The British Psychological Society
Promoting excellence in psychology

British Psychological Society response to the Department of Health and the Department of Education

Transforming children and young people's mental health provision: a green paper

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The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries
We are content for our response, as well as our name and address, to be made public. We are also content for you to contact us in the future in relation to this inquiry.

Please direct all queries to:-

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We hope you find our comments useful.

British Psychological Society response to the Department of Health and the Department of Education

Transforming children and young people's mental health provision: a green paper

	The core proposals in the green paper are: • **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** • **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** • **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?**
1.	**Please give your answer below (max 250 words)** Whilst raising the profile of mental health needs of children and young people (CYP) in schools and colleges is necessary, and improving interagency working is laudable, we are extremely concerned that these core proposals fail to address the difficulties outlined in Chapter 1. The numbers of CYP with identified mental health issues require a much more holistic and systemic approach. Moreover, in addition to any targeted individual support, the strategy needs to start with tackling the major determinants of poor mental health which are poverty, social inequality, poor housing and degraded communities, as evidenced in successive recent studies of children's mental health and well-being, Millennium Cohort Studies, (2016, 2017, 2018). All schools and colleges should be incentivised to develop an environment, which promotes individual and community wellbeing so that students experience a sense of belonging and engagement in a context able to respond to their needs. There is national and international research (see WHO, 1995 onwards), recognising that good mental health is dependent on the relationship between individual attributes, social, economic and environmental factors. We are concerned that the core proposals above will fall far short of addressing individual concerns and as well as wider systemic factors. It's noted (P 5, p117) that there needs to be a focus on earlier intervention and ***prevention,*** however, the thrust of this green paper is reactive and focuses on a "within child" model. For example a child aged 10, just preparing for secondary transfer, experiences emotional difficulties. The child and her family, were moved out of London into social housing in another borough 20 miles away from her school, due to the capping of the amount that can be paid through benefits for rent. She travels for two hours across London every day to get to school. The child is stressed and tired and living

in overcrowded and dirty conditions. It is claimed the child has mental health needs – the problem 'within' the child. Children are individually different and reasons for ill health are complicated, including underlying psychological and social causes alongside medical or biological factors. There needs to be a change in the approach, shifting away from a purely biological medical model to what many call the 'biopsychosocial' approach which is more holistic and inclusive. This approach considers the physical element (biological) of an individual's condition; as well as the circumstantial, social and psychological elements. This helps to identify multiple simultaneous causes of an individual's condition rather than focusing on identifying a single cause or symptom.

The biopsychosocial model acknowledges that the problems are environmental, that leaving the family in a home close to school is the solution rather than therapy. Many 'mental health' needs reflect the impact of austerity rather than some internal weakness in the child. Furthermore, lots of low level stresses, wellbeing issues and minor mental health needs were picked up by schools' educational psychologists provided by Local Authorities, schools pay for them through their reduced budgets. Meaning fewer children access this early preventative support. There is an attempt to put the problem 'within' the child, therefore the proposals in the green paper, are based on invalid assumptions.

We call on the Government to reinstate the robust, professional EP early intervention services for all children, irrespective of their school budget capacity, which would enable appropriate and thorough assessment of the childs needs and the identification of appropriate interventions and other forms of support which could have a sustained, positive benefit.

We call on the Government to place more emphasis on preventative measures which would have the positive effect of fewer children developing mental health issues, and therefore less demand on primary and specialist services, such as CAMHS, allowing the early intervention and quick access of those who need it.

There is no proposed development of an overarching strategy to enable schools and colleges to become a universal source of wellbeing. Furthermore, the timescale for the implementation of these proposals is does not reflect the urgent need for action. The aim is to provide for a fifth to a quarter of the country by 2022/23, suggesting that the problems identified will not be addressed for at least another four years and then, only begin to be addressed for a small proportion. As it is, there are huge local variations in services for children's mental health, and there is a need for a regulated, and government defined minimum standard of service to be offered in each Local Authority that reflects the diversity of needs within the community.

It is essential that schools and colleges have the appropriate support and supervision if this model is to work. Each school should be required to have a Designated Senior Lead for Mental Health (DSLMH) who is part of the Senior Management Team. The experience and expertise of the DSLMH and the specialist supervision that is provided is critical to ensuring that services offered actually improve mental health and well-being rather than just improve the numbers of young people 'seen by someone'. Further consideration should be given to how those two areas work in a coherent way - ensuring that it is one continuous service provision. Otherwise, there is a real risk that more young people, rather than less, will slip through the gaps between provision and services.

There is a disproportionate emphasis on schools and colleges. The proposals place a huge amount of responsibility on schools; when they are already struggling to meet the needs of pupils (especially those with special educational needs) on reduced budgets and reduced

capacity. It is suggested NHS staff will (in additional to their core work) supervise the Mental Health Support Team (but, it does not specify who will make up this team) and reduce the waiting time for referrals. NHS staff have years of specific training in order for them to do their roles; teaching staff have not. As acknowledged in the green paper, teaching staff do not currently receive adequate training in the area of mental health and emotional wellbeing. The responsibility this places on schools is considerable and it will be imperative that the Mental Health Support Teams / NHS staff work closely and regularly with schools to ensure appropriate provision is provided. If Mental Health Support Teams' are to be effective they need to include health, education and social care. Many children and young people with mental health issues live in families that need, but cannot or do not access social care provision.

The role of School Nurses has been severely reduced. They provide very valuable early intervention to extremely vulnerable and 'hard to reach' young people. They should be a core member of such teams.

There needs to be a structure for children who are on the periphery of education by virtue of their family circumstance/ ongoing difficulties: home educated children; travelling communities; excluded children and children on bespoke one-to-one support.

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?

2. **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	1
Funding allocated to local authorities and multi-academy trusts to administer to schools	=2
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 (max 250 words)

It is extremely difficult to rank the above funding approaches and we do not believe that this is an effective or valid way to consider the best and appropriate means for the distribution of the fund. . The main consideration in funding training is establishing the effectiveness and evidence base of the training and the capacity of the training providers to deliver to schools and colleges. We are concerned that if funding is administered directly to schools, there will be wide differences in the type and quality of the training.

It is essential to establish the evidence base of any training programme, including its appropriateness to the setting. It is also the case that 'one off' training is very unlikely to

	produce the necessary knowledge and understanding needed to support the mental health needs of CYP. Additionally, on-going development, support and supervision will be required. The Green Paper suggests that "there is evidence that appropriately trained and supported staff such as teachers, school nurses, counsellors and teaching assistants can achieve results comparable with those achieved by trained therapists" (P38), however these members of staff have specific duties and already are overstretched as are the NHS services (CAMHS), to suggest these staff can offer support and supervision needs reconsideration. Furthermore, there is also evidence to the contrary (Weeks et al., 2016), suggesting that the quality of services delivered by specialist staff is more effective. For example, educational psychologists ran a CBT intervention in schools with anxious girls. They found that teachers needed a lot of support with appropriate identification of those who would benefit and needed lots of encouragement to adhere to the protocols. Schools with absent staff would cancel sessions to get cover for classes and teachers lacked the understanding of the processes and theories so did things that were counterproductive. Applied psychologists are well placed to advise and support schools and colleagues; however, provision is unsatisfactory to a marked decreased in LA employed educational psychologists and the need for direct funding from Academies. **We call on the Government to consider a more radical approach, which is to have sufficient applied psychologists, both Educational and Clinical psychologists, working more directly in schools. This professionally trained workforce would be the most suitably qualified and able to guide preventative and reactive measures.** **There is no stated mechanism within the Green Paper which articulates how schools and colleges can bid for the funding to train the Designated Senior Lead for Mental Health posts. The process must be open and transparent.**
	Do you have any other ideas for how the training fund could be distributed to schools and colleges?
3.	**(max 250 words)** Consideration should be given to providing the funding to the local mental health services who would then have a contract to provide the training to all the schools in their local area. They would have the mental health expertise and also would be aware of specific local issues. It would also immediately improve links between the local services and the schools. Alternatively, schools could be offered training by their local universities, where training on mental health is available (e.g. where there are training programmes for mental health nurses / applied psychologists / IAPT workforce) to provide training to schools. A further option for consideration, is that funding should be used to develop robust training which is delivered across the country. The core training provided to school staff can and should be standard. There is a good data on high quality evidence-based approaches in England, for example, *The emotional wellbeing and mental health of young Londoners: A focused review of evidence* (2007) and Maxell et al. (2008). Furthermore, there is evidence from previous government initiatives, including the evaluations of the Targeted mental health in schools (TaMHS) and Social and Emotional Aspects of Learning (SEAL) Programmes, which could provide evidence of 'what works' for schools and colleges. Information on appropriate training could be provided via a website to all schools and colleges, such that they are able to make informed decisions about which types of training can be most effective.

	<u>Mental Health Support Teams</u> **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?**
4.	**Please give your answer below (max 250 words)** The proposal of MHSTs is positive since this provides an accessible service, can offer an individual 'school centric' service and provide a smoother transition to CAMHS. There are some models of good practice such as the Anna Freud CYP IAPT service and there needs to be a clear remit of what measures will be evaluated in terms of the effectiveness of such models through the trailblazer sites. The current Psychology Wellbeing Practitioner (PWP) role does not meet the remit required by MHSTs and it is proposed that the Society offer further tailored training, which could be a community clinical psychology specialism together with the input of clinicians who are trained to use a child development framework. There should be a clear directive of how the MHST links with other services such as educational psychology in order to avoid overlap and competition. In order to fulfil the full range of duties MHSTs must have access to specialist mental health professionals with a range of expertise. In addition, each team should have a clinically qualified mental health lead who is able to assess, identify, risk assess and make referral as appropriate. Support for children who experience traumatic events should include access to evidence based interventions (targeted CBT, EMDR) whilst children who have experienced bereavement may benefit from non-directive counselling or a counselling approach. The MHST should have the ability to offer training and supervision to both clinical and non-clinical staff. This should include training in simple behavioural and systemic interventions effective in behaviour management. Specialist child and adolescent CBT practitioners should be based within the team in order to assess and offer CBT intervention to children and adolescents presenting with symptoms of anxiety and depression. However, there needs to be clinicians with a range of seniority and experience in order to deal with the more complex presentations of anxiety and depression. Accordingly, there should be an evidence-based service for children and young people who self-harm (targeted CBT, DBT) and referral onto CAMHS for more complex presentations. Within this service there also needs to be support for the difficulties some children and young people might experience in emotional regulation. Additionally, children with eating disorders, moderate to severe depression who may require medication, severe OCD, complex PTSD, psychosis, dual diagnosis, and emerging personality issues should be referred on to specialist CAMHS. There needs to be a specialist clinician within the team who can carry out this assessment. The effectiveness of group based intervention on eating and body image issues in high-risk adolescent girls in a school based setting should be researched more thoroughly prior to implementation. The cost benefit of such an intervention should also be evaluated.

There is no mention, the Green Paper, of the use of routine outcome measures and on-going evaluation of the effectiveness of the services offered by a MHST. MHST teams should have training in research methods and data collection.

The Society has significant concerns about the trailblazer phase, which is too long and protracted and serves only to support 20-25% of the country. It is unacceptable that 75-80% of schools will receive no additional support at a time when the rates of mental health problems in CYP are increasing.. There will, therefore, be a postcode lottery of mental health support for children, young people and their families. There is also no guarantee of rollout after the initial phase, as funding has not been secured. Having partial coverage means that there is a risk of some CYP having even less access to services than they do now, if CAMHS/ new teams are linking with schools in some areas but not in others.

The Green Paper states, 'This mix of provision will look very different in different areas, we do not believe there is a single model that should be implemented nationally'. The Society agrees, however, close consideration should be given to ensure coherence and coordination of services where city and county areas adjoin each other. All the information, work, research and resources which went into developing and evaluating Targeted Mental Health in Schools (TaMHS) provides a wealth of good practice and areas for development (DfE, 2011).

In Southend services are delivering a Healthy Schools Project focused on mental health and emotional wellbeing. This training includes: an eight session block of training on attachment / trauma informed development run by the Educational Psychology Service; sessions from the Emotional Wellbeing and Mental Health Service (EWMHS – previously CAMHS); training and supervision in Video Enhanced Reflective; training from Stonewall and a range of other training focused on emotional wellbeing. Southend are also linking up with Essex and Thurrock to provide training to schools; provision for young people, such as an online counselling service [Kooth] and other initiatives.

The primary care mental health team in Leicester already does this exceptionally well, but requires funding for expansion. (Leicestershire Partnership NHS Trust – Primary Mental Health Team) They work with schools to provide consultation, short term work with children and special needs. However, it should be noted, Leicestershire County Council will close 24 Children's Centre in a bid to cut costs (see, https://www.leicestermercury.co.uk/news/leicester-news/protesters-launch-final-bid-stop-1244328)

A number of schools have bought in a clinician's time one day a week. It is helpful to have a clinician embedded within a school, to offer consultation, support and training to the school, short term work with some children and get to know the specific needs of that school.

In Oxfordshire, applied psychologists have been working for years on a countywide response to self harm, as set out in county guidelines for self harm for teachers in schools and staff in residential settings. The guidelines have been revised over the years, on the basis of feedback from professionals working with children and families. In particular, they address the dilemmas staff have with regard to confidentiality/ Safeguarding reporting and how staff can begin to work with concerns in ways which can aid decisions to refer to specialist services.

The work now is going forward with Self Harm Networks in the county as forums for multi-disciplinary work to collect data and to improve systems.

In addition, there are day conferences on self harm for professionals, especially teachers, which have always been fully subscribed.

One of the Self Harm Networks worked with a local Youth Theatre to commission, advise on the writing of a play about self harm, 'Under my skin', which is in its third year of being performed in schools. It tours secondary schools for a period of three or four weeks each year. In its first year, it was seen by over 5,000 children. Now in its third year, there are support materials for teachers before the play comes to the school; the play is performed by actors who have had briefings on the subject and have with them in each school, the school's support professionals for a discussion with the actors after the play; feedback from children and staff is taken in the form of a questionnaire; and there is then a lesson for the teachers to give a week after the play, when children have had time to process the messages.

It is noted the Mental Health Support Teams will be supervised by NHS mental health staff. We recommend Educational and Clinical Psychologists provide the required professional supervision.

Different organisations could take the lead and receive funding to set up the Mental Health Support Teams. We would like to test different approaches.

5.

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	3
Local authorities	5
Charity or non-government organisation	1
Other: _____	2

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:

6.

Educational psychologists	**1**
Local authority troubled families teams	
Local authority children and young people's services	**2**
Local authority special educational and disability (SEND) teams	**3**
School nurses	
School-based counsellors	
Charity or non-government organisation	
Youth offending teams	
Other: It is important that there is recognition of the vital link with CAMHS.	

We are concerned about the lack of clarity of how these mental health teams will ensure continuity of service provision with CAMHS in order to prevent another gap in provision

through which children, young people and families can fall. CYP and families consistently report that gaps between services cause significant distress and can result in some of the most vulnerable young people slipping through the net. The Education Policy Institute report showed there was evidence of a clear 'treatment gap' when it comes to local mental health transformation plans and it is unclear at present how the introduction of mental health teams within schools will address this. While some young people may receive a service they would not have previously had the lack of clear joined up working across mental health provisions puts at risk the increase rather than decrease of 'treatment gaps'.

The introduction of School Nurses working in secondary schools on a full-time basis has been a very effective strategy. They have been able to offer time and support to young people in school with issues beyond the scope of teaching staff, such as: contraception; self harm; puberty sessions; workshops on testicular cancer for 14+years. They link with primary care services/ records. An interesting feature of the service was the very simple expectation that they had a dedicated space in which to work. Schools need to understand this need for dedicated space to offer assessment/ interventions. Being offered a different room each time, or sharing the room with the PE store of footballs or a camp bed for children who feel sick, or a room which has other purposes and which gets interruptions, will undermine the idea of providing for the most vulnerable in our school systems.

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?

7. **Please pick your top three:**

Impact on children and young people's mental health	1
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	=2
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	
Other: _____	

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?
8.	**Please rank the following in order of importance:**

Deprived areas	3
Levels of health inequality	1
Urban areas	5
Rural areas	4
Areas where children and young people in the same school/college come under different Clinical Commissioning Groups (CCGs)	6
Other: Areas in which children and young people do not have access to a Local Authority Educational Psychology Services.	2

This focus on areas is problematic as it is too simplistic a categorisation. Difficulties were experienced in Oxfordshire in setting up a county-wide approach to self harm with local Self Harm Networks using a similar form of categorisation. When considering potential members for each network, areas became problematic, possibly more so in large rural counties. Areas vary with:

- School partnerships/ locations
- Social and Health Care areas linked to their locality teams
- Different Clinical Commissioning areas
- Cross county border cases of people living in a different county and coming in, or going to schools across a county border

Transport in rural areas can be a barrier to reaching some children and families.

We strongly recommend consideration of the establishment of a county Steering Group and link to the Clinical Commissioning Groups for guidance and to resolve specific matters.

	How can we include the views of children and young people in the development of Mental Health Support Teams?
9.	**Please provide your answer below (max 250 words)**

By making CYP part of the process at every level.

Children's views can be included by making information accessible and meaningful to them so they are able to give their views in an informed manner, by setting up groups across all age groups / needs / demographics to ensure a wide range of views are gained. By providing peer-mentors as part of the teams. And including young people on interview panels for applicants to new posts, including young people in designing the way the service will be researched, and offering work experience to young people.

Furthermore, children's views can be included by setting up focus groups within schools and CAMHS teams and inviting young people to come along to contribute and make their views known. By also offering accessible questionnaires online, advertised through social media. And by getting young people's views is indispensable, and in the Society's experience they suggest excellent ideas.

	There are many organisations who have a strong track record of working directly with CYP to access their views. These include: The Children's Commissioner Young Minds National Children's Bureau Participation works Local CAMHS Applied psychologists are highly skilled in working with CYP to enable them to have a voice and contribute their views. They would be well placed to support the development of surveys or to facilitate focus groups, (Hill et al. 2016). Schools are already monitoring children's social and emotional well-being in confidential questionnaires, to assess and tackle issues such as bullying, cyber-bullying, homophobic bullying, and racism. This could be extended to include children's views about mental health support services/ help they feel they need.
	<u>Piloting a waiting time standard</u> **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?**
10.	**Please give your example(s) below (max 250 words)** The Cwm Taf Health Board is introducing the Choice and Partnership Approach (CAPA) this is about streamlining services to offer timely, high quality care by doing the right thing at the right time with a focus on engagement and moving forward. Please see http://capa.co.uk/what-is-capa Leicestershire Partnership NHS Trust have a waiting time standard for access to initial assessments in CAMHS and receive monetary penalties if this is not adhered to. The Hillingdon CAMHS has set a waiting time standard of 18 weeks from referral to assessment. This standard has not been met, partly because the funding was not utilised because of difficulties with recruiting staff[1]. There are a number of CAMHS that operate a waiting time standard who manage this by then having an internal waiting list. Cases are seen quickly for assessment but then have unacceptably and clinically unsafe waits for treatment. Implementing a waiting time standard must recognise the current pressures on services and accordingly additional resources must be provided.
	<u>Schools and colleges</u>

[1] CAMHS Update September 2017

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?

11.

All of the information they need	
Most of the information they need	
Some of the information they need	3
None of the information they need	=1
Don't know	=1

Please tell us more about why you think this (max 250 words)

The policies cited would be very unlikely to offer much information on support for mental health as they would largely cover procedural aspects of school/college organisation. They would need to specifically request information about both wider proactive systemic interventions as well as more focused interventions. Some parents will struggle to access written policies and understand them. Schools should be encouraged to hold evenings where they talk to parents about these topics, in addition to the standard parent's evenings.

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

12. **Please give your answer below (max 250 words)**

Importantly, this could be most effectively achieved by asking CYPs about their views. This also links to our response to question 9, which, would establish a participatory process for CYP to be actively and continually involved in a cycle of implementation, review and evaluation.

Applied Psychologists would be very well placed to help schools and colleges develop appropriate techniques and approaches to enable children and young people and their carers to have a voice and contribute their views to evaluations through the development of surveys or focus groups, (Hill et al., 2016). Furthermore, through collecting data schools and colleges can measure: local demand for various levels of intervention, measure the impact of interventions on needs and numbers of referrals onto more specialist services. This data could inform the planning of future services based on evidence of local needs.

Additionally, standard outcomes sets, such as: CYP IAPT, Revised Children's Anxiety and Depression Scale (RCADS), goal based outcomes, the number of referrals to CAMHS. Another goof sources would be the Strengths and Difficulties Questionnaires (SDQs), parental reports, and teacher reports. Collating qualitative feedback (short answers) would also be a very good way to measure the impact alongside routine outcome measures.

Schools should have a good understanding of the mental health/wellbeing of the pupils, by using a baseline assessment about their wellbeing. Putting in place and evaluating evidence-based interventions to provide a targeted intervention for individuals / groups who are

	experiencing difficulties and as a preventative measure for those groups where difficulties could arise (i.e. children in care). Carrying out action research projects to track how support / interventions are working in schools. There should be a wider measure of impact via a national data collection and examination of data. Ofsted could also be involved with monitoring and measuring impact of what schools do to support mental health wellbeing. There should also be whole school measurement of emotional wellbeing with standardised questionnaires and qualitative methods, before and after introducing new support mechanisms; whole school measurement of exclusions, before and after; whole school measurement of achievement before and after and measurement of numbers of children accessing home tuition, before and after.
	<u>Vulnerable groups</u> **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?**
13.	**Please give your answer below (max 250 words)** The Society is concerned the Green Paper focusses on non-specialists identifying and supporting children and young people who might have very significant mental health needs. This is too complex a task to be able to make nuanced judgements about children's wellbeing. It is essential that skilled and experienced practitioners undertake this role - applied psychologists are well placed to do this. As applied practitioner/scientists they are uniquely well placed to offer consultation, assessment, and intervention, including systemic and individual formulations and interventions. It is important that evidence-based practice is used to inform all areas of their work. The Mental Health Teams will need to be very highly trained to engage and work with vulnerable groups of children, for example, knowledge and understanding of the impact of Adverse Childhood Experiences (ACEs); attachment and child development theories. On-going training, with up-to-date knowledge of how to support pupils will be essential. Being aware of the local area and what community based support there is. Giving the pupils opportunities (time) to build relationships and feel safe to talk about their experiences / feelings. It is also very important to have links with children's centres and social care. Also important to have professionals qualified to work throughout the life span to offer support to parents, as well as being able to work with young people. There should be flexibility in ways of working and adapting therapeutic models to individual needs (e.g. culturally appropriate interventions, community interventions). The teams must have access to qualified and experienced professionals – who are able to do multi-factorial psychologically informed individualised formulations, which ensures CYP receive a service that meets their needs (including systemic input).

It will be essential to work closely with the families / carers of the young people to offer joined up approaches that do not just focus on the individual pupil, but the wider context in which they live and the impact this may have on their mental health wellbeing.

By undertaking research to measure the impact that support / interventions have on individuals and groups would also add to the knowledge and evidence-base of what works in promoting the mental health and wellbeing of vulnerable groups.

Children with Autistic Spectrum Disorder (ASD) make up a lot of the referrals to CAMHS. What is needed is good consultation with the school and family. Having designated ASD staff/ neurodevelopmental staff embedded within Mental Health Support Teams would be very valuable. These would ideally be applied psychologists, occupational therapists, or mental health nurses with experience of working with children with ASD.

By working closely with third sector organisations, who are often more acceptable to vulnerable children and young people, to provide support. By working closely with social care to identify vulnerable young people.

The Society is concerned about the access to support for the increasing number of children who are home-schooled. How will they be reached by MHSTs?

Support to vulnerable groups needs to be in offers of work to recognise and address individual needs, alongside wider systemic work such as: a whole school approach to mental health well being or to suicide prevention. For example:

- Sandhill Council has developed a whole school approach to mental health well-being resting on eight principles: leadership; curriculum-teaching and learning; pupil voice; staff development; identifying needs, monitoring impact; working with parents; targeted support; ethos and environment. They have a well-being screening tool and offer schools Charter marks for work undertaken.
- Papyrus, an independent voluntary agency is developing work along the lines of building 'suicide-safer schools and colleges', working with staff on giving them information about suicide; prevention; intervention; post intervention.

We call on the Government to develop evidence based policy that addresses ACEs. This will go a long way in promoting and maintaining good mental health and wellbeing.

The Green Paper proposals do not cover those most at risk. There is no mention of behavioural problems which are the most common difficulties children and young people experience, the most costly and the most likely to be misinterpreted. There are some particularly vulnerable groups who currently have limited access to CAMHS, despite high levels of need. These children are omitted from the Green Paper. They include:

- children and young people with special educational needs, who are more likely to experience mental health needs yet less likely than non-disabled peers to access CAMHS;
- young offenders, who have high levels of mental health difficulties including depression and self-harm, yet are often not in full time education and able to access CAMHS, negatively impacting reoffending rates;

	• looked after children and care leavers, who are five times more likely to suffer mental health problems than their peers yet have limited access to suitable mental health support; • LGBT young people; • young people and intersectionality; • BME and refugee children (see the Society's response to Mental Health Act Consultation, January 2018); • victims of crime e.g. sexually exploited young people; • children with chronic physical health problems and/or disability; • young carers; • children whose parents have mental health problems/substance misuse problems. **The Society calls for children and young people in these groups to be prioritised for improved access to CAMHS.** Please see the Society's response to the Science and Technology Select Committee's Evidence-Based Early-Years Inquiry http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/science-and-technology-committee/evidencebased-early-years-intervention/written/75348.html
	Support for children looked after or previously looked after **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**
14.	**Please give your answer below (max 250 words)** It is a statutory requirement for Local Authorities to have a Headteacher/ Virtual School in place for the monitoring of Looked After Children. Within schools, there is a requirement to have a Designated Lead for Looked After children and the administration of Pupil Premium funded resources to the advantage of the children. This is a system which can be used to test out whether the children do get the right support. It is important that the system is fully inclusive of these vulnerable children. To be such, it needs to include: Looked after children; children subject to Special Guardianship Orders; children in Kinship Care arrangements; and adopted children. There needs to be urgent consideration of how virtual schools might expand their role to follow young people who are looked after into the Further Education (FE) sector. This would be consistent with the aims of the Children and Families Bill (2014). Current research at the Institute of Education, University College London suggests that looked after young people making the transition to Further Education are often not identified early on by the college. Therefore they are not accessing adequate support and become excluded due to poor attendance. There needs to be a more coordinated way of working across Education and Social Care to ensure that these young people are identified and supported through transition by accessing adequate support. Services should be accessible and delivered in the FE context. Clear guidance for Local Authority services on the management of transition from school to FE college for looked after young people would greatly assist them in achieving better outcomes through the timely and adequate transfer of information. This would enable advanced planning for all of their needs including, financial, emotional wellbeing, and educational.

	Support should be interconnected with the schools/support teams monitoring and evaluation of provision, i.e. are these pupils initially highlighted as a target group? Information about services and support should be given to these pupils and time given to establishing with them whether this is something they would find helpful. Ensure that the school staff directly supporting the pupils, social care teams, any other organisations and families and carers are aware of the support that the pupil could gain. Ensure the information provided to the pupils is accessible and written in a way that helps them both understand what the support is – so they feel safe enough to engage with the support (or ask more about it). Make it easy and safe for them to ask for information and support when needed. Work with these pupils to establish what type of support they would find the most helpful (group / individual / peer support etc.)
	<u>Support for children in need</u> **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?**
15.	**Please give your answer below (max 250 words)** As outlined in our response to Q14, it is very important that all agencies in the Local Authority are sharing information to facilitate transitions and to ensure ongoing support for children in need. It is well known that children who are exposed to domestic violence, are on the edge of care or have disabilities have an almost 50% risk of having accompanying mental health needs. As these populations are identified it is simply a matter of ensuring that communication systems between agencies are robust and that the data about number of children in need are used to inform local planning of mental health services. This can only happen if there is central funding and universal delivery, giving funds directly to schools makes it impossible for local areas to provide a sufficiently nuanced range of services for their community. We need to ensure robust tracking and monitoring systems are in place and that they facilitate planning in education, health and social care. Furthermore, Mental Health Support Teams and Designated Mental Health Lead should be trained in advanced safeguarding. Support for CYP must always be staffed by people who have relevant qualifications and experiences of providing for children with mental health difficulties. The right of children and families to be seen by a qualified mental health specialist in the first instance, for a formulation of their needs, should be protected.
	<u>Support for children and young people with special educational needs or disability</u> **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?**
16.	**Please give your answer below (max 250 words)**

	Currently the input to this process by Health And Social Care services is minimal and often consists of the provision of a report, a summary paragraph within a plan, and no follow up. The wealth of knowledge about these children held by their parents is one feature that isn't included in this Green Paper. The proposals can be put to the parents of these children, and their networks should be approached, for example the local Special Educational Needs and Disability Information, Advice and Support Service, SENDIASS. As in the responses to questions 13 and 14 it's known that the risk of developing mental health needs for these young people is approaching 50%, Green et al. (2005). We need to ensure that there are robust systems in Local Authorities to track these young people, to ensure that any transitions are facilitated through the timely transferring of essential knowledge about their needs. Systems should exist to ensure that data is shared between Health, Education and Social care irrespective of an Education, Health and Care Plans (EHCP) being in place. Many young people with autism do not have an EHCP but have a significant need to access support for anxiety, for example. This is better provided across a Local Authority by specialist staff, then by an individual school. Data about the types of needs within a community should inform Local Authority planning of services, in particular those for children and families with learning disabilities. Current policies that devolve money to schools have led to fragmented services and made it difficult to retain sufficient funds to provide the necessary range of more specialist mental health services for particular populations. These policies require an urgent review as they are disadvantaging vulnerable populations and diluting the quality of provision. A government defined minimum offer for mental health services in local authorities is essential. Comparisons of numbers accessing proposed teams with existing demographic information on numbers of children with SEND in that school. There should be a learning disability lead in each Mental Health Support Team. Plus adapted and targeted interventions/plans for special needs schools.
	<u>Providing evidence for an Impact Assessment</u> **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.** **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** **Please give your answer below** **Pre diagnosable: Children and young people who have mild or low-level needs which do not constitute a diagnosable mental**

17.	The decision about what level of support a child or young person needs should be based on the impact on the child's functioning and whether the service provides an intervention that can help. Many children who have experienced developmental trauma (eg exposure to domestic violence, neglect and abuse) but are living with birth family have difficulties with behaviour and emotion regulation which have a significant impact on their functioning at home and school, but do not meet the criteria for CAMHS because they do not have a 'diagnosable mental health condition' and CAMHS is not commissioned to work with Developmental trauma.
	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 **Please give your answer below**
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. **Please give your answer below**
19.	In Oxford a special school which caters for children with autism, severe anxiety, and attachment difficulties, works with a local Child and Adolescent Mental Health Service to offer a clinic in school for CPA Reviews for children and their families. The Child and Adolescent Psychiatrist comes to the school for the day. Children are seen in school with their parents. The benefits are: o Children miss much less school as they come to their appointment in school. They do not have to miss school for travelling time, waiting time, or miss the special school transport, which could mean they miss a whole day to go to an appointment. o The children see the psychiatrist in a setting with which they are familiar and they feel supported. o The school has free parking. o If appointments are running late, parents are comfortable to wait in familiar surroundings. o It is easier for teachers to make an input to the reviews in ways which they could not if they had to go out of school and travel to CAMHS. o The educational psychologist is present in all reviews, giving input from her work, but also learning a great deal from a joint approach. o From the point of CAMHS, this approach means fewer failed appointments. o This collaborative approach means there are a range of professional views available to the psychiatrist.

	Please provide any evidence you have on the impact of Children and Young People Mental Health Services therapeutic treatments **Please give your answer below**
20.	
	Is there any other evidence that we should consider for future versions of the Impact Assessment? **Please give your answer below**
21.	
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End.