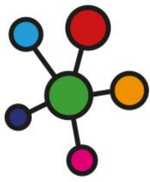

Children and Young People's Mental Health Green Paper: Consultation

Response from the Attachment Research Community

Question 1:
The core proposals in the green paper are:

1. ***All schools and colleges will be incentivised and supported to identify and train a Designated Senior Lead for Mental health who will oversee the approach to mental health and wellbeing***
2. ***Mental health Support Teams will be set up to locally address the needs of children and young people with mild to moderate mental health issues, they will work with schools and colleges link with more specialist NHS services***
3. ***Piloting reduced waiting times for NHS services for those children and young people who need specialist help***

Do you think these core proposals have the right balance of emphasis across a) schools and colleges and b) NHS specialist children and young people's mental health services

ARC welcomes the focus on schools as a universal point of access. However, we are concerned that the core proposals quickly move from a universal and holistic focus on mental health and well-being to a medicalised – diagnostic and treatment - model. ARC's experience is that much can be achieved for less when schools locate mental health not solely at an individual level but as a whole school, systemic issue. Whilst teachers are not therapists or health professionals and therefore could misdiagnose or miss a real issue, they can – as is seen in 'Attachment Aware Schools'(Rose et al 2016a, Dingwall and Sebba 2018) – work therapeutically, create safety for children with poor mental health and use universal interventions – for example 'Emotion Coaching'(Rose et al 2015) – to ensure significantly improved mental health, whilst reducing the high rates of exclusion experienced by children with unmet mental health needs.

A universal model 'owned' by senior leaders and focussed on wellbeing for all is more applicable to a school context. It should be based on the following:

- Given the centrality of mental health to learning, it is reasonable to expect all staff in all schools to have the training – preferably from their initial teacher

education onwards - to ensure they have a grasp of 'the basics' of mental health:
    - Universal human mental health needs, including attachment needs.
    - The negative impact of unmet needs and toxic stress e.g. arising from abuse or neglect.
    - How recovery from trauma and resilience is enabled by consistent, informed relational support from all the adults in a young person's life
- A universal approach must include ensuring the behaviour policies do not undermine mental health and well-being and that exclusion is not used as a 'solution' where schools are struggling.
- Ensuring that individual interventions are supported by the whole school context, which can otherwise undermine or even negate their positive effect e.g. where the school still 'grey' or fixed term excludes the child.
- Any approach must cross reference with the SEND code of practice.
- Measures of success should include:
    - The views of young people
    - Inclusion: e.g. reduction in all forms of exclusions
- The full implementation of the 2015 NICE guideline on attachment

The You Gov survey into young people's mental health published on 5 February 2018 (Barnardo's 2018a) demonstrated that the biggest cause of stress and anxiety was school itself, but only 38% of respondents would confide in a teacher. There is considerable evidence that children and young people who are most vulnerable to mental illness and suicide are those who do not attend school (e.g. through exclusion or self-exclusion) but do not meet intervention thresholds for CAMHS and social care services.

We therefore propose that:

1. The Designated Senior Lead Teacher role be made mandatory, on a par with SENDCo and Safeguarding roles, and that statutory guidance provides safeguards to prevent one individual teacher being swamped with having to undertake too many such roles within the school.
2. A member of the SLT and a governor should be responsible for the whole school strategic approach to mental health and well-being
3. Mental Health Support Teams be placed under a statutory obligation to consult with social care, local statutory and voluntary sector organisations as well as schools, e.g. via a local strategic partnership, so that all children in whatever school or not attending school access the support they need.

Question 2:
To support every school and college to train a Designated Senior Lead for Mental health , we will provide a training fund. What do you think is the best way to distribute the training fund to schools and colleges?
Please rank the following in order of preference:

- ***Set amount of funding made available to each school, for them to buy relevant training with 4***
- ***Funded training places made available locally for schools to book onto 3***
- ***Funding allocated to local authorities and multi-academy trusts to administer to schools 1***
- ***Funding distributed through teaching school alliances 2***

If you wish, please provide any further information on why you have ranked in this order of preference

Training programmes must be effectively led, with support from the head teacher and governors, and be part of a coherent strategy, which combines training, external support and opportunities for reflection (see Education Select Committee Report on the Recruitment and retention of teachers – Education Committee 2017; page 20, paragraph 76). This has been the basis of the 'attachment aware school programmes' developed for example by Bath Spa University; Somerset Public Health Emotion Coaching and by many other Virtual Schools – e.g. Birmingham, Derbyshire, Stoke-on-Trent – see Rees Centre (2018) .

It is particularly important that training programmes adopted provide a long-term framework for support and challenge to maintain the quality of work in schools. There is overwhelming evidence as to the ineffectiveness of 'one-off' school training programmes (see Education Committee 2017; page 21, paragraph 77). As indicated at question 1 above, we insist that the training programme must be owned at the most senior level possible and therefore, if this limited list is to be adopted, we suggest that it is local authorities and multi academy trusts who should be responsible for distributing the funding and held accountable for the outcomes. However, our preference would be for an alternative model, based on a local strategic partnership (see Question 3 below)

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It is vitally important that training programmes which are promoted be subject to rigorous quality control, be up to date and appropriate for the professional groups to whom they are directed. Failure in this area will undermine the credibility and effectiveness of the programme as a whole. We have reservations about documentation such as the Mental Health Toolkit (Anna Freud Centre 2018), which has been used in pilot schemes, and would suggest that this needs to be reviewed.

Question 3:
Do you have any other ideas for how the training fund could be distributed to schools and colleges?

Effective training approaches need to be led by head teachers, backed up with support and embedded through longer term active engagement across the whole school. School leadership needs to be matched by senior local accountability and challenge to schools and services.

If additional funding were available to create leadership capacity, we believe that the responsibility for establishing the training programme and distribution of additional funding could lie with the Virtual Headteacher in each local authority, as a statutory officer who has an overview of school, social care and health outcomes as part of his/her brief. The Virtual Headteacher already has a statutory responsibility for many of the most vulnerable children, who are most likely to be facing mental health difficulties, and the success of the proposed programme will need to be in bringing together these different interest groups and effectively challenging them to work together. As a single point of accountability it is important that the individual has a strong understanding of and access to schools. It is equally important that the individual concerned works closely with and is proactively supported by the Mental health Support Teams through a local strategic partnership, and on the basis of a statutory duty to co-operate.

Mental health Support Teams
Question 4:
Trailblazer phase: A trailblazer phase is when we try out different approaches Do you know of any examples of areas we can learn from, where they already work in a similar way to the proposal for Mental health Support Teams?

The Attachment Research Community, founded by Virtual Heads and academics, has a number of examples of the successful roll out of programmes to support better

universal understanding and effective responses to mental health , based on an 'attachment aware' approach. Examples from Bath Spa University include:

1. **Engagement of education, health, care and all other appropriate partners**
   From 2010 onwards Bath Spa University has worked with a range of organisations including schools, children's centres, and other services such as the Police to provide emotion coaching training within local geographical areas, funded mainly via Wiltshire Community Area Boards. While this was not formally linked to CAMHS services as such participants have included heath visitors, school nurses and local GPs (Rose et al 2015).

2. **Co-design of programme**
   Since 2013 Bath Spa University has worked with a number of virtual schools – notably Bath and North East Somerset, and Stoke on Trent to develop programmes of attachment awareness. A key feature of these programmes has been to increase schools' knowledge and understanding of local CAMHS referral mechanisms. The evidence base for this programme in supporting children and young people's health and wellbeing, as well as their behaviour and academic attainment, is growing. Independent evaluations by Oxford University have endorsed this work, particularly in supporting vulnerable children (Fancourt and Sebba 2018; Dingwall and Sebba 2018)

3. **Co-delivery of evidence based programme and further action research**
   Between 2015 and 2017 Bath Spa University worked with Somerset Public Health and EHCAP, a third sector training organisation, to train over 160 children's mental health champions in schools, children's centres and other organisations with follow up action research (Rose et al 2016c, Digby et al 2017). This work has now been subsumed into the wider Mental health and Wellbeing in Schools Project, led by the Clinical Commissioning Group, and coordinated by a new Schools Health and Resilience Education Group, funded by the CCG.

   Other examples of this type of voluntary sector programme might be the 'ACE' (Adverse Childhood Experience) awareness approach which is being deployed across the whole of Scotland and currently being adopted throughout Wales; the Friends' Resilience Programme for schools, which is endorsed and supported by the World Health Organisation, DoH and DfE; and the Nurture Group Network.

Question 5:
Different organisations could take the lead and receive funding to set up the Mental health Support Teams. We would like to test different approaches.Which organisations do you think we should test as leads on this?
Please rank the following organisations in order of preference:

- ***Clinical Commissioning Groups (CCGs) 4***
- ***Groups of schools 2***
- ***Local authorities 3***
- ***Charity or non-government organisation 5***
- ***Other: 1 Local partnership led by Virtual Head***

Question 6:
Mental health Support Teams will work and link with a range of other professionals and we would like to test different approaches. From the list below, please identify the three most important 'links' to test in the way they would work with Mental health Support Teams:

- **Virtual Heads – see note above**
- **Educational psychologists**
- Local authority troubled families teams
- Local authority children and young people's services
- Local authority special educational and disability (SEND) teams
- **School nurses**
- School-based counsellors
- Charity or non-government organisation
- Youth offending teams

Question 7:
Mental health Support Teams and Designated Senior Leads for Mental health in schools and colleges will work closely together, and we will test this working through the trailblazer phase. Out of the following options how do you think we should measure the success of the trailblazer phase? Please pick your top three:

- **1 - Impact on children and young people's mental health – measured by young people's reported well-being and by attendance, exclusion [fixed and permanent**]

- Impact on quality of referrals to NHS Children and Young People Mental health Services
  Impact on number of referrals to NHS Children and Young People Mental health Services
- Quality of mental health support delivered in schools and colleges
- Amount of mental health support delivered in schools and colleges
- Effectiveness of interventions delivered by Mental health Support Teams
- **2. Children and young people's educational outcomes**
- Mental health knowledge and understanding among staff in school and colleges
- Young people's knowledge and understanding of mental health issues, support and self-care
- Numbers of children and young people getting the support they need
- **3. Other: Self-reported confidence of staff and CYP in managing their own mental health and that of others; Children and young people's view of the service provision**

Question 8:
Trailblazer phase: A trailblazer phase is when we try out different approaches When we select areas to be trailblazers for the Mental health Support Teams, we want to make sure we cover a range of different local factors. What factors should we take into account when choosing trailblazer areas? Please rank the following in order of importance:

- ***Deprived areas 5***
- ***Levels of health inequality 2***
- ***Urban areas 6***
- ***Rural areas 4***
- ***Areas where children and young people in the same school/college come under different Clinical Commissioning Groups (CCGs) 3***
- ***Other 1: Areas with significantly lower or higher levels of exclusion and lower or higher levels of demand for support***

Question 9:
How can we include the views of children and young people in the development of Mental Health Support Teams?

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Barnardo’s has recently published a series of videos outlining young people’s concerns about this consultation process (Barnardo’s 2018b). It will be important to involve as many young people’s views as possible, including those from a range of ethnic, geographic and socio-economic backgrounds, and young people with disabilities and learning difficulties/disabilities.

There are a number of possible stakeholders, including:

- Local authority young people’s participation officers
- Local third sector organisations specialising in promoting young people’s voice. Many of these, such as Off the Record in Bath, will also have expertise in counselling and developing support for specific vulnerable groups such as LGBTQ, young carers etc. Streetwise in Newcastle have seen demand increase across the region in significant numbers.
- Local Children’s In Care Councils facilitated by local authorities and/or the voluntary sector
- Local Youth Parliament members
- National reference groups, such as Become, Young Minds, Charlie Waller Memorial Trust, Barnardo’s, and The Children’s Society.
- Foster Focus have particular expertise in consultation with young people in care and care leavers.
- The Samaritans have dedicated lines for young people particularly for self-harm and suicide risk,
- Childline have a dedicated team for mental health
- The Attachment Research Community young people’s reference group

Somerset Public Health, in establishing the emotion coaching project cited earlier, created a separate project strand to establish young people’s views, facilitated by the Charlie Waller Memorial Trust (Rose et al 2016c)

Piloting a waiting time standard
Question 10:
Waiting time standards are currently in place for early intervention for psychosis and for eating disorder services. Outside of this, are you aware of any examples of local areas that are reducing the amount of time to receive specialist NHS help for children and young people's mental health services? Can we learn from these to inform the waiting times pilots?

Waiting time should be considered in terms of the time adults supporting young people have to wait for expert advice in order to develop and sustain a whole school or universal approach.

Schools should already be using the graduated approach outlined in the SEND code of practice, but may need expert advice to support this.

Timely support for a universal approach can save the costs of one to one intervention

Northumbria police had so many referrals and calls for young people who were suicide risk they have employed their own mental health nurse team, in the divisions, for example Washington (within Sunderland) there is a mental health nurse on duty from 10-6 (approx.) overnight who attends calls with the police should they be alerted to a potential suicide or at risk young person/ child- this is also an on call provision whereby young people have the number to ring should they feel depressed and contemplate suicide

Schools and colleges
Question 11:
Schools publish policies on behaviour, safeguarding and special educational needs and disability. To what extent do you think this gives parents enough information on the mental health support that schools offer to children and young people?

- All of the information they need
- Most of the information they need
- Some of the information they need
- None of the information they need
- **Don't know**

Please tell us more about why you think this

The issue is not the lack of policies but the variation in underlying understanding of core mental health needs and issues – e.g. attachment and trauma - and of existing guidance e.g. SEND code of practice – that would inform the production and implementation of useful policy.

There are a number of Parents self-help groups such as Parents in Power (Gateshead) who have struggled to pinpoint services, as mental health tends not to

be included in school policies for SEND or Safeguarding. Some national support groups such as Adoption UK also produce helpful advice for specific groups.

Some parents may experience difficulties in accessing the policies or information via the web more generally and alternative means of providing information should be made available .

Difficulties in accessing information via web might arise from things such as:

- Not having the internet at home
- Language barriers – due to migrant status, learning disabilities or other disabilities
- Accessibility issues of website or information contained – websites not accessible for visually impaired people, language complex and not easily understood

It would be helpful to require local partnerships/ Mental health Support Teams to produce simple statements indicating website links, referral mechanisms and available support groups, and to require schools to publish these on their own websites. That requirement might be extended to GP surgeries, libraries, local authority websites and one stop shops.

Question 12:
How can schools and colleges measure the impact of what they do to support children and young people's mental wellbeing?

Although the Strengths and Difficulties Questionnaire (SDQ) is widely accepted as a general measure, there is concern that it is limited. The Child Outcome Research Centre (CORC) is currently developing new outcome measures .

Many schools have found the attachment aware schools audit helpful as a baseline for developments. This was developed in Stoke on Trent and is available via the Attachment Research Community website - https://the-arc.org.uk/
Other measures which have been used effectively in the attachment aware schools and emotion coaching projects include:
For pupils

- academic attainment,
- attendance
- behaviour interventions,
- sanctions

- exclusions – fixed and permanent

For staff

- Impact on professional confidence and practice
- Impact on self/regulation and wellbeing
- Confidence in discussing pupils' emotional and mental wellbeing

Vulnerable groups
Question 13:
In the development of the Mental health Support Teams, we will be considering how teams could work with children and young people who experience different vulnerabilities. How could the Support Teams provide better support to vulnerable groups of children and young people?

The Support Teams will need to be linked into wider local support/involvement mechanisms for young people, particularly in the third sector and including children in care councils (see responses to question 9 above). Our experience is that it is precisely those young people who fall outside formal service definitions and thresholds who are the most vulnerable and most likely to be missed. School Designated leads will need to work closely with pastoral teams, SENDCos and Safeguarding leads, and with other school-facing professionals – Education Welfare, Education Psychology and specialist services – to maximise intelligence and reduce the numbers of those falling through the net.

There is a particular issue that schools may miss speech language and communication needs, particularly with children who appear to demonstrate difficulties with emotional regulation and/or social interaction and/or are experiencing mental health problems. This could result in mis-diagnosis and inappropriate interventions if wider community services are not included within the Mental Health Support Team framework.

The role of alternative provision – PRUs for example - and informal education settings - youth centres, supplementary schools and local activity/advice centres - needs to be fully acknowledged and these providers should be included in the development of the Mental Health Support Teams and evaluation of their effectiveness.

Support teams will also have to ensure that their services are culturally appropriate to meet the needs of people in their jurisdiction. This might involve working with

organisations for particular ethnic or religious groups to develop such understandings.

Support for children looked after or previously looked after
Question 14:
As we are rolling out the proposals, how can we test whether looked after children and previously looked after children can easily access the right support?

As indicated in previous answers, there is a clear role for local virtual schools and children in care councils in testing the effectiveness of the new arrangements. We would argue that there be a formal statutory requirement for annual statistical monitoring of this involving education, health and social care services. In particular there will be a need to monitor the links between exclusions within SEND linked to behaviour where the pupil has a EHCP in place (see also response to question 16 below).

Any proposal should cross reference with the SCIE Report on the improving mental health for young people, chaired by Peter Fonaghy, Christine Lenehan and Alison O'Sulllivan (Milich et al 2017)

There are particular concerns about the position of children who have been adopted, especially those adopted from care. Although there has been some improvement in monitoring outcomes for the latter over the past few years, and Virtual Heads have increased responsibilities for this, there is still very little hard evidence, despite growing concerns among adoption agencies as to the level of unresolved childhood trauma within this group. Issues include

- the extent to which schools are willing to take account of adopted children's special status
- appropriate use of adopted children's pupil premium money, and involvement of adoptive parents in decisions
- specific mental health issues around need for control, resistant behaviours, ability to trust
- children adopted from care, in particular, may well have faced trauma, serious abuse or neglect
- whilst in primary school some children may seem problem-free, new issues can emerge as they move into secondary school and the long view is required to monitor what help might be needed.

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Specific areas that need targeting are around attachment difficulties, concentration to learn, pressures to achieve and social issues with friends and authority figures. Teachers training in ITE provision need to receive specific input relating to the added burdens adopted children face

Support for children in need
Question 15:
As we are rolling the proposals out, how can we test whether children in need who are not in the care system can access support?

Sebba et al (2015; page 12) demonstrate that, with the exception of children who have come into care in the past 12 months, children in need perform worse in school at age 16 than any other group, including those in longer term care. This is often the same group who have not reached thresholds for active intervention, even though their needs are recognised. Mental health Support Teams will need to work closely with Children's Social Care, virtual school heads and the local voluntary sector to identify individual children who fall into this category and again we would suggest that there be a formal statutory requirement for annual statistical monitoring of this involving education, health and social care services. Support teams will also need to take into account other informal intelligence from non-statutory bodies concerned with vulnerable children, as outlined under question 13

The Green Paper makes little reference to the needs of care leavers, as outlined The Cabinet Office report 'Keep on caring' (DfE 2016). This makes particular reference to 'difficulties in accessing the health support they need, in particular help to maintain their emotional health and well-being' (p12) and acknowledges that 50% of young people in care have SDQ scores which are borderline or indicate cause for concern (p14). The report refers to difficulties in accessing adult mental health services, post age 18, and to overwhelming issues of isolation and loneliness (p18). Despite a specific commitment under Outcome 4 to improve access to mental health services (paragraph 3.69, p 43) Thorley and Armiger (2017) suggest that CAMHS services have failed to recognise the required tiers of support for young people in or leaving care; and that the level of support at lower tiers received from Mental Health First Aiders is inappropriate and may at times be dangerously ill-informed.

Other key groups who are often overlooked by support services include

- Children with parents in prison: the figure is unknown as there is no official published data yet there is evidence that these children are at a higher risk of becoming offenders themselves, are of necessity growing up in single parent

families one parent for example, can be bullied, depending on the parents crime, and can be very isolated

- Children who are bereaved, who can receive little support at school and are expected to 'get over it' within an unreasonably short space of time - see Aynsley-Green (2017)
- Young carers, where often the school and other agencies are unaware of their situation until it reaches crisis point

Barnardo's and the Children's Society have considerable research evidence of the needs of these 'hidden' groups (Barnardo's 2018a; Children's Society 2018)

Support for children and young people with special educational needs or disability
Question 16:
As we are rolling the proposals out, how can we test whether children and young people with special educational needs or disability are able to access support?

The Green Paper is explicit about the role of the graduated approach advocated in the SEND Code of Practice (DfE and DoH 2015) within the framework for supporting mental health . The implementation of the 'Assess, Plan, Do, Review' cycle, along with a school SEND register, appropriate access to EHCPs and an appropriately funded local offer should provide evidence of the effectiveness of support for SEND learners. Mental health and wellbeing should also be included in the school accessibility plan.

There is a strong evidence base, for example, the DfE Report on Wellbeing and SEN in Secondary Schools (Barnes and Harrison 2016), pointing to additional obstacles to wellbeing for SEND learners. This will be exacerbated where there are the additional risk factors such as unmet attachment needs.

There should be an explicit link between SENDCo's and Mental health Leads. They cannot work in isolation. Training should be explicit about the risk to wellbeing for learners with SEND, including learners that are not in receipt of EHCP's.

Specific SEMH interventions, for example, Emotion Coaching, should be piloted with learners with an SEN or Disability, where that need has an evidenced impact on wellbeing.

As proposed above (paragraph 14) there should be a requirement monitor the links between exclusions within SEND linked to behaviour where the pupil has a EHCP in place. This should also include consideration of the number of BME SEND children, which could highlight difficulties in the cultural appropriateness of services. All documentation about the Mental Health Teams initiative and particularly any monitoring measures should also be explicit about the legal requirements with regard to mental health disability under the Equality Act (2010).

Providing evidence for an Impact Assessment

A consultation stage Impact Assessment was published alongside the green paper. The following questions seek to gather further evidence to inform future versions of the Impact Assessment. We welcome references to any evidence, published or in development, or expert opinion on the topics set out above to help refine our final Impact Assessment.

If you have not read the Impact Assessment or do not wish to respond to these questions then please skip to the next section.

Question 17:

Please provide any evidence you have on the proportion of children with diagnosable mental health disorders, who would benefit from support from the Mental health Support Teams

We are concerned about the potential misuse of the term 'disorder' – which should only be used in relation to a formal clinical diagnosis - for what would be more properly described as 'difficulty' or 'need'. It could be argued that the language of 'disorders' in this context does not align with the UN Convention for the Rights of Persons with Disabilities (Equality and Human Rights Commission 2018)

Question 18:

Pre diagnosable: Children and young people who have mild or low-level needs which do not constitute a diagnosable mental health condition but are at risk of developing one and would benefit from a form of support

Please provide any evidence you have on the proportion of children with pre-diagnosable mild to low-level mental health problems who would benefit from support from the Mental health Support Teams

Research undertaken by Bath Spa University suggests that in any classroom between one third and a quarter of children will have some form of mental health vulnerability:

- At least one third of children have an insecure attachment with at least one caregiver (Bergin and Bergin 2009)
- As many as 80% of children diagnosed with ADHD have attachment issues (Clarke et al 2002; Moss and St-Laurent 2001)
- 98% of children surveyed experienced one or more trauma event – for one in four this trauma resulted in behavioural and/or emotional disturbance (O'Connor and Russell 2004)
- 7/29 pupils in a top set year 8 class in a social housing area, many of whom were identified as gifted and talented, were in care or on some form of support plan (Stewart-Parker 2014)

Question 19:
Please provide any evidence you have of the impact of interventions for children with mild to moderate mental health needs, as could be delivered by the Mental health Support Teams. We are interested both in evidence of impact on mental health and also on wider outcomes such as education, employment, physical health etc.

The evidence from the Bath Spa University emotion coaching and attachment aware school projects demonstrates that a training programme with ongoing external support for teachers and other staff (including roles such as midday supervisors), can produce significant improvements. Such a role could be taken on by the Mental health Support team, as is now the case in the Somerset Mental health and Wellbeing in Schools Project (see Question 4). Improvements observed include:

16% improvement in meeting or exceeding expected reading achievement
13% improvement in meeting or exceeding expected writing achievement
18% improvement in meeting or exceeding expected maths achievement
12% improvement in meeting or exceeding expected English achievement
51% reduction in sanctions
44% reduction in exclusions
12% reduction in SDQ scores

(Rose et al 2016b)

Teachers reported that, from their perspective, there was the acquisition of more sophisticated psychological understandings, informing the ways in which they dealt with conflict…
They alluded to increased sense of agency on the part of students, and the developing aptitude to articulate their feelings in calmer, more planned interactions, as opposed to the previous outbursts of anger…
Parents, too, confirmed improved attitudes and relationships. This was not simply relating to behaviour but to the ways in which their children viewed themselves and others…
Children also spoke positively about their personal development

(Parker and Levinson 2018)

Question 20:
Please provide any evidence you have on the impact of Children and Young People Mental health Services therapeutic treatments

Question 21:
Is there any other evidence that we should consider for future versions of the Impact Assessment?

RJP/TC revised 28/02/2018

This document has been agreed by the ARC HE Network, with specific inputs from:

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