussing on their client, and exploring their client's world, as their primary role. Instead, the approach is to view the person through the ideological lens of the oppressed versus the oppressors, heteronormativity, victimhood and intersectionality.

For example, gender-related issues continue to be significant in school. The current approach endorsed by therapists appears to be largely to accept unquestioningly a child's beliefs about themselves. To illustrate the irresponsibility of this approach, imagine carelessly affirming the beliefs of a young person whose discomfort with their body manifested as anorexia.

One practitioner, writing on the BACP website, simply asks 'what it would be like if schools celebrated trans kids', [53] despite the known risks to psychological, emotional and ultimately physical health of transitioning, and the common comorbidities associated with 'trans' identification. Any suggestion of a more curious and cautious approach is regarded as 'negative'. There is talk of children learning to 'grow and develop into themselves', without acknowledging that they are in fact being encouraged to try to be someone that they never can actually be, as the recent Supreme Court ruling confirmed.

A substantial majority of the gender-questioning young people – mainly girls – with whom I have worked have suffered or witnessed domestic violence, or extreme and degrading porngraphy. As a result, in their acute distress, they have come to the conclusion they must 'identify out' of becoming a woman or a man, if what they have seen is indicative of what it means to be an adult male or female. Many would rather opt-out of adult life altogether, and becoming 'non-binary' offers that option. Most also find themselves trapped outside increasingly rigid and reductive stereotypes of what it means to be male or female, or experience same-sex attraction, leading them to believe that they must have been 'born in the wrong body' – a view encouraged by gender ideology. It takes time, skill, trust and patience for their stories to emerge.

52 BACP, *Professional Standards Authority reaccredits BACP* (28 February 2025).

53 Anonymous blog, *Schools guidance on gender-questioning children,* BACP (7 March 2024).

In a significant oversight, astonishingly the BACP has yet to comment on the landmark *Cass Review*, the independent review of gender identity services for children and young people, maintaining that 'our members have no role in these medical interventions'.[54] This is despite the report finding that in the best interests of children, 'most clinical teams would still see psychological interventions as the starting point in a care pathway'.[55] Members' efforts to counter the 'affirmative' approach to gender confusion have largely been rebuffed.

Over thirty organisations, including the BACP, are signatories to the Memorandum of Understanding on Conversion Therapy (MoU). This document seeks to outlaw 'conversion therapy' within the UK. Significantly – and highly unusually – this document fails to make any distinction between working with adults and with children, and does not distinguish between addressing sexuality and gender confusion, which are two very different things. The MoU tells us that, 'for people who are unhappy about their sexual orientation or their gender identity, there may be grounds for exploring therapeutic options'.[56] However, where a young person claims to be certain – and many in early adolescence claim to be certain – standard exploratory therapy is increasingly likely to be interpreted as 'conversion therapy'.

The United Kingdom Council for Psychotherapy (UKCP) bravely left the MoU in April 2024, on the grounds of 'concerns around child safety'.[57] This led to great upheaval within the organisation, attempts to unseat the Board of Trustees (which failed) and the resignation under enormous pressure of the UKCP Chair. The BACP, meanwhile, remains committed to this highly questionable approach.

More generally, the BACP's *Good Practice across the Counselling Professions* guide to 'gender, sexual and relationship diversity' (GSRD) seeks to undermine 'heteronormativity'. It challenges widely accepted and biologically accurate definitions of sex, asserting that sex is 'assigned' at birth, and adopts the term 'cisgender'. The practice guide later moves on to address, among other things, 'kinkphobia' and outlines the circumstances in which 'kink affirmative therapy can be very helpful' before declaring that some people 'find their kink practices to be healing'.[58] The author has non-binary pronouns and 'has published hundreds of academic books and papers on topics including non-monogamous relationships, sadomasochism, counselling and mindfulness'.

Currently, the BACP is also engaged in updating its Ethical Framework, to which all members are committed. 'Decolonising ethics provides us with opportunities for re-evaluating and reimagining ethical perspectives', write those responsible for the revision. They continue, 'primarily, it challenges the traditional Eurocentric framework of ethics and encourages a more inclusive and culturally sensitive approach'.[59] This reflects changes to the newest edition of the DSM. The latest revision included a work group on ethnoracial equity and inclusion, so that appropriate attention was paid to 'risk factors like racism and discrimination and the use of non-stigmatizing language'.[60]

54 BACP, personal communication (02 May 2024).

55 Cass, H, *Independent review of gender identity services for children and young people: Final Report* (April 2024).

56 BACP, *Memorandum of Understanding on Conversion Therapy in the UK – Version 2* (July 2024).

57 UKCP, *UKCP update on conversion therapy* (5 April 2024).

58 Barker, M-J, *Gender Sexual and Relationship Diversity (GSRD)*, BACP (April 2019).

59 Morahan, M and Reeves, A, 'Reshaping the Ethical Framework', *BACP Therapy Today* (March 2024).

60 American Psychiatric Association, *About DSM-V-TR* (accessed 12 February 2025).

In their 2024 Election Manifesto, even the Royal College of Psychiatrists asserted that 'the climate and ecological crisis poses a catastrophic threat to public mental health and is already leading to an increase in the prevalence of mental illness and exacerbating pre-existing mental illness'. [61] Just as people are encouraged to look inwards as never before, and vital social and community bonds are intolerably strained, controversial socio-political factors are being blamed for our unease.

In advocating for a counsellor in every school, it is worth considering that many school counsellors, or mental health professionals going into schools, will be influenced by these ideas and may be committed to them – inadvertently or otherwise – through membership of a professional body. Do we want more of this in our schools?

The Volunteers

Although the BACP would like to see qualified counsellors in schools, based on current practice, it is highly likely for structural reasons that many counsellors will be volunteers, and possibly not yet qualified. Counselling training models ensure this, as trainees must complete a certain number of placement hours in order to qualify, usually between 100 and 150 hours. These are generally unpaid, because organisations know trainees need the work in order to progress to qualification and to be registered.

After qualification, there can be an additional hurdle – officially voluntary, but many employers now require it. This is 'accreditation', which requires 450 hours of experience. Often, the easiest way to achieve this is further voluntary work. Some counsellors move straight into private practice to avoid this. An article in the BACP's magazine *Therapy Today* explains that 'although originally devised as a gold standard to mark experienced practitioners, in recent years accreditation has come to be seen by many employers as a minimum standard'. [62]

Views on this are fiercely divided, with some practitioners feeling that to be qualified is enough (as it is in many other professions), while others feel additional hours of experience are necessary. There is an acknowledgement that in that situation, counsellors are subsidising provision with 'their own free labour' and that some 'services would not be viable without volunteers'. To illustrate the scale of the issue, a successful campaigning group, Counsellors Together UK, was formed by the late Maria Albertsen in 2017 to 'end the culture and prevalence of unpaid work in the profession'. [63] Today Counsellors Together UK has 10,000 members.

61 Royal College of Psychiatrists, *Preventing mental Illness: Our manifesto for the next UK General Election* (2024).

62 Brown, S, 'Working for free', *BACP Therapy Today* (2 April 2018).

63 Counsellors Together UK.

Strangely, therefore, the business model of a counselling organisation can rest on the core work being done by an endless supply of volunteers, who need hours, while all other staff are paid. For example, high profile school counselling charity Place2Be uses 'skilled volunteers' to work alongside clinicians delivering services for which schools pay. Typically these volunteers commit to working one day per week in term-time, over the course of a year. This is despite the charity having an income of almost £25 million in the year to 31 March 2024, and 27 government contracts. According to the Charity Commission data, almost half of those working for Place2Be were volunteers, while 16 employees were earning over £60,000 per annum, including one on a salary of over £100,000. [64]

It is worth considering whether or not counsellors in school will be qualified and being paid, or will be unpaid trainees on placement. This is not always immediately clear when 'counsellor' is an unprotected title. It will be important to ensure that schools do not become embroiled in the politics – and possible exploitation – inherent in the counselling industry.

Third Parties

As is illustrated above, mental health and wellbeing services in schools can be contracted in from external providers. Some of these organisations might better be described as 'activist' or campaign groups, rather than experts in their field. There is increasing concern that this undermines accountability, as school staff may not be directly involved in the delivery of services or the production of materials. Questions have also been raised about the suitability of a one-size-fits-all approach to 'whole school' initiatives, where mental health and wellbeing is broached in assemblies or through targeted activities in class, of which parents may not be fully aware.

We need to be aware that 'there has never been a generation of young people so colonised at such a young age by mental health propaganda'. [65] While prompting some young people to seek much-needed help, it may have a detrimental effect on others.

FOLLOW THE MONEY

Government Expenditure

As will have become clear, there is a huge amount of money in the provision of mental health services, even if not directly for some of the counsellors involved. In the Green Paper in 2017, the then-Government reiterated their commitment to spend £1.4 billion on children and young people's mental health over the following five years. [66] By 2023-24, projected spending was £1.1 billion for that year alone, excluding funding for treating eating disorders, up from confirmed spending of £1 billion the previous year. [67]

64 Charity Commission, Place2Be.

65 *Op. cit.*, Timimi, S (2025), *Searching for Normal.*

66 Department of Health/Department for Education, *Transforming Children and Young People's Mental Health Provision: a Green paper,* HMSO, December 2017.

67 Garratt K, Kirk-Wade E, Long R, *Children and young people's mental health: policy and services (England)*, House of Commons Library (26 January 2024).

Big Business

Mental health charities now manage huge budgets. Mind's income in the year to 31 March 2023 was £59 million; Rethink Mental Illness received £40 million; Young Minds had an income of £6 million. To complicate matters, some of this, however, comes from government contracts. For example, in the years mentioned above, almost £24 million of Rethink Mental Illness's £40 million income came from 105 government contracts, with a further £193,000 from government grants. The charity Barnardo's, meanwhile, was operating 12 of the MHSTs in January 2023.

There are also the independent providers of all the related products – the 'assessment protocols, questionnaires, medications, courses, books, experts, institutes, therapies, support groups and so on' referenced by Timimi. [68] As waiting lists grow for NHS diagnosis, so a plethora of private providers has sprung up to address parental concern and juvenile distress.

Picking a website at random, I took a short multiple choice quiz in a couple of minutes, and was able to establish that 'my results are highly consistent with ADHD'. A message below read 'we recommend speaking to a healthcare professional'. Their contact details were offered. They explained that without a diagnosis, 'we cannot offer you support and treatment that can make a huge difference'. This particular provider charges £995 to assess a child for ADHD and £2,250 for an autism assessment. There are opportunities offered to spend a great deal more money on additional services. [69] This is not unusual.

We now have what Dr Timimi and others call a 'mental health industrial complex'. Timimi explains that 'psychiatric diagnoses are not diagnoses – they are marketable brands. Each brand has a collection of products that sit within its field'. [70] He is not alone in noticing this. As a paper published last year in *Discover Psychology* showed, 'psychiatric diagnoses have evolved beyond categorizing patients but have become interwoven within the societal blueprint of our consumer-driven healthcare system'. [71]

This situation is evidently of increasing concern. In answer to a question at a recent conference for General Practitioners, Primary Care Minister Stephen Kinnock said he was 'very worried that there are diagnoses being given out by the private independent sector which are not rooted in clinical expertise'. He acknowledged that 'demand just continues to go through the roof'. [72]

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68 *Op. cit.,* Timimi, S (2025), *Searching for Normal.*

69 Clinical Partners (accessed 03 April 2025).

70 *Op. cit.,* Timimi, S (2025), *Searching for Normal.*

71 Corzine, A and Roy, A, 'Inside the black mirror: current perspectives on the role of social media in mental illness self-diagnosis', *Discover Psychology* (15 April 2024).

72 Kaffash, J, 'Minister announces crackdown on private sector therapists at Pulse conference', *Pulse* (19 March 2025).

Squeezing till the PIPs Squeak

There is also money available for educational establishments and individuals. Schools receive additional funding for students with Education, Health and Care plans (EHCPs). Individuals aged 16 and over, regardless of income, can apply for Personal Independence Payments (PIPs) to help with extra living costs arising from long-term mental health conditions, as well as physical illnesses. Younger teenagers and children can access Disability Living Allowance (DLA). For some families, there is a clear financial benefit in having a child diagnosed with a 'disorder' which can be classified as a 'disability'. [73]

ARE CURRENT INTERVENTIONS RESULTING IN AN IMPROVEMENT?

The government has recently reiterated its promise to provide access to mental health support in school for every child who needs it, and ministers insist that they 'are following proven methods that work'. [74] However, the most pressing question has to be – are these measures actually improving the wellbeing of children and young people? The short answer, in general terms, must be 'no'. At best, 'there are mixed results on the success of psychological interventions delivered in school settings'. [75] It is clear that while more resources than ever before are being expended on mental health, the situation appears to be getting worse year on year. Increasing numbers of children and young people are receiving mental health diagnoses or feel themselves to be mentally unwell.

Assessing the Success or Failure of Interventions

Again, most commonly, we are reliant upon subjective assessment, often interwoven once more with 'lived experience'. Many questions about wellbeing are open to different interpretations and allow little room for nuance. For example, using one assessment tool for emotional literacy, young people are asked to state how much they agree with the following statement, 'I calm down quickly after I have got upset?'. The options for reply are that it is: 'very like me', 'quite like me', 'only a bit like me' and 'not at all like me'. [76] Almost all young people when given that task will say, 'Well, it depends – on what I am upset about and who has upset me'. Hearing that their parents are about to separate is very different from a classmate pouring water in their pencil case.

73 Gov.uk, *Personal Independence Payments (PIP)*.

74 Philipson B and Streeting W, 'We will intervene early to help struggling children', *Telegraph* (16 May 2025).

75 Lisk S *et al*, 'Brief Educational Workshops in Secondary Schools Trial (BESST): a cluster randomised controlled trial. Secondary analysis in those with elevated symptoms of depression', *BMJ Ment Health*, 29 August 2024;27(1):e301192. doi: 10.1136/bmjment-2024-301192. PMID: 39209761; PMCID: PMC11367360.

76 *Emotional Literacy: Assessment and Intervention – Ages 11 to 16*, GL Assessment Limited (2003).

Some research has been done into the success or otherwise of various programmes implemented in schools. However, if 'mental health' is difficult to define, and diagnosis of mental illness is highly subjective, assessing the success of programmes is not going to be straightforward. Whether it is projected savings resulting from early intervention, or increased tax revenues from mentally healthier adults, many assessments of success admit that projected outcomes rest on modelling and assumptions, rather than actual data.

A report on the Brief Educational Workshops in Secondary School Trial (BESST), looking at the effectiveness of a brief self-referral CBT stress workshop programme for sixth formers, found it had been able 'to both reach and significantly assist with elevated depressive symptoms both clinically and cost-effectively'. However, it noted that assessments were based on self-reports rather than clinical evaluation, and stressed the importance of assessing whether or not 'positive outcomes remain after a longer period'. The paper also noted that other studies have shown 'iatrogenic effects of mental health interventions in young people'. [77]

Here Today, Gone Tomorrow

For reasons outlined above, at best, assessment of individuals can only supply a snapshot of a particular moment in time. With children and young people, whose moods and feelings naturally fluctuate, doing the assessment on a different day of the week, or at a different time of the day, can result in entirely different scores. This is before assessors account for young people who play the system – who know what answer to give, to achieve the desired result (often after being carefully coached by 'influencers' in real life or online).

It is worth, then, looking at what mental health interventions in school offer. First, there are 'whole school' initiatives. There is a school of thought which says that by making young people aware of mental health issues, and openly discussing different common difficulties, taboos are broken and wellbeing will be improved.

However, speaking recently in an interview about his new book, *No More Normal: Mental Health in an Age of Over-Diagnosis*, Dr Alastair Santhouse, a neuropsychiatrist working at the Maudsley Hospital in London, explained that 'the more people are aware of a particular illness, the more people start to identify with the symptoms'. [78] If whole year groups in school have assemblies on mental health issues, it is inevitable that some present who may previously have been unbothered, will start to wonder if passing feelings are more significant than they actually are, as everything is interpreted through a therapeutic lens.

77 *Op. cit.,* Lisk S *et al*, *Brief Educational Workshops in Secondary Schools Trial* (2024).

78 Shirref, L, 'Are we over-diagnosing our mental health? This psychiatrist thinks so', *Telegraph* (31 March 2025).

In her book, *Bad Therapy*, Abigail Shrier highlights another issue. Checking-in on emotions tends to induce a *state orientation*, which affects a child's ability to do what they need to do in school, as they focus on themselves. She explains how an individual is far more likely to get things done if they adopt a task orientation – in other words, it is more productive for a person to focus on the job in hand than hone in on their own feelings. [79]

Some years ago, the Mental Health Foundation pioneered a Peer Education Project in secondary schools, a school-based, peer-led intervention designed to support secondary school students to develop skills and knowledge to safeguard their mental health and that of their peers. The evaluation found, however, that while some pupils appreciated peer support, 'the intervention might also lead to an *increase* [their italics] in reporting, potentially 'cancelling out' reduced difficulties among some students'. [80]

Certainly, not all parents are supportive of these approaches. As long ago as 2016, a Scottish council apologised to a mother whose seven-year-old daughter was given 'unwanted mental health counselling at primary school'. Following an assembly with a presentation, a project worker visited classrooms 'to encourage pupils to share their worries'. The child's mother felt that this happened 'without proper consultation and parents were led to believe it was just to deal with bullying issues, but it is much more than that'. She continued, 'I'd question why parents have to opt their children out of a third sector therapy scheme when it should be an opt-in to ensure proper informed consent'. [81]

How About the Mental Health Support Teams?

Early evaluation of the MHST Trailblazer programme, published in 2021, found 'a clear and strong rationale for the programme's investment in mental health prevention and support within educational settings'. Interestingly, however, researchers noted a 'divergence in views and opinions between the quantitative and qualitative findings'. The quantitative evaluation, reliant on questionnaires which focused on people's expectations and intentions, were overwhelmingly positive. Qualitative feedback, focussed on the day-to-day reality of delivering MHST services, 'were more critical and point to difficult challenges in the programme'. There was a strong feeling from those who participated in initial research that for the programme to have maximum impact, it must enhance mental health provision for those who need it most. [82]

Even as Mental Health Support Teams (MHSTs) continue to be rolled out, whether or not they offer the answer to the youth mental health crisis remains unclear. A report to ascertain the impact of MHSTs, published in the Journal of Mental Health two years later, found that interviewees universally welcomed their creation but felt there was 'a lack of clarity about their purpose'. [83]

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79 *Op. cit.,* Shrier, A (2024), *Bad Therapy: Why the kids aren't growing up.*

80 Zamperoni V and Deighton J, 'Evaluating the Peer Education Project in secondary schools', *Journal of Public Mental Health* (January 2019).

81 Preuss, A, 'Mother of girl, 7, given unwanted counselling at school gets apology from council', *The Express* (31 July 2016).

82 Ellins, J *et al,* *Early Evaluation of the Children and Young People's Mental Health Trailblazer Programme*, University of Birmingham (July 2021).

83 Ellins, J *et al*, 'Implementing mental health support teams in schools and colleges: the perspectives of programme implementers and service providers', *Journal of Mental Health* 2024, Vol 33, No 6 714-720 (25 August 2023).

Those interviewed had concerns that the standardised Cognitive Behavioural Therapy (CBT) interventions being offered were not working well for some children. This is reflected in a report from Barnardo's. [84] The charity found an average improvement of 57% across a range of symptoms, including low mood and anxiety, but also stated practitioners identified 'the complexity of children and young people's support needs as a factor affecting how effective CBT can be'.

The MHST's remit to address mild-to-moderate difficulties appears to be an ongoing issue. Schools felt that MHSTs were offering 'more of the same' at a time when 'help for children with more complex mental health problems presented a greater need'. Mention was made of there being nowhere to refer children, whose needs exceeded school provision, but did not meet the threshold for NHS Child and Adolescent Mental Health Services (CAMHS), resulting in more children falling between the gaps. These are young people for whom, ideally, an integrated and ongoing care plan is needed.

Part of the difficulty may lie in the two different interpretations of the purpose of MHSTs – that they are either an extension of children's mental health services into new settings, or exist to promote wellbeing more generally in schools. The study published in the Journal of Mental Health, found that around half of the teams' time was spent on one-to-one interventions, with the rest of the time spent on 'whole school' approaches, giving advice and liaising with other services. The purpose of MHSTs perhaps needs to be redefined, enabling them to concentrate resources year-round on those in greatest need.

There are some indications that the government may be addressing this, with the recent announcement of a rapid expansion of provision, to ensure more provision of one-to-one support for pupils who fall below the threshold for other services. If this is the case, there may well be a case for including qualified counsellors in every team to work specifically with these children, but over a longer time-frame and using a variety of different modalities, which are appropriate for each individual.

Retention of EMHPs is proving problematic, apparently because of their workload and lack of career progression. As a result, 'there was a widespread view that the programme must prioritise the issue of career development and progression opportunities for EMPHs, to reduce attrition and promote workforce stability'. If, however, the programme is going to prioritise the needs of the adult workforce over the needs of the young people, for whose assistance it was created, that is not a good sign. Continuity and consistency are important elements of mental health services for children, given that building a good working relationship is key to the effectiveness of any therapy.

84 Barnardo's, *It's Hard to Talk: Expanding Mental Health Teams in Education* (December 2022).

Mind out for Mindfulness

Teaching mindfulness is widely regarded as helpful, as it enables people to live in the moment, taking notice only of what is happening in the here and now. This in turn can help improve emotional regulation, a vital skill, with which many young people struggle. For this reason, there is an argument for schools implementing mindfulness-based programmes because skills taught 'naturally complement a variety of learning objectives'. [85] A study published last year in the BMJ Mental Health found that 'social-emotional learning curricula, when implemented with care, can result in positive outcomes'. [86]

However, in 2023, a paper published in a peer-reviewed journal owned by the Royal College of Psychiatrists (RCP) found that, 'a recent trial assessing mindfulness lessons in secondary schools found that overall there was no change in depressive symptoms in the intervention (or control) group, but that adolescents with elevated levels of mental health symptoms at baseline experienced a small increase in depressive symptoms after the intervention'. [87] The BMJ Mental Health study made similar findings.

The RCP paper suggests that school-based interventions inadvertently encourage adolescents to 'ruminate on their negative thoughts and emotions'. Adolescents are especially susceptible to peer influence and school-based mental health interventions often occur in groups, in which young people can influence each other's negative moods as well as learn problematic behaviour from each other. The paper states that 'we should be very cautious about the idea that providing any mental health intervention in a school is always better than not providing one at all'.

On occasion, I have witnessed serious adverse responses to mindful interventions in school. Some children, when asked to close their eyes or focus on their senses or their breathing, can suffer a trauma-induced response, involving flash-backs and panic attacks. Any school-wide interventions of this kind need to take the possibility of adverse reactions in some young people into account and plan accordingly.

Double-edged Sword

CBT and Mindfulness are not the only options. Schools are currently offering a variety of interventions. In February 2025, the Department for Education published a report about pupil perspectives on different programmes offered in primary and secondary schools. While students reported feeling more connected and knowledgeable about each other's lives and mental health challenges, participants also felt 'that reflecting on their own mental health and learning about unsafe situations could provoke anxiety'.

85 Jobin K *et al*, 'Mindfulness-based interventions for enhancing adolescent mental health and well-being: A scoping review', *Clinical Epidemiology and Global Health*, Vol 32, March-April 2025.

86 *Op. cit.,* Lisk S *et al*, *Brief Educational Workshops in Secondary Schools Trial* (2024).

87 Foulkes, L and Stringaris A, 'Do no harm: can school mental health interventions cause iatrogenic harm?', *BJPsych Bulletin* 47(5):267-269, October 2023doi: 10.1192/bjb.2023.9. PMID: 36843444; PMCID: PMC10764817.

Quantitative findings from two programmes found that, while there were some benefits, neither Youth Aware of Mental Health (YAM) or alternative programme The Guide 'are recommended interventions for English secondary schools due to potential negative effects in the longer term that warrant further exploration'. [88]

In a different paper, the Early Intervention Foundation argues that there is 'an urgent need for high quality school-based support to address young people's mental health and behavioural needs', despite finding 'substantial gaps' in evidence for the effectiveness of these interventions, and reporting that long-term follow up shows no consistency in results. [89]

It would appear that we can tinker around the edges of the problem, but something more fundamental is required to see a wholesale change and improve the lives of those children suffering most acutely.

What About the Economics?

An economic evaluation of Place2Be's Counselling Service in primary schools generated headlines in 2018, with the assertion that every £1 invested in the service in 2016-2017 results in benefits of £6.20 in terms of improved long-term outcomes. If this is correct, it would suggest that the programme is impressively successful.

It is necessary, however, to question these findings – three of the four approaches to quantifying the benefits of universal counselling provision start with the word 'assume'. The report acknowledges the 'relative lack of a comparable evidence base on the impact of secondary school or college-based counselling, or the likely impact of demand for CYPMHS [Children and Young People's Mental Health Services]'. The findings are based on modelling, and gains to the Exchequer in the form of 'a lower welfare bill', when we know that currently that bill is seeing a steep increase, and is projected to rise further in future. [90]

The report acknowledges that 'cost and benefit figures are estimates that are based on several assumptions and uncertainties' and confirms that 'the extent to which improvements in mental health are sustained after counselling is uncertain'. [91]

In an update on this report in 2022, even while acknowledging that 'mental health in our schools is continuing to worsen' the Place2Be programme was estimated to generate £8 in benefits for every £1 spent, even as the cost of delivering the programme rose from £923 per child to an average £1,100 per child. [92] Again, Place2Be captures mental outcomes using the Strengths and Difficulties Questionnaire (SDQ), which presents the same challenges with regard to subjectivity as outlined above – perhaps even more so with primary-aged children. [93]

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88 Department for Education, *Pupil perspectives on school mental health literacy interventions* (February 2025).

89 *Op. cit.,* Clarke A *et al* (21 July 2021).

90 Public First, *The Case for Counselling in Schools and Colleges - A socioeconomic impact assessment* (June 2024).

91 Pro Bono, *Economic evaluation of Place2Be's Counselling Service in Primary Schools* (2018).

92 Gomez, R, *Place2Be's one-to-one counselling service in UK primary schools: an updated cost-benefit analysis*, Pro Bono Economics (June 2022).

93 Anna Freud, *Mentally Healthy Schools* (accessed 4 April 2025).

SO WHAT IS GOING ON?

It would appear that, as a society, we have a very large, complex and growing problem on our hands, and very little idea of how to solve it. A less charitable view is that we lack the courage or conviction to look beneath the surface of the 'mental health crisis' and address some difficult and controversial aspects of the way we live today, and the impact that this is having on our children.

Individuality

At every counselling session I have ever offered, I have expected to meet an individual – someone who is unlike anyone else I have previously met. Of course, people share experiences; there are basic but broad patterns in behaviour; but no two people are the same, react in the same way or – most importantly – have the same story to tell. I have never looked at a young person through the lens of a 'diagnosis', even when one has been offered, by school, parents or the individual themselves – I simply take them as I find them, and we go from there. I have yet to work with a young person who obviously has something 'wrong' with them, other than understandable distress arising out of their experiences, environment and relationships.

To me, this is extraordinary. To be clear – I have yet to find a child who 'has ADHD' to be hyperactive or lack attention; neither have I worked with an 'autistic' child who had challenges in communication with me, or any of the host of ambiguous 'symptoms' attributed to these conditions, the vast majority of which are nothing other than largely normal variations in human 'being'. As we shall see below, the roots of much challenging behaviour associated with these 'disorders' is likely to lie elsewhere, not in some form of 'neurodiversity'.

Conformity

Conversely, while we have more options than ever before – and diversity, equity and inclusion dominate everything – we live in an age of extraordinary conformity. We are expected to fit into boxes, describe ourselves fully through multiple choice questionnaires, use the right language and opt for 'either/or' rather than the 'both/and', which is a far better descriptor for most people.

We are individuals, each of intrinsic worth and all of equal value – but we are different. As human beings we also have well-documented needs and in the case of too many children, these are not being adequately addressed in school or at home. This being the case, we should not be surprised about the scale of the problem we face.

Emotional Regulation

As is evidenced simply by looking around at behaviour in the wider world, we are witnessing a crisis in our ability to regulate ourselves emotionally. Among many other challenges, we have 'road rage' and 'air rage'; we have people threatening violence those who have different views and values; and we have teachers being assaulted in the classroom. Being able to manage our feelings – and respond appropriately in any given situation – is a vital life skill we learn, ideally from our primary care-givers in our earliest years.

Children need a loving, responsible and responsive adult to model this for them. With a breakdown in meaningful family relationships, this is not happening as it should. The Early Intervention Foundation found that good social and emotional skills can reduce symptoms of depression and anxiety, and states that 'it is essential to support the development of social, emotional and behavioural competencies at a universal level. A growing body of evidence indicates this is a key determinant to young people's mental health and wellbeing'. [94] However, this learning happens most effectively in the home in the very early years.

One definition of madness is doing the same thing over and over again, and expecting a different result. Instead of trying new methods to pull floundering children out of the river downstream, we should perhaps be taking a walk upstream to see where they are falling in – and take measures to prevent this from happening.

FINDING THE ANSWERS

The acute suffering of many young people arises perfectly understandably from their adverse experiences, environment and relationships. Nurture, in fact, shapes nature. [95] We need to take a clear-eyed look at where we are going wrong, and not focus on what is allegedly 'wrong' with our children.

Primarily, children and young people are curious, creative and imaginative individuals. They learn by example, and need adult guidance, support and 'containment' in order to grow healthily. Above all, children need connection and secure attachment, with at least one loving, consistent, responsible and responsive care-giver from birth. As studies from Harvard University demonstrate, 'responsive relationships with adults have a double benefit, both promoting healthy brain development and providing buffering protection needed to prevent very challenging experiences from producing a toxic stress response'. [96] It is these healthy relationships, now so sadly lacking, which are the best protection against 'mental illness' further down the line.

94 *Op. cit.,* Clarke A *et al* (21 July 2021).

95 Harvard Center on the Developing Child, *Epigenetics and Child Development: How Children's Experiences Affect Their Genes* (19 February 2019).

96 Cohen, S, *Science to Policy and Practice*, Center on the Developing Child – Harvard University (October 2017).

Currently, we are rushing to treat and manage the 'symptoms' of our children's distress. Our lack of curiosity about its origins risks overlooking their suffering and leaving their story untold. Ultimately, it means we are unlikely to provide them with the tools they need to overcome adversity and build resilience. That involves facing some very serious questions about how we live today, and the priorities that we have. We need to look again at the value we place on family and on meaningful relationships. Children's needs have fallen to the bottom of the pile.

Fundamentally, we know this already, but are seemingly not prepared to make the societal shifts necessary to address this. Interestingly, the focus of a recent webinar about the *National Mental Health Intelligence Report: Estimating the proportion of 0–4 year olds in England that have a mental health need* inadvertently shed light on what is being overlooked among older children. This webinar was not, in fact, about 'disorders', but focused very much on the importance of good early relationships for healthy development. The paradox is that we continue to look at a medical model to solve problems which we know are social in origin – whether through our unwillingness to acknowledge the diversity of human beings or our neglect of basic human needs.

Attachment

The single most common issue which I hear from young people in the counselling room is that they feel lonely or isolated. Far too many, when asked who 'has their back' in an emergency, pause briefly before saying 'nobody'. I am sure that many of the parents of these children would deny this – but this is how the young people see it. Either they feel that there are things they can't tell their parents or caregivers, because they will get angry or not understand, or they feel that their parents are too burdened with their own difficulties – volatile relationships, their own mental and physical health struggles or more general life stresses.

Relationships require time, trust and intimacy. Far too many children do not know their parents in any meaningful sense – and children do not really know their parents. This leaves the young people much more vulnerable to external influences, including peer pressure and the online world. These influences play on our human need to belong and be accepted, with some dangerous results. Another result of the breaking of bonds is a loss of parental confidence – parents who do not know their children are de-skilled from helping them effectively, and more likely to look elsewhere to 'fix' issues.

Instead of supporting family life, government policy is geared towards encouraging as many mothers as possible to return to the workforce as quickly as possible. Tax-free childcare was introduced in April 2017, and now the amount of financial support available to parents is being extended. Much of this is driven by economics – mothers will pay tax, as will those they employ to do everything they cannot do while they are at work. There is also a nod to equality – the clear message being that ensuring equal opportunities comes ahead of the wellbeing of children.

97 NHS England, *National Mental Health Intelligence Report: Estimating the proportion of 0–4 year olds in England that have a mental health need* (16 October 2024).

The number of booked full-day places in group-based childcare providers has risen steadily from 502,400 in 2019 to 618,200 in 2024. At the same time, the number of children being cared for by childminders in smaller, more personal environments, has fallen from 91,300 to 78,100. Almost half (49%) of the children being cared for in group settings are aged two and under, and ratios of staff to children are being relaxed. Latest statistics demonstrate that an average of four children aged two were cared for by each staff member in 2024. Even as the birth-rate falls in the UK, the mean number of registered places per childcare provider is increasing. [98]

This is happening despite the fact that we know that 'a mother's presence and attachment to her baby in the first three years of life are critical for the development of the social part of the baby's brain and for the ability of the baby to cope with stress'. As social worker and psychotherapist Erica Komisar explains, 'we would like to believe that our children are 'just fine' when we leave them, so we can hurry back to our careers and social lives as quickly as possible. The truth is not always this simple.'

She then makes a connection which all policy makers should carefully consider – 'as we struggle to explain the increase in the numbers of children diagnosed with conditions on the autism spectrum, ADHD, and other social and developmental disorders, we have to consider that this rise may be directly related to increased maternal stress and the lack of consistent, intimate engagement of mothers (and other caregivers) with children'. [99]

As a 2019 paper on the genetics and epigenetics of autism spectrum disorder reminds us, the causes of autism 'remain largely unknown'. While a genetic component has been established, we need to remember that 'gene-environment interaction can lead to epigenetic abnormalities and cause alterations in the brain's anatomy and connectivity'. [100] A further widely-publicised study, in 2024, from the University of Maryland, offered 'further encouraging evidence of autism spectrum disorder reversal through a personalized, multi-disciplinary approach focusing predominantly on addressing modifiable environmental and lifestyle risk factors'. [101]

Early Chaos and Family Breakdown

We have also forgotten that we are designed to live in families, preferably extended families, which are relatively stable and on whom we can rely. In turn, these families should be an integral part of communities. While throughout history, illness, accident and death robbed people of close relatives, family break-up of the kind to which we are now accustomed is a new phenomenon, as is the failure to create a committed family in the first place. Similarly, living without involvement in a wider community of any kind is a new departure for humanity.

97 Cohen, S, *Science to Policy and Practice*, Center on the Developing Child – Harvard University (October 2017).

98 Gov.uk, *Childcare and early years provider survey – Reporting year 2024* (12 December 2024).

99 Komisar, E (2017), *Being There: Why Prioritizing Motherhood in the First Three Years Matters*, Tarcher Perigee.

100 Wiśniowiecka-Kowalnik B, Nowakowska B A, *Genetics and epigenetics of autism spectrum disorder-current evidence in the field. J Appl Genet*. 2019 Feb; 60(1):37-47. doi: 10.1007/s13353-018-00480-w. Epub 2019 Jan 10. PMID: 30627967; PMCID: PMC6373410.

101 Lambert E, Tallman Ruhm H. *Reversal of Autism Symptoms among Dizygotic Twins through a Personalized Lifestyle and Environmental Modification Approach: A Case Report and Review of the Literature.* J Pers Med. 2024 Jun 15;14(6):641. doi: 10.3390/jpm14060641. PMID: 38929862; PMCID: PMC11205016.

A working paper published recently in the US demonstrates the scale and depth of the problems faced by children whose parents divorce. After careful analysis of tax and census data covering all children born in the US between 1988 and 1993, it concludes that divorce 'represents a significant turning point in children's outcomes'. Expanding on this, the paper finds that 'following divorce, parents move apart, household income falls, parents work longer hours, families move more frequently and households relocate to poorer neighbourhoods with less economic opportunity'. All of these factors have been found to have adverse effects on children's mental and emotional wellbeing.

Moreover, the authors highlight that 'because divorce has a negative effect on outcomes and is more common among low-income families, marital instability 'perpetuates disadvantage across generations'. [102] We are now well into a third generation where family break up is commonplace, and we see the consequences all around us.

Numerous studies have demonstrated that children flourish best when raised by two loving parents who are committed to each other and to them. Fatherlessness is currently a huge problem, depriving both boys and girls of good male role models, and the regulation they can offer for both excitement and aggression. We now have children for whom a 'stepfather' can be a man whom their mother met only last week, and young people who are unsure exactly how many siblings they have. We also know that domestic disharmony and uncertainty impacts young children – they may not remember what happened, but they will remember how they felt. We have ceased to put the needs of children and young people first and provide them with what they most need, frequently leaving them anxious and depressed.

As a 2016 paper published in the *London Journal of Primary Medicine* tells us, 'without a good initial bond, children are less likely to grow up to become happy, independent and resilient adults'. [103] The authors go on to say, 'the most valuable gift that a child can receive is free; it's simply a parent's love, time and support. This is no empty sentiment; science is now showing why baby's brains need love more than anything else'. Just as 'parenting' became a word, it seems as if we have forgotten its importance – and too many children grow up with inadequate ties to one or both parents.

As might be expected, the Early Intervention Foundation notes that 'effective early intervention works to prevent problems occurring'. [104] This intervention is, however, most effective in the years before school. Forging strong bonds and secure attachment in the early years can have a lifelong effect on a child's ability to form relationships later in life. And as any therapist will confirm, much developmental trauma and later emotional distress is caused by dysfunctional relationships.

102 Johnston, A *et al*, *Divorce, Family Arrangements and Children's Adult Outcomes*, National Bureau of Economic Research (May 2025).

103 Winston R, Chicot R. 'The importance of early bonding on the long-term mental health and resilience of children'. *London Journal of Primary Care (Abingdon)*. 2016 Feb 24;8(1):12-14. doi: 10.1080/17571472.2015.1133012. PMID: 28250823; PMCID: PMC5330336.

104 *Op. cit.*, Clarke A *et al* (21 July 2021).

In a panel discussion as part of a course in which I participated last year, psychotherapist Anne Alvarez, retired co-convenor of the Autism Service at the Tavistock, said, 'practically every child I hear about has diagnosis of autism and ADHD, whether they are autistic or not, that's the diagnosis they've got – and usually they have complex trauma'. [105]

Nebulous Nihilism

Just as bonds are fraying, our children are being exposed to more choice and challenge than ever before. Of course, young people need to learn progressively more and more about the world into which they will emerge as adults, and offering increasing choice and agency throughout childhood is an important aspect of growing up.

However, today young people cannot escape endless calls to action to address the 'climate emergency', the ills of empire, anti-racism, the demands of critical social justice and gender ideology. Too often, the claims of these movements and their demands are internalised, resulting in both increased levels of anxiety and depression.

Society's casual attitude to human life does not go unnoticed either. Several young people have told me of the respect they have for their mothers and when asked why, immediately responded saying, 'because she didn't abort me'. With the clamorous 'right to choose', and now the moves to legalise 'assisted dying', children are in no doubt about the disposability of human lives. The unwanted, the sick and the old are apparently dispensable. Particularly for immature and imaginative brains, this is a frightening prospect.

WHAT DO WE NEED TO DO TO HELP CHILDREN TO FLOURISH?

An early observation I made, when undergoing counselling training, was how much of psychotherapy is rooted in common sense. We know at a visceral level what we need, and we know why we feel pain when things go wrong. The edifice of 'mental health' merely pathologises life's ups and downs, dressing them up in scientific language and offering medical solutions. While the most severely afflicted will always need support, our children do not need more mental health professionals in school, more diagnosis or more medication. Instead, schools could address the areas of life in which children are most vulnerable.

1. Identity

Historically, our identity was something flexible, forged seamlessly and silently as we grew. It sprang out of our role in our family, community and religious affiliation. It was garnished with our personality traits, interests and experiences. It was not a one-dimensional badge, bought off the shelf, because of a drive to belong and to be accepted, in a rootless and impersonal world.

105 Alvarez, A, *A Panel Discussion on the treatment of Borderline and Narcissistic Presentations*, CONFER – Fragile Selves: Working with Narcissistic and Borderline States of Mind (accessed 2 September 2024).

We need to offer children these connections once again, and celebrate their intrinsic value, if we are to reclaim their wellbeing and reduce the power of social media's 'collective identity cultivation'. [106]

As Suzanne O'Sullivan remarks, 'autistic traits exist on a continuum, meaning we all have some'. [107] It may be helpful to remember then, that we are all 'on the spectrum' and start to look at young people more through a lens of 'ordinary and extraordinary, rather than normal and abnormal'. [108] Young people need to understand that no two people are the same; that deeply feeling a range of emotions is normal; that everyone has strengths and weaknesses; and that environment is critical in managing those healthily. There is no one way 'to be'. Within the broad boundaries necessary for society's flourishing, there are as many ways to be an individual person as there are individual people.

2. Community

Communities are fractured, but school is a good place to start rebuilding broadly based links with each other. It is no accident that the 'beating heart' of Michaela Community School, one of the most successful schools in the UK, is 'family lunch'. It is hard for children to feel isolated or 'different' for too long when they sit down in tables of six to eat and talk together, each one also having a role in serving or clearing away the meal. Teachers eat with children, encouraging conversation on the 'topic of the day'. [109] Anxiety about interacting with others, and eating alone in a corner of a school corridor, focussing inwardly, are not options. Communal meals are both civilising and confidence-building.

Starting the day with daily assemblies is another way to rebuild the sense of community, rather than assemblies being the social justice add-ons delivered once a week which they have too often become. These need not be religious in nature – although religion can provide a valuable moral framework to underpin school life – but could instead focus on a 'thought for the day' or useful reflection, rather than a call to arms against the latest social ill. The main benefit is bringing people together daily with a shared purpose. Social connection gives people a sense of connectedness and a sense of their place in society.

Out of school, parents and other adults need to set an example of community service and involvement. A survey in 2019 by the National Council for Voluntary Organisations (NCVO) found that 77% of volunteers reported that volunteering improved their mental health and wellbeing. [110] Rates of volunteering are, however, declining which has an adverse effect on the health of communities.

106 Corzine, A and Roy, A, 'Inside the black mirror: current perspectives on the role of social media in mental illness self-diagnosis', *Discover Psychology* (15 April 2024).

107 *Op. cit.,* O'Sullivan, S (2025), *The Age of Diagnosis.*

108 *Op. cit.,* Timimi, S (2025), *Searching for Normal.*

109 Michaela Community School.

110 NCVO, *Time Well Spent – A National Survey on the Volunteer Experience* (1 January 2019).

3. Stimulating Brains and Looking Outwards

Competence breeds confidence, and lack of confidence underpins much of the emotional distress that we are witnessing. Children also need to have their natural curiosity stimulated and their capacity for creativity and thirst for knowledge satisfied. All of this encourages young people to look outwards, beyond themselves and their own narrow interests – it also provides a focus for their attention. When a person is in a 'flow' state, entirely focused on what they are doing, anxieties are forgotten. As mentioned above, many schools focus more on skills now, even as a recent examination of school curricula demonstrates, knowledge is a 'prerequisite for improved learning, critical thinking, and deep reading comprehension, as a facilitator for collective discourse and as a catalyst for equitable opportunities for all'. [111]

The scale of functional illiteracy in the UK also needs to be addressed. Over one third of pupils leave primary school without having reached expected standards in reading, writing and maths combined. [112] Many children therefore arrive in secondary school unable to access the curriculum fully. This leads to boredom, disengagement, misbehaviour and shame – some of which may ultimately lead to a 'mental health' diagnosis. If we want children to participate fully in society – to their benefit and ours – we need to ensure that they are equipped with the right tools.

It is also worth considering the findings of a 2023 paper which found that even if school-based interventions are only ineffective, rather than actually harmful, they amount to an opportunity cost, as 'time is taken away from other activities that could potentially be more enjoyable or more conducive to better mental health for adolescents'. [113] Giving children information and ideas to think about can be more helpful to their mental wellbeing than encouraging children to check in on their feelings. As Dr Alastair Santhouse explains, "when you're told that someone else needs to give you a treatment for you to cope and become happier, it is harder to experience personal growth in response to adversity". [114]

Generally people – including young people – are happier when they do not have to watch every word they say, for fear of saying the 'wrong' thing and being cancelled or ostracised as a result. It is therefore incumbent upon school authorities to stress the importance of freedom of speech, and encourage open debate and discussion in the classroom. Debates where pupils are randomly allocated an argument to make can foster breadth of thought and understanding.

111 Surma, T *et al,* (2025), *Developing Curriculum for Deep Thinking – The Knowledge Revival*, Springer.

112 Gov.uk, *Key stage 2 attainment – Academic year 2023/24.*

113 Foulkes, L and Stringaris A, 'Do no harm: can school mental health interventions cause iatrogenic harm?', *BJPsych Bulletin* 47(5):267-269, October 2023 doi: 10.1192/bjb.2023.9. PMID: 36843444; PMCID: PMC10764817,

114 *Op. cit.,* Shirref, L, 'Are we over-diagnosing our mental health? This psychiatrist thinks so', *Telegraph* (31 March 2025).

4. Leadership

Adults need to re-enter the room and take responsibility for what is happening to our young people's emotional wellbeing. It is the role of adults to set an example to young people – something which is far more powerful than any amount of teaching. We can demonstrate resilience, but it is very hard to teach it. We need to model healthy relationships and well-regulated emotions, if we want our children to handle difficult situations effectively.

The need to involve children and young people in the design of mental health interventions is a common thread running through provision. Of course, it is important to involve those using any service, to see whether or not it is effective – it is also, however, for adults to resume a position of leadership. Feelings are not facts, and 'lived experience' should not be used to avoid being challenged. What children may want or say that they need may not necessarily be what is best for them. Carelessly taking an 'affirmative' approach with gender-confused young people, because that is what they want, is evidence of this.

5. Addressing the Different Needs of Boys and Girls

It is time to acknowledge that while boys and girls should be treated equally and have the same opportunities at school, they are in fact different. In the teenage years, the differences can be profound as girls generally mature earlier.

While there will always be those who are gender non-conforming, which is an integral part of our natural diversity, boys should not be discouraged from embracing traditionally masculine traits, while girls should not be dismissed for – or encouraged to abandon – traditionally feminine traits. Any talk of 'toxic masculinity' should be balanced with mention of 'toxic femininity' which is equally destructive.

Both sexes need to understand that unrestrained 'sex positivity' is unlikely to result in long-term happiness or inner peace, and resilience enabling real choice and the ability to say 'no' – and mean it – should be encouraged. Children need to understand that healthy and meaningful relationships contribute most to life satisfaction.

Finally, schools need to be places of truth. False narratives that human beings can change sex, be 'born in the wrong body' – or need to adhere to rigid and outdated stereotypes or else their 'gender' is in doubt – need to be challenged wherever they appear. The pressure to choose how to 'identify' causes a huge amount of anxiety and distress, as does pressure to 'choose' a sexuality.

CONCLUSION

Rather than address widespread structural, social and moral issues within our society which cause very real problems, mental health ideology has been allowed to infiltrate all areas of life, to explain the current distress of so many of our children.

In fact, whether we are talking about children whose chaotic lives are impacting their wellbeing, young people dealing with challenging circumstances or those influenced by the culture of the time, we have a crisis brought on by the way that we as adults have chosen to live during the last couple of generations, combined with an unhealthy focus on ourselves and our emotional wellbeing. We have also abdicated our adult responsibilities with regard to these children. As Suzanne O'Sullivan reminds us, 'better lives for children will lead to fewer neurodevelopmental problems in children'. She acknowledges that this is often neglected in public discourse because 'it is a much more delicate and difficult one to have than one about brain chemistry'. [115]

As Sami Timimi says, 'most of the important decisions that affect children's lives are not made by them but by various people in caring relationships to them'. [116] These decisions have a profound effect on how these young people see the world and their place in it. He goes on quite reasonably to ask, therefore, 'do you need to be a qualified 'counsellor' to talk to people about their social (often financial and living conditions) and relationship problems?'.

More specifically, Erica Komisar states that the 'increase in the incidence of mental illness in children is, I believe, connected to the increasing disinterest in and devaluing of mothering in our society'. [117] It is time to resume the age-old responsibilities which adults – both mothers and fathers – have always had for nurturing and shaping the next generation. As Abigail Shrier writes, 'having kids is the best, most worthy thing you could possibly do. Raise them well, You're the only one who can'. [118] If parents can build healthy relationships, with securely attached children, adequately stimulated and challenged in school, those young people will be very much more resilient to many of the external pressures so often blamed for deteriorating mental health.

Carol Homden, chief executive of children's charity Coram, recently said in an interview, Britain is currently 'not a country for children'. She continued, 'the future of our society depends on the future of our children, and children can't wait'. [119] We need to do far better than provide a 'mental health professional' in every school – we need to address chronic family instability, and work to ensure that every child can benefit from the presence of a committed, loving and engaged parent in their home during their formative years. This is likely to have a far more beneficial effect on the wellbeing of all children, and reverse the tide of distress.

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115 *Op. cit.,* O'Sullivan, S (2025), *The Age of Diagnosis.*

116 *Op. cit.,* Timimi, S (2025), *Searching for Normal.*

117 *Op. cit.,* Komisar, E (2017), *Being There: Why Prioritizing Motherhood in the First Three Years Matters.*

118 *Op. cit.,* Shrier, A (2024), *Bad Therapy: Why the kids aren't growing up.*

119 Steafel, E, 'As IVF has become more successful, fewer people are willing to adopt', *Telegraph* (27 March 2025).

CASE STUDIES

Case Study 1

Jason is 14 and the oldest of four children, each of whom has a different father. He lives with his mum and all three half-siblings. He has a possible diagnosis of generalised anxiety disorder (GAD) and is thought to be depressed. He has been referred to 'learn strategies' to help him, during six sessions of school counselling. Jason tells me that he is upset and resentful because his 10 year-old-brother's dad comes every weekend and brings him a Lego kit each time; his own dad is in jail and he hasn't seen him anyway since he was about five years old. He's also worried about his sister, who is 12. He thinks she might be sending nude selfies to a boy at school, possibly a boy he knows, and is being encouraged by her older half-sister who lives nearby. Finally, he is anxious about his mum – she has told him that her partner is being increasingly aggressive towards her when they are alone, and he knows she separated from his own dad because he was violent to her in the home. The weight of all of this burdens Jason, who somehow feels he needs to 'do something about it'. His teacher wonders if he has ADHD, because he can't concentrate and is always fidgeting. A counsellor can give Jason strategies to cope with day-to-day life – but it is fundamental change within the family which would most help Jason.

Case Study 2

David is 12 and has spent much of his early life on the move. His mum was very young when he was born, and couldn't settle anywhere. He has a vague recollection of a lot of abrupt departures. Sometimes he went to school, and sometimes he didn't. He reckons there was about a year where he didn't attend school at all, and they travelled in South East Asia. David tells me he can't talk to his mum because she 'has issues of her own' and he doesn't like to bother her. He has always been quiet in class and felt he didn't fit in. He once told some classmates some stories about his life, but they didn't believe him and made fun of him – so he stopped talking, even in lessons. Instead he spent his time drawing planets and stars – he found it comforting to sit at his bedroom window at nighttime and wonder what was out there. One day, someone suggested that he might be autistic, because he didn't talk and was obsessively interested in space, and now drawing detailed models of space-ships. Not being able to read or write well, he was also in the 'nurture' group at school. He was angry about this, because all the others were 'really thick' and not interested in anything. David has been referred for counselling because he has uncontrolled angry outbursts. A counsellor can work on ways to help David manage his anger and regulate his emotions – but support for his mother and better support from school, especially with literacy, would prove more effective in the long term.

CASE STUDIES

Case Study 3

Lena is 16 and lives with her mum and step-dad, both of whom are high-flying professionals, as is her own dad. Lena knows that she is 'privileged' – she lives in a lovely home, can buy almost anything she wants and regularly goes on expensive holidays. She has no full siblings, but her dad has two other children, one older than her and one younger, by two different women. The age difference means she doesn't see that much of them. Her mum has a much older son, whom she never sees – he prefers being with his dad and his new family. Lena doesn't spend much time with her mum and step-dad – they are always working. When she was little, she had a childminder whom she loved – but she tells me she's too old to need anyone now. Lena has been referred to counselling because she is anxious, depressed and self-harming. Our conversations reveal that Lena has had a number of sexual experiences – she wants boys to like her, and when they do, she doesn't feel she can say 'no' to their sexual demands. Often they are very popular boys and she would be ridiculed across social media if she didn't do what they ask. She is frightened by what has happened and wonders if perhaps she is a lesbian. However, she is also having problems with female friends, who feel that she should always 'treat' them as she 'has money'. Lena often cries silently in counselling sessions. Her reason is always the same – 'I just want someone to like me'. A mental health professional can listen to Lena, and explore these issues, but nothing would help her more than the undivided love and attention of her parents.

These case studies are composites, drawn from experience over years of working with young people.

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