Making a lifetime of difference to children in schools

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Place2Be's response to the Green Paper: Transforming Children and Young People's Mental Health Provision

About Place2Be

Place2Be is a UK-wide charity providing mental health support to children, young people and families in partnership with schools.

We work directly with 282 partner schools, providing emotional and therapeutic support to pupils and, where appropriate, their parents. Through our unique and evidence-based service, we support more than 116,000 pupils each school year.

We also support schools though training programmes to help both classroom teachers and school leaders understand mental health and work towards creating a mentally healthy environment through a whole school approach. Last year we trained 650 delegates from more than 75 different schools and organisations.

We provide training and clinical placements to over 1,000 child counsellors each year, with the aim of building a high-quality, experienced mental health workforce that schools can access.

Our response to Transforming Children and Young People's Mental Health Provision

Place2Be welcomes the Green Paper and the government's ambitions to significantly improve children's mental health provision. We're particularly pleased that the Green Paper recognises the crucial contribution that school-based provision can play to improve children and young people's mental health. We know from our experience of working directly with schools over the last 23 years that such provision can help to create a culture of openness, can ensure that potential mental health problems are identified at an early stage and that children access support in a safe and familiar environment without the stigma often attached to mental health services in the NHS. There is much good practice on which to build.

Below we set out our response to some of the specific proposals in the Green Paper and also include our response to the consultation questions.

Designated Senior Lead for Mental Health

Place2Be welcomes the expectation outlined in the Green Paper that all schools will have a Designated Senior Lead for Mental Health. Consistent effective practice will only be achieved if Designated Senior Leads are well trained and the requirements of the role are sufficiently clear and consistent.

Designated Senior Leads should be expected to have an agreed level/standard of training

- Training for Designated Senior Leads should consist of a taught course which covers (as a minimum) children's emotional development, taking a whole-school approach to children's mental health, methods of assessment and impact evaluation and building relationships with parents, referral pathways and working with specialist CAMHS and engaging with other wider agencies.
- As such the expectation should be that training will be taught over several days and include opportunities for reflection/consultation and on-going CPD.
- Training should be refreshed every two years. The Green Paper assumes that within 5 years all schools should have had the opportunity to train a Designated School Lead. However this will not be a one-off exercise: on-going re-fresh training for school leads will also be necessary.
- There is evidence that training in children's mental health which is of sufficient quality and quantity can have a lasting impact on the ability of teaching staff to improve children's mental health. For example an evaluation of Place2Be's programme for teachers by the National Centre for Social Research found that the programme (consisting of four taught sessions and four consultation sessions over a period of four to six months) led to higher levels of knowledge, ability and confidence six months after finishing the training[1].
- Good quality training should be made available to schools in all local areas by ensuring that funding is only allocated to mental health training providers with a proven track record.

The role of Designated Senior Leads should be more clearly defined, Leads should have suitable capacity and time to undertake and be expected to meet an agreed standard of practice

- 49% of schools and colleges already have a dedicated lead for mental health - but not all provision is good. Research shows that the remit of mental health leads is often broad but typically leads spend no more than 5 hours a week on the role[2], which in a large secondary school is unlikely to be sufficient. The evaluation of the mental health services school links pilot found that a critical success factor was the need for leads to have sufficient time to attend joint planning and training activities with NHS CYPMHS[3], for example.

[1] http://scotcen.org.uk/media/1123182/Evaluation-of-Place2Bes-Talented-Teacher-Programme.pdf

[2] Marshall, et al. (2017). Supporting Mental Health in Schools and Colleges: Quantitative survey. Department for Education. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/634726/Supporting_Mental-Health_survey_report.pdf

[3]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/590242/Evaluation_of_the_MH_services_and_schools_link_pilots-RR.pdf

- As a minimum Designated School Leads should be expected to:
    - maintain an overview of a school's plans to improve mental health, including championing a whole-school universal approach to mental health and ensuring that it is reflected in the design of behaviour policies, curriculum and pastoral support, how staff are supported with their own mental wellbeing and how pupils and parents are engaged;
    - maintain an overview of the mental health needs of all children at the school and the needs of individual children exhibiting signs of mental ill-health;
    - maintain an overview of the provision of school-based interventions and be responsible for ensuring that there is evaluation of the impact of school-based provision;
    - be the link person to Mental Health Support Teams and specialist CAMHS;
    - provide advice and support to staff in contact with children with mental health needs.

- Senior Mental Health Leads should be part of, or report directly to, the school's senior leadership team.
- To ensure some clear accountability the quality of practice of Designated School Leads needs to be within scope of Ofsted inspections.

Mental Health Support Teams

Establishing Mental Health Support Teams in communities could provide an opportunity to meet the mental health needs of more children, more quickly; the proposal to increase capacity to respond to children's mental health needs before they reach the threshold for specialist CAMHS services is most welcome. However, the impact of Mental Health Teams will depend on the skills and experience of team members; this work cannot be undertaken by new graduates. Given the scale of need, the creation of Mental Health Support Teams must not substitute existing practice.

Further consideration needs to be given to the range of skills required of staff within Mental Health Support Teams

Mental Health Support Teams will be expected to undertake a wide range of functions:

As such teams will require expertise in:

- Assessment and referral – staff will need expertise in assessing a range of diagnosable and non-diagnosable conditions and understand the likely efficacy of different interventions
- Delivering evidence-based practice - practitioners will need to be trained in several types of interventions or the teams will need to have a mix of skills (CBT, counselling, family-based therapy, parenting support etc)
- Design and delivery of information to support self-help – this is likely to require understanding of how to use digital technology to support self-help
- Supporting a culture of mental health, for instance with drop-in groups for children and/or teaching classes about mental health, and recognising issues in oneself and other young people
- Signposting – this will require knowledge of existing local services (including voluntary and community sector organisations, as well as statutory services) and this knowledge will need to be refreshed and kept up-to-date. Mental Health Support Teams are likely to uncover mental health needs for parents and families so knowledge of adult and family services will also be necessary
- An understanding of and ability to work with parents including those who are often described as 'hard to reach'; engaging positively and building trust with parents who may otherwise be resistant to engaging with statutory services or where there is a perceived stigma to accessing mental health services for their children

- Training - practitioners will be expected to train others in evidence-based practice
- Full commitment to evaluation to enable the systematic evaluation of different types of support teams

Given the range of skills required, practitioners in Mental Health Support Teams will need to have previous experience of working with vulnerable children and young people along with their families in communities

- Practitioners in Mental Health Support Team should have experience of working with children with mental health needs in the community, whether in the statutory or voluntary sector. These are not roles that can be undertaken by new graduates.
- Practitioners should have a suitable qualification and experience in relevant therapeutic child-focused practice. We do not envisage that these roles could be undertaken, for example by early career or newly qualified psychology graduates or Children's Wellbeing Practitioners.
- Based on the assumptions set out in the Impact Assessment, we recommend that practitioners should be at NHS grade 6 (£26,565-£35,577 p.a.) as a minimum – we do not think that pay grades 4 and 5 reflect the level of qualifications and experience required.

The resourcing of Mental Health Support Teams needs to reflect the level of demand for services

- The Green Paper assumes that 364,000 children nationally will access support from Mental Health Support Teams each year, around 45 children for each member of the 8,000 FTE workforce planned. The 364,000 figure has been calculated by assuming that 60% of the 390,000 children who have a diagnosable mental health condition but are not currently referred to CYPMHS and 50% of the 260,000 children who receive a CYPMHS assessment but do not meet the CAMHS threshold would receive specialist support through these Mental Health Support Teams.
- Another way of assessing need based on the currently available prevalence data is to consider the total pupil population. 10% of the child and adolescent population (850,000) are estimated to have a diagnosable mental health disorder at any one time but there is no accurate data on the number of children with pre-diagnosable, lower level needs. Some suggest as many as 20**%** of adolescents may experience a mental health problem in any given year[4].
- Certainly our own experience suggests that the prevalence of children with mild to moderate mental health problems is high. For example, half of the children referred to Place2Be services and who are not accessing CAMHS have or are at high risk of developing severe mental health needs (abnormal scores on the SDQ).
- The Green Paper outlines plans for a new workforce of 8,000 FTE, one worker for around 1,000 children in primary or secondary school (or approximately one worker for every 2.5

[4] WHO (2003). Caring for children and adolescents with mental disorders:Setting WHO directions. [online] Geneva: World Health Organization.Available at: http://www.who.int/mental_health/media/en/785.pdf

schools[5]). E.g. there are 57,000 children in primary schools and 39,000 children in secondary schools in Oxfordshire, so Oxfordshire would expect to have a team of nearly 100 workers (or several smaller teams)[6]. Even if the prevalence of mild to moderate mental health problems is only around 10%, such teams could be expecting to support around 10,000 children.

In order to meet need most effectively Mental Health Support Teams there should be a clearer definition of 'mild to moderate' mental health conditions

- The Green Paper refers to examples of mild to moderate mental health conditions as: anxiety, low mood and common behavioural difficulties. However there is no agreed definition of mild to moderate mental health conditions.
- Half (52%) of the children to whom Place2Be provides its early intervention service have mild to moderate needs, in that they show subclinical scores on the basis of the teacher completed Strengths and Difficulties Questionnaire (SDQ) (they score in the 'normal' (32%) or 'borderline / moderate' (19%) range on the Total Difficulties score). This includes children who have mild / moderate difficulties in their emotional needs (anxiety and low mood) – 11% - and in behavioural needs such as conduct (10%) and hyperactivity (9%).
- In our experience there are many children within schools with diagnosed and undiagnosed conditions who have severe mental health difficulties and are not accessing CAMHS. Mental Health Support Teams are likely to encounter many children and young people with severe mental health needs and they will need to have the relevant skills, as well as fast-track referral to CAMHS and other specialist services, to respond to these children and young people.

Mental Health Support Teams should focus on providing interventions where there is a strong evidence base of efficacy

- It will be important to ensure that Mental Health Support Teams are only providing (or commissioning) interventions with a good evidence base or, in view of the lack of trials in this age group, are evaluating their work systematically and benchmarking.
- The evidence base needs to relate to children and be age-specific. For example while group CBT is helpful to reduce symptoms of depression and anxiety in adults and young people, there is less evidence of the effectiveness of CBT for children under the age of 8[7].
- Not all evidence-based interventions will have been subject to a randomised-controlled trial and given the limited nature of the existing evidence base it will be important to include evidence-informed practice.

[5] There are 4.7 million primary school pupils and 3.2 million secondary school pupils (state-funded only) and 16,800 primary schools and 3,400 secondary schools in England

[6] Oxfordshire has 235 primary schools and 35 secondary schools

[7] Minde, K et al (2010) The Effectiveness of CBT in 3–7 Year Old Anxious Children: Preliminary Data, Journal of journal of Canadian Academy of Child and Adolescent Psychiatry 19(2): 109–115.

- Outcomes from Place2Be practice demonstrates its effectiveness at improving children and young people's mental health;
  - two in three (64%) of all children we see improve after our support and 52% of children who started with moderate needs improved following our intervention so they no longer had this level of need.
  - 66% of those who had moderate emotional / anxiety issues no longer had these issues after Place2Be's support. 55% who had moderate conduct difficulties, and 51% of those who had moderate hyperactivity no longer had these moderate needs after a Place2Be intervention.
- There needs to be an on-going commitment on the part of government and others to continue to fund research into the effectiveness of different interventions particularly in the early intervention sphere.

Urgent consideration needs to be given to ensure that existing services are not displaced as a result of the Green Paper measures.

- There are currently no measures in the Green Paper that would discourage a school (for example) from decommissioning good quality school-based provision that they are currently funding in anticipation of services and interventions to be provided by the Mental Health Support Teams. It will be important to clarify commissioning to ensure that the new service does not drive out existing good practice, especially at a time when budgets in schools as elsewhere are under pressure with many competing demands. If schools were to decommission established services this could result in an overall reduction of locally available, accessible and trusted service provision.

SPECIFIC QUESTIONS IN THE GREEN PAPER CONSULTATION

1. **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?**
   - We warmly welcome the Green Paper's proposals to increase school-based support for children's mental health.
   - We agree that school-based interventions should be evidenced based and subject to clinical supervision.
   - We agree that mental health interventions, when delivered in school settings, can be highly effective in providing support when mental health difficulties are first identified by school staff and that this kind of provision has the advantage of being non-stigmatising for children.
   - However the Green Paper does not provide sufficient assurances that interventions will be primarily delivered in schools rather than in NHS settings.
   - Nor are the lines of accountability sufficiently clear. Mental Health Support Teams cannot be "jointly managed by schools, colleges and the NHS". Mental Health Support Teams should be managed by the NHS but schools and colleges should be their primary 'customer'. Any teams that are commissioned from a third party such as a private company or VCS organisation should be subject to a robust evaluation and contract review process to ensure both effectiveness and customer satisfaction.
   - Mental Health Support Teams should not be seen as the sole provider of interventions for mild to moderate mental health needs. Teams should be able to commission services provided by others (e.g. voluntary sector organisations) delivering services in schools.

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:

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

Additional comments:

- We recommend that funded is provided (via TLIF or other funding programmes) so that free training places are made available to each school to book onto. Such funding programmes must have selection criteria that guarantee a minimum standard of quality of training for Designated Senior Leaders.
- We do not believe that giving schools funding themselves is desirable because it will produce a mixed market of provision with no guarantee of quality.
- We do not believe that funding should go to local authorities and multi-academy trusts to administer to schools for the same reason.

- Teaching school alliances have experience of commission high quality training for schools but are not experienced in commissioning high quality training for children's mental health.

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

- See above.

4. **Trailblazer phase: 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? (max 250 words)**
    - The Mentally Healthy School Pilot Greater Manchester brings together Place2Be, Youth Support Trust, 42nd Street and Alliance for Learning across 31 schools identified by the Alliance for Learning Trust. The programme of training and workshops will support the schools to develop the schools' ethos and policies, their workforce and the children and young people to improve the culture around mental health, developing lasting skills and strategies to develop a whole school approach to good mental health.

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:**
    1. **Charity or non-government organisation**
    2. **Clinical Commissioning Groups (CCGs)**
    3. **Groups of schools**
    4. **Local authorities**

    Additional comments:

- While we think it important that each trailblazer has CAMHS as clinical lead, trailblazers could be led by any one of the organisations listed above provided they undertake to keep the funding ring-fenced. CCGs in particular have a poor record of using funding intended for mental health to other priorities.
- In order to trial how Mental Health Teams avoid new services displacing existing services provided by charities or non-government organisations, we think it is important that some of the trailblazers are led by charities or non-government organisations with experience of providing evidence-based services at scale

6. **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:**
    1. **Charity or non-government organisation**
    2. **School-based counsellors**
    3. **School nurses**
    4. **Local authority children and young people's services**

5. **Local authority troubled families teams**
6. **Local authority special educational and disability (SEND) teams**
7. **Educational psychologists**

7. 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
2. Numbers of children and young people getting the support they need
3. Quality of mental health support delivered in schools and colleges

Additional comments:

- There should be evidence that provision by Mental Health Support Team is additive – e.g. it does not substitute existing services provided by the voluntary sector

8. 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?

- At least half of the trailblazers should be in areas where there is already evidence of strong collaboration between CAMHS, schools and charities/non-government organisations
- Some of the trailblazers should focus on areas where there aren't existing services. For example, a survey undertaken by NAHT and Place2Be in 2016 found considerable variation in access to a school-based counsellor, with provision lowest in West Midlands, Yorkshire and East Midlands.
- We recommend a mix of urban and rural areas
- We recommend a mix of deprived and less deprived areas

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

- The commissioning, design and delivery of mental health services should be informed by the participation of children, young people and their families.
- Amplified (Young Minds) provides a clear model on which to build.

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?

- There are some examples of good practice in local areas, for example where we have established a "step up – step down" approach with local CAMHS services.

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?

- **Some of the information they need ***

- Some of the information they need but we recommend that Schools share a whole-school plan for improving children's mental health and we help schools to devise such plans as part of the training that we offer to mental health leaders in schools.

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

- Measurement should be based on assessment of progress against a clear strategy and action plan to implement a whole school approach. It can combine both quantitative and qualitative factors.
- Schools should be encouraged to use (or work with providers who use) standardised screening tools such as Goodman's Strengths and Difficulties Questionnaire (SDQ). Place2Be uses the teacher-completed and parent-completed SDQ. However, schools will need support in collecting, using and interpreting data of this kind.
- There are a range of other screening measures that can be used to measure impact such as the Boxall Profile. However consideration does need to be given to the value of having a common tool/approach to measuring impact on mental wellbeing across schools to allow for comparison.
- Other school-specific measures can be used to track progress such as attendance, behaviour and attainment.
- Schools can also monitor output measures such as the number of staff trained in mental health awareness, the number of children accessing interventions delivered by Mental Health Support Teams, the number of referrals to Mental Health Support Teams and to CAMHS.
- Quantitative measurement of a 'whole school approach' given all the many factors and variables is challenging. There would be value in investing in a research study to progress this area.

13. 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?

- Looked after children are more likely to experience mental health difficulties (around 7% of the children Place2Be work with are looked after compared to the wider population of 0.6%). It is important that schools are made aware of this heightened risk and actively monitor their mental wellbeing.

14. 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?

- It is also important that schools are made aware of the increased risk of poor mental health among children in need and that their mental wellbeing is actively monitored.

15. 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?

- Children with special educational needs are more likely to experience mental health difficulties (32% of the children Place2Be worked with in 2016/17 were looked after compared to the wider population of 15%). It is also important that schools are made aware of the increased risk of poor mental health among children with special educational needs or disability and that their mental wellbeing is actively monitored.
- Children with special educational needs or disability may need additional help accessing support. 10% of the children at Place2Be worked with in 2016/17 had communication and interaction needs. Our school project managers have specialist training to support these additional needs.

16. 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. 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

- Trial evidence for benefits for children with ADHD from health advice given to teachers Tymms P, Merrell C. The impact of screening and advice on inattentive, hyperactive and impulsive children. European Journal of Special Needs Education. 2006; 21:321–337.
- Evidence for training school counsellors in CBT
  Beidas, R.S., Mychailyszyn, M.P., Edmunds, J.M. et al. School Mental Health (2012) 4: 197. https://doi.org/10.1007/s12310-012-9074-0

17. 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

- Half (52%) of the children to whom Place2Be provides its early intervention service have mild to moderate needs, in that they show subclinical scores on the basis of the teacher completed Strengths and Difficulties Questionnaire (SDQ) (they score in the 'normal' (32%) or 'borderline / moderate' (19%) range on the Total Difficulties score). This includes children who have mild / moderate difficulties in their emotional needs (anxiety and low mood) – 11%; and in behavioural needs such as conduct (10%) and hyperactivity (9%).
- While our expert school-based teams are already supporting children with mild and moderate mental health and wellbeing needs as set out above, it is also important to note that just under half (49%) of children and young people we support in our partner schools have severe needs. In our experience there are many children within schools with diagnosed and undiagnosed conditions who have severe mental health difficulties and are not accessing CAMHS. Mental Health Support Teams are likely to encounter many children and young people with severe mental health needs and they will need to have the relevant skills, as well as fast-track referral to CAMHS and other services, to respond to these children and young people.

18. 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.

If you would like further details of evidence of Place2Be and The Art Room practice in schools, we would be very happy to provide impact reports.

20. Is there any other evidence that we should consider for future versions of the Impact Assessment?

- Review of mental health interventions in schools:
  Merry, S.N. and Moor, S., 2015. School-based mental health interventions. *Rutter's Child and Adolescent Psychiatry*, pp.545-558.