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**What good looks like in psychological
services for schools and colleges**

Primary prevention, early intervention and
mental health provision

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Executive summary and recommendations

A person experiences greater psychological and physical development and change during childhood than at any other time in their lives. Experiences during childhood also have an important and lasting impact on both the individual, their family and others close to them.

Children and young people will experience episodes of psychological distress during childhood and adolescence, from cutting their fingers, to losing a pet, or falling out with their best friend. For most this will be short-lived and through the social support of family and friends may increase their resilience and ability to cope with upsetting events later in life.

For some however, the nature of the experience, for example abuse, significant bereavement, the extent of the distress or the lack of positive social and family support can have an extremely negative impact on their mental health which may be life-long unless the right help is provided at the right time and in the right way.

Current statistics show that:

- Approximately one in ten children and young people have a diagnosable significant psychological difficulties.
- Around one in four children and young people show signs of a mental health condition, including anxiety and depression.
- This means that up to three children in every classroom may have psychological difficulties which could be helped.
- Only 25–40 per cent of these young people receive input from a mental health professional early enough, if at all.

Whilst it is not compulsory for children and young people to attend school in order to receive their education, the majority will attend. Outside of the home, school is often the most important consistent influence in children's development. There are therefore significant opportunities for high quality psychological services to promote resilience and wellbeing; as well as creating a psychologically healthy school environment for both children and staff. The option of delivering help in the school to children and young people who are experiencing psychological difficulties is increasingly being explored.

Children's mental health has never had a higher profile than it does now. 'Future in Mind' (Department of Health, 2015) developed by the Children and Young People's Mental Health and Wellbeing Taskforce, made recommendations for the future development of children's mental health services in the NHS that were later incorporated into the 5 Year Forward View for Mental Health. The Government's response outlined a £1.4 billion investment in child mental health over the 2017–20 period, including:

- Making mental health first-aid training available to all secondary schools, with the aim of having trained at least one teacher in every secondary school by 2019.
- Evaluating different approaches which schools can use for mental health promotion and prevention.
- Launching a pilot programme on peer support for young people in schools and online.
- Possible Care Quality Commission and Ofsted joint inspections on children's mental health and wellbeing.
- £20 million to the Time to Change anti-stigma programme, improving the attitudes of young people towards mental health and reaching 1.75 million young people and 1.5 million parents each year by 2020.
- Reporting on the prevalence of mental health conditions in children and young people by 2018

With a Green Paper on children and young people's mental health being published later this year, which will have a focus on mental health and schools, reviewing what the role of psychological services in schools might be, and how psychologists can be involved in the debate over the design of what services could look like is crucial to inform the shaping of future Government policy in this area.

In this volume, we will briefly review the issues and the evidence and discuss the practical ways in which psychological wellbeing can be addressed in school settings, as well as the implications for commissioning and delivery of provision. This will further develop a key part of any ambition to create integrated Psychological Health and Wellbeing services (PHWBS) of which CAMHS would be a part. For more discussion of this concept, see 'What good could look like in integrated psychological services for children, young people and their families: Preliminary guidance and examples of practice'.

Most of the text in this publication refers to schools for convenience but should be taken as applicable to colleges as well.

In the first chapter the various roles that schools could undertake are discussed, including primary prevention, early intervention and mental health provisions and the role of applied psychologists and psychological services.

Chapter 2 reviews the demographics and mental health conditions in children and young people and considers the importance of addressing risk factors and building resilience.

Chapter 3 considers the key elements in the provision of a good psychological service in school settings.

The final chapter considers the practical ways that psychological services can be organised in schools and the ways they can contribute at universal, selective and integrated levels of provision.

Summary of recommendations

Recommendation 1:

Early recognition of problems, leading to high quality holistic assessments should mean that the right help is provided in the right place and at the time when it is most likely to be effective. **CCGs, Local Authority and other commissioners** should develop models of mental health provision which 'front-load' specialist expertise early in the clinical pathways. These have the potential to make a significant impact and reduce the pressures on CAMHS provision.

Recommendation 2:

Commissioners and Service Providers should consider siting specialist provision in schools or families of schools, including CAMHS teams, as a means of overcoming the barriers to access that currently exist. This is likely to be of particular value for the families with the highest levels of need and those who do not traditionally access clinic-based services.

Recommendation 3:

As some young people may not feel that school is an environment where they feel safe to be open about their mental health concerns, **Commissioners and Service Providers** must give the child, young person and family choice in where they can gain psychological support.

Recommendation 4:

Joint work needs to be undertaken by the **Department for Education and the Department of Health** to develop both the PHSE and wider curricula together with models of support and resources to tackle issues like bullying and other social concerns, academic and sexual pressures. This will need to include training for teachers in delivery, both during training and in schools.

Recommendation 5:

The Department of Health and Public Health England need to develop national policy, guidance and interventions to reduce the prevalence of known risk factors based on psychological evidence and these should be implemented by **CCG and local authority commissioners** at a local level in order to reduce the long term impact of these problems on mental health.

Recommendation 6:

Schools should be supported by **Department for Education, Public Health England and Local Authorities** to build cultures and develop resources which aim to improve social cohesion and prevent bullying. The development of a wider range of opportunities outside the curricula, including sport, creative and volunteering activities perhaps in partnership with the local community, should be supported as these can help to ameliorate some of the effects of poverty and social exclusion and build confidence and life skills. This should be part of a local strategy agreed across local commissioning groups.

Recommendation 7:

Bereavement is a significant risk factor for the development of later mental health problems. Training and support for teachers should be provided so that they both understand what normal distress is and what is likely to help, and recognise when more specialist help may be needed. **Health and Wellbeing Boards** should take the lead in developing collaborative approaches between education, voluntary sector groups, health and social care to support joint training, and help to build good care pathways that will support all agencies in developing good quality care for bereaved children, including specialist help if needed.

Recommendation 8:

Children with neurodevelopmental and learning difficulties often present challenges in schools, due to the problems they may have with staff and peer relationships as well as with learning and they are at high risk of developing mental health problems. **CCGs and Local Authority Commissioners** need to support schools in recognising where there is the need for specialist assessment and with working with parents and carers to achieve this. This should be developed by Provider Trusts or voluntary sector groups who can also help with developing positive strategies to help children to cope and other children to understand them. This can have a major impact on their experiences growing up and enhance their life chances significantly. **Commissioners and Providers** should adjust specialist CAMHS referral criteria to allow these children to remain on their caseloads and 'dip in and out' of services as and when needed.

Recommendation 9:

Children with chronic physical illnesses and disabilities are at higher risk of mental health problems. **CCGs and Provider Trusts** need to ensure that schools have access to advice from the specialists working with the child, both in hospital and in the community to understand the physical and psychological nature of the problems (this may include but not be limited to bullying and social exclusion) and what steps need to be taken to support them.

Recommendation 10:

CCG and Local Authority Commissioners need to ensure that Services have the capacity to assess and intervene at a systemic, especially family, level rather than individual work with the child or young person in order to provide an evidence-based service.

Recommendation 11:

Service Providers should ensure that the process of deciding at what level to intervene (directly/indirectly, lower or higher intensity) is done collaboratively with the young person, their family and their support network and should integrate assessment, research evidence, family or young person's preference, clinical expertise and formulation.

Recommendation 12:

Access to high quality, timely, psychological assessment is essential to provide an accurate and informed formulation and to quickly identify any risk of harm to the self or others. **Commissioners and Service Providers** should ensure that assessment is **multi-modal** and multi-informant and considers the child across all relevant contexts. Risk assessments should be thorough, reviewed regularly and lead to achievable, clear crisis plans where necessary. Risks and associated plans should be shared with the network around the child or young person, including family members, carers, school staff and other agencies involved.

Recommendation 13:

Authentic participation by children, young people, families and other users of the service, including teachers, should be integral to service provision. This will also strengthen the ability to meet the needs of diverse populations within the school. Most schools already have arrangements like School Councils and these can be built upon in developing psychological service provision.

Recommendation 14:

Psychological intervention should be a critical part of the ways in which **schools and colleges** deliver Public Health England's (2015) whole school approach to promoting emotional health and wellbeing.

Recommendation 15:

The research base on the effectiveness of primary prevention and schools-based approaches is relatively new and development of it should be a priority both for psychologists developing new models on the basis of psychological theory and for practitioners who are implementing these. This could be a priority area for key research funders such as the Economic and Social Research Council. In addition the important role of practitioner research should be supported by **employers and commissioners**.

Recommendation 16:

Whilst enhanced training for teachers is recommended, **commissioners, service providers and employers** should recognise it is essential that it is not seen as a stand-alone solution. Effective training requires adequate follow-up in terms of ongoing access to consultation, support and supervision from more highly trained and experienced staff.

Recommendation 17:

The development of psychologically healthy schools which support the wellbeing of staff and students should be a priority for all including **commissioners, service providers and employers**. Use of community psychology models and methods would be a positive way to approach this jointly with staff, students, families and local communities.

Foreword

This volume is an updated and expanded version of the chapter ‘Delivering psychological services in schools to maximise emotional wellbeing and early intervention’ in ‘What good looks like in psychological services for children, young people and their families’ *The Child and Family Clinical Psychology Review*, Volume 3, Summer 2015. It builds upon that work and also on ‘What good could look like in integrated psychological services for children, young people and their families: Preliminary guidance and examples of practice’, *The Child and Family Clinical Psychology Review*, Volume 4, Winter 2016. Both earlier volumes are free to download at:

www.bps.org.uk/system/files/user-files/DCP%20Faculty%20for%20Children,%20Young%20People%20and%20their%20Families/public/cfcpr_3.pdf

www.bps.org.uk/system/files/user-files/Division%20of%20Clinical%20Psychology/public/CFCPR%204%20web.pdf

There is more detail on many of the ideas in this publication in the earlier volumes and examples and resources to found in Volume 4.

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Please note that most of the text refers to schools for convenience but should be taken as applicable to colleges as well.

A note on language

Given the wide range of professional groups for whom this paper will be relevant, it is worth noting that there are likely to be some differences in the use of language, terminology and concepts. We hope that this paper will be useful, in fact, in providing clarity and a shared understanding over definitions and the concepts discussed.

We are aware that there is a lot of debate around how best to describe some of the issues discussed in this paper. The use of diagnostic and medical language is often considered problematic in psychological services, and we have tried to use non-medical language in as much of this publication as possible. There are some instances, however, when we have used medical language (such as when discussing other published work which has used a medical framework). Using these terms does not mean that we support medical explanations of mental health difficulties in children and young people. For more detailed discussions of these issues please see:

- DCP Position Statement ‘Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift’ (May 2013); and
- DCP Guidelines on Language in Relation to Functional Psychiatric Diagnosis (March 2015);

Both available from: <http://www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology/publications>



Chapter 1: Schools and mental health

Primary prevention and early intervention

The opportunities to use educational settings to both promote psychological wellbeing and to intervene early when problems arise has had a rather chequered history over the years. The potential has long been recognised but various national initiatives have suffered from short-term funding that was later withdrawn despite positive evaluations. Three examples of these are:

- The National Healthy Schools Programme began in 1998. This covered PHSE lessons, Healthy Eating, Physical Activity and Emotional Health and Well-being <http://webarchive.nationalarchives.gov.uk>
- The Extended Schools Programme began in 2006 and funded activities designed to support learning, promote healthy lifestyles and connect with families and local communities. Many schools used these to develop psychological support provision <https://www.gov.uk/government/collections/extended-schools>.
- Targeted Mental Health in Schools (TaMHS) ran from 2008 and was rigorously evaluated (Department for Education, 2011). It piloted a number of different models of psychological intervention in educational settings <https://www.gov.uk/government/publications/findings-from-the-national-evaluation-of-targeted-mental-health-in-schools-2008-to-2011>.

The descriptions of the services and the learning from them are still available (see links above) and many local authorities have used the learning from these programmes to develop their own local provision after the national funding was withdrawn.

There is currently considerable interest in developing mental health promotion and early intervention services in schools and it is anticipated that this will be

a key theme in a Government Green Paper due out later in 2017. Outside of the home, school is usually the most important ongoing influence on children's development, with full-time education or training compulsory up to 18 years in England. Primary-age children in England receive an average of 861 hours of compulsory teaching each year, rising to 912 hours in secondary school (OECD, 2014). A growing number of children also attend out-of-hours provision at school, such as breakfast or homework clubs. Given the influence of school on children and young people's lives, and considerable evidence that applied psychology is effective in schools, there is a great opportunity for high-quality psychological services to promote resilience and wellbeing and minimise adversity in the school environment. Teachers are also in a good position to identify mental health concerns early (Loades & Mastroiannopoulou, 2010) and work collaboratively with psychological staff to facilitate interventions.

Very recently, Layard (2017) has argued for increased work in schools to promote psychological wellbeing. The literature points to the childhood origins of adult happiness, and the importance of emotional health at age 16.

Building on this analysis, he sees that the role of schools can be to promote mental health for all and to get help for those in difficulty, and argues for, amongst a range of recommendations, that schools can promote mental health by focusing on teaching evidence-based life skills once a week, including Secondary SEAL, which is manualised with trained teacher delivery, and the Penn Resilience Programme (18 hours), weekly from age 5 to 18.

However, it must be pointed out that the evidence base on health promotion and primary prevention in schools is not currently well-developed and this

indicates the urgent necessity for more psychological research in this field and rigorous evaluation of initiatives, both large and small, to build the base of what works, where and with whom.

This increased focus on psychological health and wellbeing in schools is consistent with their primary function as places of learning, because health and education outcomes are closely related (Bradley & Greene, 2013; Suhrcke & de Paz Nieves, 2011). Children with mental health difficulties have more time off school, are more frequently excluded from school, and more likely to be significantly behind in their learning (Green et al., 2005). A recent interim report by the Institute for Public Policy Research concluded:

- Researchers found that one in two excluded pupils experience recognised mental health problems, compared with one in 50 pupils in the wider population. Estimates suggest this might be as high as 100 per cent once undiagnosed problems are considered.
- Meanwhile government data has shown that only one in a hundred children who have been permanently excluded from mainstream schools go on to receive five good GCSE grades.

Schools are likely to admit more pupils with poor mental health and complex needs in future, as these difficulties are expected to continue to rise generally in the population under 18 years old.

Mental health provision

All schools are very aware of the pressing needs of the children and young people in their classrooms who are showing signs of significant emotional and behavioural problems but for whom there often seems to be little or no help available. Studies have estimated that up to 75 per cent of children and young people who experience mental health problems do not have input from specialist mental health services. There have also been a number of high profile media reports on the impact of mental health problems in schools. As an example, a recent *Times Educational Supplement* report (Bloom, 2017) noted that:

‘Stretched children and adolescent mental health services (CAMHS) are driving growing numbers of pupils to make what look like suicide attempts just so they can have their mental illness treated.’

According to a survey by the NAHT heads’ union and the children’s mental health charity Place2Be, 56 per cent of school leaders say it is ‘difficult to find’ mental health services for their pupils. (Place2Be and National Association of Head Teachers, 2017).

The Institute of Public Policy and Research

published *Education, education and mental health: Supporting secondary schools to play a central role in early intervention mental health services* in 2016 in which they analysed the current situation https://www.ippr.org/files/publications/pdf/education-education-mental-health_May2016.pdf?noredirect=1.

They found the following:

- Demand for access to child and adolescent mental health services (CAMHS) has accelerated since 2010.
- At the same time, mental health services have faced growing financial pressures. In 2012/13, just six per cent of the total NHS spend on mental health went to services for children and young people.
- The erosion of NHS and local authority early intervention services means that local CAMHS systems have become trapped in a vicious cycle that is reducing their ability to meet the growing level of need. The value of the ‘early intervention’ allocation received by local authorities fell from £3.2 billion per year in 2010/11 to £1.4 billion in 2015/16, a reduction of 55 per cent.
- A consequence of cuts to services combined with a rising tide of mental ill-health is that secondary schools are being forced to pick up the pieces. In 2016, 90 per cent of secondary school headteachers reported an increase in rates of mental health problems such as anxiety and depression among their pupils over the previous five years (IPPR, 2016).

Therefore they made key recommendations about what was needed if schools were to be able to undertake this role effectively:

1. **Funding:** Schools largely lack the funding required to provide pupils with targeted mental health support. They have long been unable to access funding, or services paid for by health providers, that would allow early intervention services to be provided on-site.
2. **Commissioning and representation:** In an increasingly academised school system, schools often lack the internal expertise they need to commission mental health support effectively. Schools also lack established mechanisms through which to influence commissioning decisions at a CCG level.
3. **Quality:** The quality of mental health support (particularly school counselling) available to schools is inconsistent, and schools do not receive sufficient guarantees that the specialists they commission or purchase have suitable levels of training and experience.
4. **Accountability:** Ofsted inspectors are not routinely assessing schools’ mental health provision, despite recent changes to that end. This means there are

insufficient external checks on the appropriateness and quality of the particular 'professional mix' that individual schools bring together to meet their pupils' mental health needs. Just one third of a sample of Ofsted reports published since the changes were introduced make explicit reference to pupils' mental health and/or emotional wellbeing.

Almost all children and young people are in schools or other educational settings including those who would be described as having the most complex difficulties when seen in a mental health service. Amongst these are children being helped by services but many others who have not been referred or whose referral has not been accepted. There are also a significant group who cannot or will not access traditional clinic based services even when they are offered. CAMHS Transformation plans emphasise the need to improve referral and engagement for child mental health services (NHS England, 2017). This problem disproportionately affects families with high levels of need (Scott et al., 2014). There are many potential barriers to engagement with clinic-based services, including parental mental or physical health difficulties, substance or alcohol addiction, concern about the young person missing school and practical constraints such as travel, work or other family commitments. Siting provision in schools can therefore be a significant step in improving access.

Linking specialist mental health services more closely with schools and colleges is also a valuable way to increase young people's choice about where they are seen. Locating applied psychological services in schools means that help can be provided in a familiar setting (Children and Young People's Mental Health and Wellbeing Task Force, 2015). For some young people, however, school may not be an environment where they feel safe to be open about their mental health concerns (Department of Health, 2015). It is therefore crucial to give the child, young person and family choice in where they can gain psychological support.

Many schools and individual teachers show an impressive commitment to supporting the psychological wellbeing of their students despite the many challenges they face. The psychological difficulties that impact on children and young people in school often have their origins in the child's life experiences of poverty, social deprivation, family difficulties, physical health problems and trauma. These children and young people are usually supported by the pastoral system within the school but the difficulties can be overwhelming for non-specialist staff to deal with. Other children have neurodevelopmental difficulties like being on the Autistic Spectrum or having problems with attention and impulse control, and generalised or specific

learning difficulties. They will usually be supported by a Learning Support Team under a Special Needs Coordinator (SENCO) but their psychological problems may need more specialist assessment and support.

One of the issues for schools is that these are not just individual children with difficulties but part of an intense and complex social world and a student's psychological difficulties can place major limitations on their ability to engage with teachers and other students in a positive way. Often their difficulties affect everyone in their classes as teachers try to deal with their needs and behaviours whilst continuing to teach. In addition, children with difficulties interact with each other often in negative ways exacerbating situations in classrooms and in non-lesson time.

It is also the case that there are elements of school life that can lead to the development of or deterioration in psychological difficulties: bullying, academic pressures, social difficulties and sexual pressures are examples of these. Some schools aim to tackle these issues directly through anti-bullying campaigns, peer mentoring schemes, social and extracurricular opportunities and enlightened Personal and Social Education (PHSE) curricula. Creative use of the academic curricula, especially in arts subjects, can build confidence and expand a young person's range of understanding and responses. Sadly, this is not found everywhere and many young people in organisations like Young Minds give testimony about the ways that their school experiences caused them further harm. Unfortunately, it remains the case that excluding a child or not taking them onto the roll can appear the most effective solution from a school's viewpoint even whilst it is usually creating more damage to the child.

Within a school or a chain of schools there is only so much that staff can do with their limited training and very high workloads. To develop schools into environments that can support the psychological wellbeing of children and young people; they need to be able to access and incorporate more specialist knowledge into their organisations. School nursing used to be a very valuable asset, both in providing some first-line input and in providing a bridge to other services. In some areas, this is still the case but in many others school nursing provision has been significantly reduced and can no longer serve that function.

Many schools have employed staff, often from a counselling background, to help the students with psychological difficulties within school. Whilst these are often an asset, there are problems in some areas with staff who are poorly trained, or who have inadequate supervision. They can be the first or only point of help without assessment as to whether this is appropriate for the child's difficulties. The interventions

are often focused on the individual child and may not involve the family or other significant parts of the system around the child. The isolation of in-school provision is a frequent issue as it does not form part of the clinical pathways and networks operating in the local area mental health provision. The Department for Education has recently published guidance in this area to try to improve the situation (Department for Education, 2016).

Currently, the more specialist psychological services in schools may be provided by NHS (particularly Community Child Health and CAMHS), local authority, charitable and independent sectors and have different funding streams (from individual schools, local authorities, Clinical Commissioning Groups [CCGs] and central government). At best these provisions work together in networks and use clinical pathways to tie their work together in the interests of the children and young people. Some CAMHS are commissioned for provision in schools as part of their remit but many are not. The overall picture of the provision of psychological services in schools is that it is fragmented and inequitable.

Young people and parents have reported poorly integrated services and poor joint working between services (Young Minds, 2014). The TaMHS initiative (TaMHS, 2008) advocated for all agencies to work together to deliver flexible, responsive and effective early intervention mental health services linked to a school base. Integrating applied psychological services in schools provides an accessible context for children and young people to be seen (TaMHS, 2008).

More recently, in summer 2015, NHS England and the Department for Education (DfE) jointly launched the Mental Health Services and Schools Link Pilots. The pilot programme was developed in response to the 2015 report of the Children and Young People's Mental Health Taskforce, *Future in Mind*, which outlined several recommendations to improve access to mental health support for children and young people. A total of 22 areas, incorporating 27 CCGs and 255 schools, were funded to establish named lead contacts within NHS CYPMHS and schools.

Overall, the evaluation (Day et al., 2017) found that the pilots had considerable success in strengthening communication and joint working arrangements between schools and NHS children's mental health services. This was often the case even where relationships were said to have been weak at the start of the pilot programme, although the extent of change varied between pilot areas.

Applied psychologists and psychological services

Educational and clinical psychologists are the main groups of applied psychologists working in schools, as well as people trained in psychological therapies, including counsellors (some of whom will be qualified counselling psychologists).

In some areas of work in schools, educational and clinical psychologists may be undertaking the same kind of duties, but they also have different areas of specialisation. Both professional groups have a strong emphasis on preventing the development of psychological difficulties and promoting wellbeing. They are committed to high quality assessment of difficulties, which may include cognitive testing, to understand the full nature of a child's problems and then tailoring a response based on that assessment. They take a holistic and systemic approach to children, seeing them and any difficulties they have in the context of their family, the wider social and community situation they have grown up in. This often means that the psychologists offer consultation based approaches as well as individual or family approaches to difficulties. Clinical psychologists are trained, predominantly within the NHS, to work with people of all ages who have a range of psychological and/or physical health difficulties. Educational psychologists have particular expertise in the educational impact of children's difficulties and helping a school to manage teaching and learning. They also have statutory role regarding the Code of Practice for Children with special educational needs and disability (SEND).

Applied psychologists work most effectively and efficiently in school settings when they are part of wider networks both in the school and without. Most children who are experiencing distress do not need specialist intervention but are likely to benefit if the people around them are better able to support them through a difficult time. Ways that this can be achieved are discussed in more detail in later chapters but some examples are:

- The provision of training to school staff and helping the school to develop into a supportive environment. Education has not tended in the past to have systems equivalent to clinical supervision found in the NHS and elsewhere and schools need help in developing these. Training alone is not enough. Ongoing systems of consultation and advice for all staff and supervision for those undertaking a more formal therapeutic role are essential.
- Some schools have developed multidisciplinary psychological services, usually in conjunction with CAMHS, which allows for a greater scope and capacity to create change.

- Developing systems to support and advise families and other carers through the school is another key way that wellbeing can be improved and that psychological services can work with schools to develop.
- Finally harnessing the potential of young people themselves can make a real difference.

Models of mental health provision which ‘front-load’ specialist expertise early in the clinical pathways have the potential to make a significant impact on the wellbeing of children and young people and to reduce the ever-growing pressures on CAMHS provision. Early recognition of problems, leading to high quality holistic assessments should mean that the right help is provided in the right place and at the time when it is most likely to be effective.

Recommendations

Recommendation 1: Early recognition of problems, leading to high quality holistic assessments should mean that the right help is provided in the right place and at the time when it is most likely to be effective. CCGs, Local Authority and other commissioners should develop models of mental health provision which ‘front-load’ specialist expertise early in the clinical pathways. These have the potential to make a significant impact and reduce the pressures on CAMHS provision.

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Chapter 2: Mental health, psychological wellbeing and resilience

How many children and young people have psychological difficulties?

Children and young people (those aged 0 to 19 years) make up approximately 24 per cent of the UK population (Office for National Statistics, 2011). While most children and young people will not experience mental health problems, a significant number will. The most common mental health difficulties reported in children and young people are conduct disorders, anxiety, depression and hyperkinetic disorders (Green et al., 2005). It is difficult to accurately estimate the numbers of children and young people who experience mental health problems, with reports of prevalence varying throughout the literature. The most recent systematic survey in the UK was carried out over 10 years ago (Green et al., 2005), and estimated that at any time point 9.8 per cent, of young people aged 5 to 16 years had a diagnosable mental health problem, with higher prevalence rates of 12.19 per cent reported for teenagers aged 13 to 15 years.

Other authors have suggested that as many as one-in-three children will have at least one episode of mental health difficulties before the age of 16 (Costello et al., 2003), and the prevalence increases further still if we extend the age range up to 25 years, and for those in social care (48 per cent) (Burns et al., 2004) or the criminal justice system (65 to 70 per cent) (Skowrya & Coccozza, 2006). There is a clear need to maintain a regular systematic national review of mental health in children and young people to tailor services to meet the need. A new review of prevalence rates is planned for 2018.

International figures suggest overall rates of mental health difficulties may be fairly stable. For example, the large-scale US National Comorbidity survey with 8 to 15-year-olds reported 12-month prevalence rates of 13.1

per cent for any diagnosable mental health disorder (Merikangas et al., 2010). Similarly, a meta-analysis of worldwide mental health prevalence rates, for young people aged 6 to 18 years with data from 87,742 young people across 27 countries reported a prevalence rate of 13.4 per cent for any diagnosable mental health problem (Polamczyk et al., 2015). However, there is evidence that some mental health difficulties might be increasing (Fonagy et al., 2015). This is particularly apparent for children and young people with eating disorders, self-harm and Attention Deficit Hyperactivity Disorder (ADHD). This fits with perceptions within school communities that some difficulties, such as self-harm, are an increasing problem they have to deal with (Place2Be survey, 2017).

Some difficulties have also been demonstrated to increase with age, such as social anxiety, panic, depression and substance abuse (Costello et al., 2003), and there is a clear correlation between social deprivation and the prevalence of mental health difficulties in children (Campion & Fitch, 2012). As children grow older, their mental health difficulties are more likely to be accompanied by other problems that affect their lives (Costello et al., 2003), and are likely to have significant impact on their physical health, educational achievement, employment prospects, risk of involvement with the criminal justice system and life expectancy (Department of Health, 2015).

Without effective intervention, the likelihood of mental health problems continuing into adulthood is significant, and it is vital that interventions are right first time to prevent the likelihood of lifelong mental health difficulties.

Currently around 50 per cent of lifelong mental health problems develop before the age of 14 years, with 75

per cent developing before the age of 25 years. Yet, only 25 to 40 per cent of children and young people with mental health difficulties receive input from a mental health professional at all, or at a sufficiently early age (Green et al., 2005).

Psychological wellbeing and resilience

Children in the same school clearly do not all have the same experiences, and will respond very differently to the environment they share. Developmental psychopathology, the study of how psychological problems develop over time, suggests that it is the interplay of risk and protective factors across different areas of life that shapes outcomes for individual children (Cicchetti, 1989; Rutter, 1985, 2013; Patalay, 2016b). In other words, school will influence children's development in the context of their unique combination of genes, physical health, temperament, coping style, family relationships, social and other factors. Some positive features of a school, such as a well-managed classroom, will be beneficial for all children concerned. Other factors, such as a strong attachment bond with a teacher, may exert a protective effect for vulnerable children facing adversity elsewhere in life (Verschueren & Koomen, 2012).

Schools may also contribute unique risk factors to some children's wellbeing and development. Examination stress is well documented to affect some students and to have a negative impact on their mental health as well as their academic attainment (Hutchings, 2015; Putwain, 2009). Large, longitudinal studies from the UK and US have recently found that young people bullied by peers were twice as likely to become depressed in young adulthood, relative to those never victimised (Bowes et al., 2015). Peer bullying may even place young people at greater risk of later mental health problems than physical, emotional or sexual abuse (Lereya et al., 2015; Fink et al., 2017).

Resilience, successful adaptation in the presence of adversity, is a framework for understanding some of the great variability in outcomes that is the experience of most professionals working in schools (Masten, 2001). Resilience is an ongoing and interactive process between the child and the risk or protective factors in its environment, rather than a stable or innate characteristic (Masten, 2007). The idea that resilience can and should be promoted at the level of institutions or social systems is receiving growing research attention. For example, the UK Resilience Project reported the positive impact of a universal, manualised programme of resilience workshops on the psychological wellbeing of pupils in Year 7 (i.e. 11 or 12 years old; Challen et al., 2011).

When adapting to adversity is impossible or incomplete, and psychological difficulties ensue for the child, it can often seem that problems at school go together with difficulties at home. Research on developmental

'cascades' has shown how functioning in one area affects other domains over time (Cicchetti & Masten, 2010). Furthermore, when there are multiple sources of adversity in a child's life their effect can be cumulative (Evans, Lee & Whipple, 2013). The corollary is that successful intervention in one area of a child's wellbeing can have positive effects more widely in their life.

Evidence is starting to emerge that the factors which promote positive psychological wellbeing are not necessarily those which are the opposite of risk factors. In a detailed analysis of 11-year-olds in the UK Millennium Study, Patalay and Fitzsimmons (2016) found, for example, that enjoying school and spending time outside school with friends were associated with higher wellbeing scores but did not seem to have a strong impact on symptom scores on the Strengths and Difficulties Questionnaire.

Working on risk factors and building resilience

By improving the psychological wellbeing of our families and young people we are making their lives better and helping their communities function more effectively. It is also the most effective means of reducing the high levels of demand on specialist services.

A 2014 House of Commons Health Committee investigated the effect of a scaling back of early intervention services on specialist CAMHS. The committee received the following two submissions, from a clinical commissioning group and a mental health trust respectively:

'Reductions in Tiers 1 and 2 provision largely as a result of budget reductions [were] leading to a lack of early intervention. Hence children and young people were tending to access services at too late a stage hence they required more complex and time consuming interventions to address their presenting challenges.'

'In order to manage demand, teams may be left in a position of turning an opportunity for preventative psychologically-based work away. This means a young person and their family have been turned away from early help only to return when their condition has become more challenging to work with or, distressingly, requires admission to T4 [tier 4] in patient services.'
(House of Commons Health Committee, 2014)

Whilst it is outside the scope of a school to prevent many of the risk factors, awareness of them and their impacts on children can lead to the greater understanding and the development of appropriate strategies to help. Many children who have suffered the types of experiences listed here will show their distress through their behaviour in school, often getting into trouble

as a result. Greater understanding of the underpinnings to observed behaviour can lead to better ways of managing it and helping the child. Schools can also develop strategies to help reduce the incidence of risk factors like bullying and social isolation.

There are many factors that may lead to the development of mental health difficulties in children and young people. The World Health Organisation categorises these into three broad areas:

- Social circumstances: like loneliness, bereavement and neglect.
- Environmental factors: like injustice, discrimination and exposure to trauma.
- Individual factors: like cognitive/emotional immaturity and medical illness.

For a fuller discussion of this topic, please refer to Chapter 3: Building Resilience in Children, Families and Communities: Making Psychological Health Promotion, Prevention and Early Intervention Central in 'What good could look like in integrated psychological services for children, young people and their families: Preliminary guidance and examples of practice'.

Poverty and social inequality

There are many studies which have demonstrated the correlation between living in relative poverty in various societies and poorer mental health in both adults and children. Gershoff, Aber and Raver (2003) identified three pathways by which poverty has an impact on children:

1. Parental Investment: This describes how poverty impacts on the quality of the home environment the parents can provide, the activities they are able to afford for their children, etc.
2. Parental Behaviour and Stress: This describes how the stress of living in poverty leads to the parents having insufficient psychological resources to care for their children though high levels of depression and parental conflict.
3. The impoverished local communities in which the families are living.

There are therefore opportunities for schools to enrich the lives of children growing up in poverty, enabling them to access opportunities and experiences otherwise denied to them. The development of a wider range of opportunities outside the curricula, including sport, creative and volunteering activities perhaps in partnership with the local community, can help to ameliorate some of the effects of poverty and social exclusion and build confidence and life skills.

Trauma and maltreatment

Childhood maltreatment and trauma is now known to be one of the biggest risk factors for children and

young people developing mental health difficulties. Maltreatment can take several different forms, including neglect, emotional abuse, physical abuse and sexual abuse. The harm caused by child maltreatment can have wide ranging effects on the child or young person's emotional, psychological, behavioural, educational and interpersonal functioning. Recent evidence is pointing to child maltreatment as perhaps the biggest risk factor in the development of short and long-term psychological problems (Patalay et al., 2015). Child trauma has a negative effect on the quality of the relationships a child can make with people close to them, both now and in the future with their own children, thus making trauma an intergenerational issue. Reducing trauma and maltreatment may be one of the biggest primary prevention strategies available to us.

Adverse Childhood Events (ACEs)

There is a growing body of research in this field that is providing an evidence base demonstrating that childhood experiences, both positive and negative, have a very significant impact on lifelong health and opportunity. Early experiences are an important public health issue. The negative childhood experiences are being researched under the umbrella term of Adverse Childhood Experiences (ACEs). Examples are: multiple types of abuse; neglect; violence between parents or caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence.

Adverse Childhood Experiences have been linked to:

- Risky health behaviours;
- Mental health difficulties;
- Chronic health conditions;
- Low life potential; and
- Early death.

As the number of ACEs increases, so does the risk for these outcomes. An excellent summary of the research and what preventative strategies can be developed can be found on the American Centers for Disease Control and Prevention website: <https://www.cdc.gov/violenceprevention/acestudy/>

Changes to how trauma and maltreatment are identified and prevented are needed urgently. People working with children and young people across all sectors need to be able to recognise warning signs and ensure safeguarding is in place. This requires ongoing training and support. However, it is also essential that more resources are made available to enable positive action when warning signs are identified, with much more emphasis on supporting families. Positive strategies to work alongside parents who can be predicted to have a higher likelihood of difficulties should be developed and schools could have a very important role to play in this.

Social isolation and bullying

The importance of having friends and feeling accepted by other children or young people of the same age cannot be overstated. Children who feel rejected by their peers can experience a range of difficulties as well as feeling isolated and lonely. Social isolation also means that a young person will have fewer resources to help them deal with any difficulties in their lives, as they will not have people to turn to for advice or support.

There has been considerable research into this field and a significant amount of guidance is available from Government and the voluntary sector for both the general population and specific groups. What is needed is for this to be implemented at local levels, particularly in schools and youth services.

There is a key role for schools particularly to identify and intervene with bullying and social isolation. Provision of social opportunities through play schemes and youth services can be crucial to developing a child's social world outside of school and must not be restricted to those children whose parents can pay. Moreover, sporting opportunities are often only available to those who are 'good' at the sport: they need to become more inclusive.

The issues around social isolation and bullying need to be tackled across agencies through joined up commissioning that enables the development of a local strategy. There are several approaches that can be taken. Public Health England and UCL Institute of Health Equity have published a Practice Resource 'Reducing social isolation across the life course' (September, 2015) which covers children and young people and parents, and contains much valuable information on incidence and patterns together with ideas for cost-effective interventions: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf

There has been much work developing both anti-bullying strategies for schools and ways to support children and families who experience it. The rising importance of social media in the lives of children and young people with the impact of cyber bullying has also been recognised.

There are several groups who are more likely to experience both isolation and bullying. Identification of these groups can enable preventative strategies to be put in place. These groups include Young Carers, Lesbian, Gay, Bisexual, Transgender and Asexual (LGBTQA) young people, ethnic minorities, refugees, and those who are obese, or have long-term conditions or disabilities.

Bereavement and loss

The death of a loved one is an experience that many children and young people are likely to face; this can include pets as well as people. Feelings of loss and grief are, of course, completely natural reactions to losing

someone, although everyone responds differently in such times and there is no 'right way' to respond to someone dying. In most cases, the feelings of sadness and grief tend to ease over time and with the support of friends and family. However, for some children and young people these feelings can feel overwhelming for a lengthy period, leading to significant difficulties in them moving on with their lives. The death of a parent or sibling has been shown to lead to mental health difficulties in around 25 per cent of bereaved children, who experience more 'internalising problems' such as major depressive episodes (Stikkelbroek et al., 2015).

There is a need for training and support for teachers who come across bereaved children so that they both understand what normal distress is and what is likely to help, and recognise when more specialist help may be needed. In addition, developing a collaborative approach between education, voluntary bodies, health and social care can support joint training initiatives and help to build good care pathways will support all agencies in developing good quality care for bereaved children including specialist help when needed.

Neurodevelopmental and learning difficulties

These children often present challenges in schools, due to the problems they may have with staff and peer relationships as well as with learning and they are at high risk of developing mental health problems. Schools need support in recognising where emerging difficulties indicate the need for specialist assessment and with working with parents and carers to achieve this. Positive strategies in school to help these children to cope and other children to understand them can have a major impact on their experiences growing up and enhance their life chances significantly. These children/young people will need ongoing support and a shared care plan in the longer term, and this in turn means that specialist CAMHS may need to adjust their referral criteria to allow them to remain on their caseloads and 'dip in and out' of services as and when needed. They usually require additional support in the transition to secondary and further education.

Chronic or serious physical health problems and physical disability

This is another group of children who are at higher risk of mental health problems and for whom positive school experiences can make all the difference. Schools need to have access to advice from the specialists working with the child, both in hospital and in the community to understand the physical and psychological nature of the problems and what steps need to be taken to support them in school. Peer relationships are often problematic with higher risks of bullying and social exclusion as well as learning issues due to missed schooling.

Recommendations

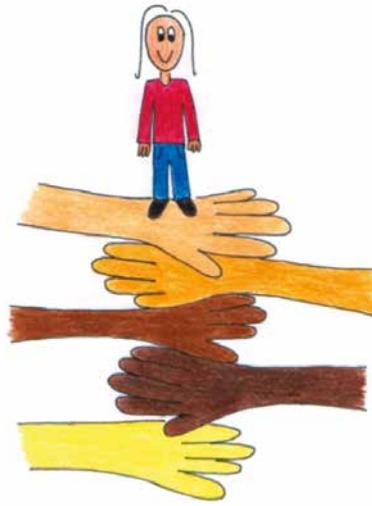
Recommendation 5: The Department of Health and Public Health England need to develop national policy, guidance and interventions to reduce the prevalence of known risk factors based on psychological evidence and these should be implemented by CCG and local authority commissioners at a local level in order to reduce the long term impact of these problems on mental health.

Recommendation 6: Schools should be supported by Department for Education, Public Health England and Local Authorities to build cultures and develop resources which aim to improve social cohesion and prevent bullying. The development of a wider range of opportunities outside the curricula, including sport, creative and volunteering activities perhaps in partnership with the local community, should be supported as these can help to ameliorate some of the effects of poverty and social exclusion and build confidence and life skills. This should be part of a local strategy agreed across local commissioning groups.

Recommendation 7: Bereavement is a significant risk factor for the development of later mental health problems. Training and support for teachers should be provided so that they both understand what normal distress is and what is likely to help, and recognise when more specialist help may be needed. Health and Wellbeing Boards should take the lead in developing collaborative approaches between education, voluntary sector groups, health and social care to support joint training and help to build good care pathways that will support all agencies in developing good quality care for bereaved children.

Recommendation 8: Children with neurodevelopmental and learning difficulties often present challenges in schools, due to the problems they have with staff and peer relationships as well as with learning and they are at high risk of developing mental health problems. CCGs and Local Authority Commissioners need to support schools in recognising where there is the need for specialist assessment and with working with parents and carers to achieve this. This should be developed by Provider Trusts or voluntary sector groups who can also help with developing positive strategies to help children to cope and other children to understand them. This can have a major impact on their experiences growing up and enhance their life chances significantly. Commissioners and Providers should adjust specialist CAMHS referral criteria to allow these children to remain on their caseloads and 'dip in and out' of services as and when needed.

Recommendation 9: Children with chronic physical illnesses and disabilities are at higher risk of mental health problems. CCGs and Provider Trusts need to ensure that schools have access to advice from the specialists working with the child, both in hospital and in the community to understand the physical and psychological nature of the problems (this may include but not be limited to bullying and social exclusion) and what steps need to be taken to support them.



Chapter 3: Key elements of psychological approaches in schools

Evidence-based practice is advocated for work in schools (Future in Mind, 2015) where the best available research is addressed, client preference is considered and the individual's context is taken into consideration (Murphy & Fonagy, 2012). Recent government guidelines on the provision of counselling services in schools advocated strongly for practice to be more robustly informed by an evidence base (Department for Education, 2015).

Applied psychologists utilise the range of therapeutic approaches at their disposal and their knowledge and experience to tailor interventions for the young person, parent or school as relevant. This may include adapting an established evidence-based approach for specific groups such as looked after children, young carers or asylum seekers. Indeed, working at the level of a school or family of schools offers the opportunity to improve the reach of services to meet diverse populations if care is taken to develop both inclusive and appropriate input. To provide an evidence-based mental health service, staff and clinicians need to be able to intervene beyond the individual child or young person alone.

Locating applied psychological services for children, young people and families in schools offers a unique opportunity to offer specialist, interconnected interventions at a universal and a targeted level and both directly (to children, young people and parents/carers) and indirectly (to school staff).

As well as working with school staff, it also offers more opportunities for applied psychological services to work jointly with other agencies connected to child and adolescent mental health in schools. This includes Local Authority services such as Children's Social Care and Behaviour Support services, and Community Child Health, as well as lower intensity voluntary sector and

school counselling services (including Place2Be and art therapy).

The process of deciding at what level to intervene (directly/indirectly, lower or higher intensity) should be done collaboratively and should integrate assessment, research evidence, family or young person's preference, clinical expertise and formulation.

Provision of training and consultation for school staff

As only a small proportion of children with mental health needs will have contact with specialist mental health services (Ford, Hamilton, Goodman & Meltzer, 2005) and as children very rarely self-refer to mental health services (Stanger & Lewis, 1993), the ability of others to recognise and respond to childhood psychological difficulties is crucial.

Staff support and training is a key intervention targeted at the whole school population that does not involve face-to-face contact with children or parents. Few school staff have specific training on emotional well-being and mental health (University of Nottingham Centre for Special Needs Education and Research, 2007). Training can be for whole school staff teams and for smaller, specific group such as pastoral care teams, early years and senior management on.

Broad-based, multifactorial assessment in schools

Conducting **psychological assessments** in schools has many benefits, including improved interagency communication, higher ecological validity of observations and increased accessibility of services for harder to engage families. Access to rapid, high quality, psychological assessment is essential to provide an accurate and informed formulation, and to identify any risk of harm to the self or others as soon as possible.

Assessment should be **multi-modal** (using questionnaires, observations and clinical interviews with child, parent and teacher) and multi-informant (obtaining the views of child, parent, school and other agencies involved) and consider the child across all relevant contexts. Risk assessments should be thorough, reviewed regularly and lead to achievable, clear crisis plans where necessary. Risks and associated plans should be shared with the network around the child or young person, including family members, carers, school staff and other agencies involved.

Formulation and interventions

Most models of intervention used by clinical and educational psychologists with children and young people take account of context and relationships. Systemic psychotherapy is predicated on the idea that psychological difficulties or symptoms have relational or interpersonal causes and resolutions. Cognitive behaviour therapy (CBT) has become a dominant approach in the NHS for people affected by anxiety or depressive difficulties. CBT with young people involves working with the whole family's patterns of emotions, behaviour and thinking, not just the child's (Fuggle,

Dunsmuir & Curry, 2012), with parents significantly involved in the therapeutic work (Creswell & Cartwright-Hatton, 2007).

In clinical practice, psychologists use psychological models to develop a formulation of a young person's psychological difficulties (British Psychological Society, 2011). Psychological formulation states hypotheses about the development and maintenance of the problem, and is developed in part or in whole with the young person and their family*. The value of a formulation-based approach in schools' work is the ability to integrate information from many different sources, and produce a coherent plan for targeted work with a young person, incorporating their family or school staff as needed.

Communicating this formulation to young people, parents, schools and networks is essential and can be an intervention as it can allow key people to view difficulties in a different way and feel more empowered to effect change. Sharing formulations helps to make links between emotional wellbeing and learning more explicit, which can be helpful for school staff to understand.

Case example

Abdullah (age 6) was referred for a clinical psychology assessment because his school reported that he was having difficulties with friendships and was displaying 'attention seeking and disruptive behaviour' in the classroom, impacting on the learning of the rest of the class. The clinical psychologist met his teacher, who reported feeling worn out and increasingly deskilled by Abdullah's behaviour. Abdullah's mother reported that her husband had experienced significant mental health difficulties and she was now caring for Abdullah on her own following domestic violence and fleeing the family home. This information was integrated with observations and direct assessment sessions in school and a shared formulation of Abdullah's difficulties was developed. The formulation hypothesised that Abdullah's early attachment experiences had influenced his current relationships and expectations of adults. He had learned he could not always rely on adults to be reliable, consistent or predictable and had learned to escalate his behaviour to ensure he received the attention he needed to feel safe. The formulation was shared with the teacher and management staff at school, used to reflect on the meaning and function of his behaviour, and adapt Abdullah's Individual Education Plan (IEP). Recommendations included having a key identified adult allocated to Abdullah, consistent management of his behaviour and prioritising the development of peer relationships. It was also recommended that there would be meetings between the clinical psychologist and the teacher to provide a space to think about the presenting difficulties and the emotional impact on the teacher.

* A leaflet written with and for young people by the Faculty for Children, Young People and their Families to help them understand formulation can be downloaded from: <https://www.bps.org.uk/system/files/user-files/DCP%20for%20Children,%20Young%20People%20and%20their%20Families/public/Formulation%20young%20people.pdf>

Evaluation and outcome monitoring

Applied psychologists collect service user feedback from young people, families and schools about their views of the service received alongside goal based measures, screening questionnaires and objective outcomes measures. This progress and outcome data should be collected regularly and should be 'used in a positive, thoughtful and meaningful way' (Law & Wolpert, 2014) and with the child or young person exercising choice in the measures and how they are used. There is evidence to suggest such measurement can improve outcomes for young people (Bickman et al., 2001).

Outcomes can be evaluated using readily available validated questionnaire measures, such as the Strengths and Difficulties Questionnaire (Goodman, 1997), Revised Childhood Anxiety and Depression Scale (Chorpita et al., 2000) and others that are feasible for use in routine practice (Berry, Khan & Patel, 2013; Neave & Patel, 2014; Falconbridge & Hunt, 2010; Patel & Aveyard, 2007). Me & My Feelings (Deighton et al., 2013) is a brief school-based measure of child mental health. It covers two broad domains: emotional difficulties and behavioural difficulties, and draws on the evaluation of the Targeted Mental Health in Schools Evaluation (Department for Education, 2011). Outcome evaluation should also consider indicators of wider improvements directly relevant to schools, such as increased school attendance, reduced school exclusions or increased understanding of a child's difficulties for staff. It is also important to get feedback from the schools to assess their satisfaction with the service offered, adapting this where necessary.

Building in participation and co-production

All good psychological services should work to hear the voices of children, young people and parents/carers, to understand what works well and, more importantly, to hear and understand what works less well and change it.

There are varying degrees of participation from being informed, through adults initiating but sharing decisions, to children and young people and adults initiating and sharing decisions together. There are also different approaches from consultation through to the development of advisory or reference groups. Co-production is the term that describes a higher level of participation where the users of a service or those with lived experience work as partners or lead the development of services. Overall, authentic participation is participation that impacts every aspect of service delivery and supporting those it sees to go from passive recipients to active contributors to service design and delivery. Most schools already have arrangements like School Councils and these can be built upon in developing new psychological services.

More detailed discussion of the basics of good psychological services can be found in 'What good looks like in psychological services for children, young people and their families'.

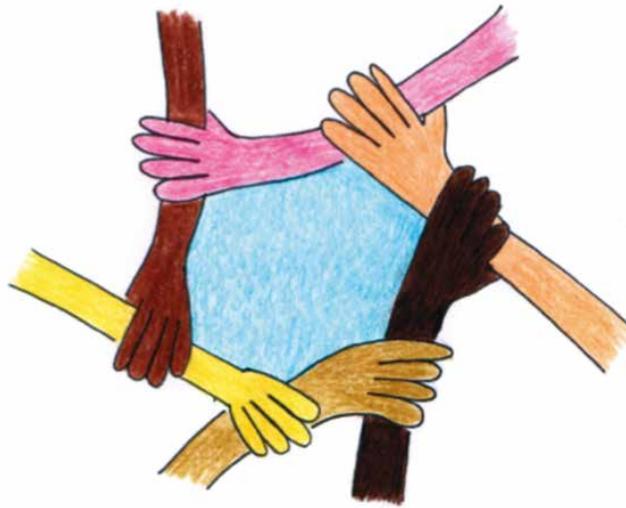
Recommendations

Recommendation 10: CCG and Local Authority Commissioners need to ensure that Services have the capacity to assess and intervene at a systemic, especially family, level than individual work with the child or young person in order to provide an evidence-based service.

Recommendation 11: Service Providers should ensure that the process of deciding at what level to intervene (directly/indirectly, lower or higher intensity) is done collaboratively with the young person, their family and their support network and should integrate assessment, research evidence, family or young person's preference, clinical expertise and formulation.

Recommendation 12: Access to high quality, timely, psychological assessment is essential to provide an accurate and informed formulation and to quickly identify any risk of harm to the self or others. Commissioners and Service Providers should ensure that assessment is multi-modal and multi-informant and considers the child across all relevant contexts. Risk assessments should be thorough, reviewed regularly and lead to achievable, clear crisis plans where necessary. Risks and associated plans should be shared with the network around the child or young person, including family members, carers, school staff and other agencies involved.

Recommendation 13: Authentic participation by children, young people, families and other users of the service, including teachers, should be integral to service provision. This will also strengthen the ability to meet the needs of diverse populations within the school. Most schools already have arrangements like School Councils and these can be built upon in developing psychological service provision.



Chapter 4: Models and examples of psychological approaches in schools

Introduction

Psychological interventions in schools are feasible, effective and acceptable to users of the service and can be directed at different levels of a school system,

Universal, selective and indicated provisions

Every school or college should now adopt a whole school approach to promoting emotional health and wellbeing (Public Health England, 2015). Psychological intervention is a critical part of delivering this strategy. Preventative interventions are especially important in schools, since staff often are often aware of pupils' individual and group risk factors, and may notice early signs of difficulties. Provision may be categorised as universal, selective or indicated, depending on their purpose and target population (Gordon, 1983; Haggerty & Mrazak, 1994).

Universal approaches aim to maximise the social and emotional wellbeing of everyone in a school. They can reach the most children, may be less stigmatising and usually do not require specialist skills and training to deliver, but may yield smaller treatment effects.

Selective interventions target pupils at greater risk of developing a psychological problem, because of known factors (e.g. poor parental mental health) (Weare, 2015). Like universal work, selective interventions aim to prevent problems occurring. They differ by targeting resources more precisely at pupils who may need help, although this approach requires additional resources and expertise to identify pupils at risk, and can be more complex to deliver.

Indicated interventions are those offered to pupils who already show some signs of a psychological problem. They aim either to prevent the escalation of symptoms to a clinical level (prevention), or to ameliorate an existing clinical problem (treatment). This targeted support is often carried out by non-teaching professionals including applied psychologists, school nurses, community paediatricians, art therapists, family therapists, cognitive behavioural therapists, child psychotherapists and counsellors. A wide range of providers contribute targeted interventions, including the NHS, services commissioned by local authorities or individual schools, voluntary agencies, charities and for-profit companies.

Schools are expected to work actively with parents and carers, to embed clear systems for identifying mental health needs and develop a cycle of support for vulnerable pupils using an 'assessment, plan, do, review' process (Department for Education, 2015). Pupils will be identified in different ways: by their presentation in school, through parental concerns, by the presence of known risk factors, through mental health screens and via multi-agency discussions, for example in Team Around the School (TAS) meetings.

Coordination at school level is essential to allocate resources efficiently and prevent children and young people being offered inappropriate support. In schools, where typically a small number of helping professionals support a large population of children, it is important to offer support to the right young people at the right time. It should be noted that psychological therapy has the capacity to harm as well as help so that the assess-

ment of the best treatment option is essential. Studies typically find that around five per cent of participants report harmful effects of psychological therapies – see Parry and Crawford (2016) for an introduction. There are also the negative effects of having experienced a therapeutic intervention that did not help in terms of confidence in trying a different type, similarly with an effective treatment being badly delivered or tried at the wrong time.

The range of psychological practitioners and providers in schools also brings many different models of conceptualising and intervening in psychological difficulties, as well as multiple thresholds for support and referral pathways. For a minority of children with significant additional needs, an Education, Health and Care Plan (formerly a Statement of Special Educational Needs) formally coordinates support at an individual level. This can include specific psychological interventions such as therapy or consultation to staff.

There is clear evidence that psychological services to schools have beneficial effects. Large-scale reviews of research evidence support the efficacy of whole-school approaches to wellbeing (Adi et al., 2007; Adi, Schrader McMillan et al., 2007; Weare & Nind, 2011). Psychological interventions have been shown to improve behaviour, reduce exclusions, improve attendance and reduce emotional and behavioural symptoms (Ballard et al., 2014; Wolpert et al., 2013). NICE treatment guidelines, based on systematic reviews of research evidence, recommend school-based direct and indirect interventions for difficulties including depression, ADHD and conduct problems (NICE, 2008b, 2013, 2015).

Early intervention in mental health problems, and improving access to specialist services, are key recommendations of the Future in Mind report (Department of Health, 2015). Early intervention can reduce clinical symptoms and the need for more expensive interventions later. Some of the most effective interventions are made in the pre-school and primary years (Greenberg et al., 2001). Unfortunately, as many as 70 per cent of children and young people who experience clinically significant psychological difficulties do not have access to appropriate interventions at a sufficiently early age (Department of Health, 2015).

Several school-based prevention programmes are efficacious in preventing or reducing common mental health problems in the short-term (Corrieri et al., 2013; Neil & Christensen, 2009; Stallard, 2013; Werner-Seidler, et al., 2017). Many can be delivered as either universal or indicated interventions. Most of anxiety-focused interventions derive from CBT, with the FRIENDS programme (Barrett & Turner, 2001) a well-established example. Most depression prevention programmes are also CBT-based, although promising results have been observed for skills training groups

based on interpersonal therapy (IPT-AST; Young et al., 2016). Stronger effects have generally been found for anxiety interventions than for depression. In the most recent analysis, targeted programmes outperformed universal programmes for depression, but universal and targeted anxiety programmes were equally effective (Werner-Seidler, 2017).

There is a need for further research and refinement of school-based prevention programmes. Longer-term follow-up, important for evaluating prevention success, suggests only marginal gains after 12 months. Few studies to date have included active control conditions (Neil & Christensen, 2009), and study designs that can distinguish between prevention and treatment effects are largely untried (Gillham, Shatté & Freres, 2000). Staff competence and organisational culture are likely to be key issues for the effectiveness of these interventions under routine school conditions. There are indications that, for depression, interventions delivered by external professionals outperform those by school staff (Werner-Seidler et al., 2017). Much remains to be established, too, about the impact of these programmes on outcomes of interest to schools, such as attendance, behaviour and educational attainment.

Besides large-scale reviews or clinical trials, there is also a wealth of practice-based evidence for the efficacy of psychological services in schools. Local service evaluations of school-based CAMHS or clinical psychology input have found positive effects on wellbeing in primary and secondary schools (Faulconbridge & Hunt, 2010; Neave & Patel, 2014; Picciotto, 2014).

Examples of intervening at different levels

Interventions at all levels may be direct (involving contact with the index pupil or parents/carers), or indirect (working through school staff that have contact with pupils).

Universal provision

Providing training and consultation for staff

Staff support and training is a key intervention targeted at the whole school population that does not involve face-to-face contact with children or parents.

As only a small proportion of children with mental health needs will have contact with specialist mental health services (Ford, Hamilton, Goodman & Meltzer, 2005) and as children very rarely self-refer to mental health services (Stanger & Lewis, 1993), the ability of others to recognise and respond to childhood psychological difficulties is crucial.

Teachers and school staff are an important group well placed to promote preventative measures, early intervention and self-help skills for young people's mental health difficulties (Vostanis et al., 2013), and school staff are often the first people to be consulted

by a child or family regarding concerns around psychological functioning (Ford, Goodman & Meltzer, 2003). Improved staff understanding of mental health could lead to a number of benefits, such as increased knowledge of how to prevent mental ill-health, better recognition of mental health difficulties, better understanding of effective treatments, and skills in self-help and 'first aid' (Jorm, 2012).

Research has shown, however, that teachers' knowledge of mental health is often low (Rothi et al., 2008), as is their confidence in responding effectively to mental health difficulties (Kidger et al., 2010), and their assessments of the presence and severity of mental health difficulties often do not correspond with young people's own self-assessments (De Los Reyes & Kazdin, 2006).

Teachers have not always seen mental health support and promotion as part of their role (Bostock et al., 2011), or have found that practical and organisational barriers prevent them from engaging with this area (Reinke et al., 2011). In addition, school staff often state they feel uncomfortable discussing mental health difficulties with young people (Knightsmith et al., 2013), and are often unaware of potential interventions or positive strategies they could use to improve children's mental health (Reinke et al., 2011).

Teacher training both pre- and post-qualification has been felt to be inadequate in preparing teachers to understand and respond to young people's mental health needs (Andrews, McCabe & Wideman-Johnston, 2014). In order for staff to be able to confidently adopt the role of promoting positive mental health of young people, therefore, specific training is needed (Andrews et al, 2014), as well as ongoing support from specialist practitioners to sustain change (Han & Weiss, 2005).

There is evidence that teacher training on mental health awareness (Jorm et al., 2010) can produce improvements in knowledge and confidence in responding to young people's needs. However, there is a significant practice-to-evidence gap in terms of whether training of this type leads to sustained behaviour change in teachers or improved outcomes for young people themselves (Jorm et al., 2010).

However, our understanding of how mental health training transfers into changes in practice (e.g. Baldwin & Ford, 1988) shows that three key factors determine whether training 'works':

1. 'Learner' characteristics: is training relevant and accessible to the target audience?
2. Training design: does the training content fit learners' needs and is it delivered well?
3. Workplace/organisational factors: is there opportunity, commitment and support within the workplace to implement the training and to change practice?

This highlights that in order for training for school staff to be successful it needs to be planned with this specific audience in mind and be designed in a way that can be practically translated into actions that fit with the roles and responsibilities of school staff, as well as being consistent with the values of the particular school setting.

Research evidence on the transfer of training into practice (e.g. Gibbs, 1988) also shows that using reflective practice models such as consultation and peer/group supervision can greatly enhance the effectiveness and implementation of new learning. Teachers have reported on the value of being able to discuss concerns and ask advice from CAMHS clinicians on an informal basis and with a named person (Gowers et al., 2004). Evaluation reports from CAMHS and Clinical Psychology Services in schools (Faulconbridge & Hunt, 2010; Picciotto, 2014) and research (van Roosmalen et al., 2012) have highlighted the importance of consultation to school teams to support staff.

Effective training works best when based on assessment of need within the school and integrated into a whole school approach to mental health. It is essential that training for teachers is not seen as a stand-alone solution. Training requires adequate follow up in terms of ongoing access to consultation, support and supervision. This needs to be provided by more highly trained and experienced staff. The role of teachers should be recognised as being part of the wider multidisciplinary care pathways not as a replacement for them

Examples in schools include:

- Delivering Solihull Approach Training: The School Years (Douglas, 2011). This is a whole school staff training in understanding early infant and child development, attachment theory, children and young people's behaviour and emotional blocks to learning.
- Contributing to Child & Adolescent Mental Health Literacy (sometimes referred to as Mental Health First Aid). This includes an introduction to mental health awareness for staff including early identification of mental health difficulties, understanding risk and preventative factors for mental health, first line support responses and knowledge of the referral process for additional help. A good example would be the Mental Health Awareness programme delivered rolled out in Surrey schools to over 3000 teachers from 2011 to present (Surrey County Council, Surrey & Borders NHS Trust & Babcock 4S: Pote, 2013 & 2015).
- Contributing to joined-up initiatives on promoting positive mental health and resilience in schools. These may be led by other bodies such as Public Health England or the Health and Wellbeing Service.

- Delivering topic-based trainings for staff, for example on ADHD and classroom management, Autistic Spectrum Disorder, attachment difficulties, identification of risk including eating disorders, self-harm and prevention of suicide, courses for staff in Mindfulness (Weare, 2014) and stress management.
- Offering consultations to support school staff. A key activity, given reports that 81.2 per cent of teachers reported experiencing stress, anxiety or depression (NUT, 2013) which is likely to reduce their own resilience and capacity when teaching children with complex needs. A good example would be CAMHS consultations in schools for teachers and classroom teams to use as a reflective space (Islington CAMHS in Schools Service). This has complemented the referral pathway by providing CAMHS support when a direct intervention with the family is not appropriate. Teachers and TAs have used these consultations to think together about dilemmas or difficulties in their work with a peer group or whole class. (Picciotto, 2014).
- Working with School Health Services: Although the pattern of provision varies across the country, school nurses and community paediatricians can be a very valuable part of psychological services in schools. They can have a particularly important role in supporting psychological wellbeing in relation to physical health, sexual health, neuro-developmental disorders, physical and learning disabilities, in conjunction with psychological practitioners.
- Contributing to school culture: Applied psychologists in schools can have an active role in service and organisational development, pioneering and implementing improvements connected to mental health. This may include developing services and knowledge in the whole school and wider community based on feedback from children and young people, outcomes and progress data, and family and school feedback. They can provide support to the school but can also challenge the established system when change may be beneficial.

Case study

The Lancashire Emotional Health in Schools Service is commissioned by the Public Health department within Lancashire County Council to provide an Emotional Health in Schools Service to provide training, consultation and supervision to high school staff across the county via a team of qualified clinical psychologists. Work has focused on the development of skills and competencies around understanding and supporting children's mental health for the pastoral support team. Input to the school began with a whole school training session on 'What is Mental Health?' to the full staff team. A range of teaching sessions were then delivered to the pastoral support team over a number of months. Sessions included understanding anxiety and anxiety management, understanding depression and low mood, communicating with children who are distressed, and using solution-focused and motivational interviewing techniques.

Following the training sessions, the clinical psychologist facilitated a number of case discussion/team formulation sessions in which a staff member discussed their concerns around a particular young person in school, and the clinical psychologist and team members then discussed together how they could better understand the difficulties, and what strategies or interventions the school or member of staff could use to improve the situation. These sessions aimed to consolidate learning from the training sessions by providing opportunities to discuss how the team could use the ideas from the training in real-life situations.

Individual training and consultation sessions were arranged between the psychologist and school SENCO to discuss young people that she is working with on a one-to-one basis around their emotional wellbeing. Training delivered individually to the SENCO has focused on methods for assessing mental health needs and formulating this information into an understanding that can be shared with the young person and other professionals and which can inform intervention plans.

Working with other services and agencies

Services in schools will always work most efficiently and effectively in networks with other local provision. Key examples would be:

- School Health or Community Child Health Services: Although the pattern of provision varies across the country, school nurses and community paediatricians can be a very valuable part of psychological services in schools. They can have a particularly important role in supporting psychological well-being in relation to physical health, sexual health, neuro-developmental disorders, physical and learning disabilities, in conjunction with psychological practitioners.
- CAMHS and other mental health providers
- Social Care, especially around safeguarding and looked after children
- Youth work and Voluntary sector providers

Direct universal provision

- Mental Health screens of cohorts or year groups. Although they have clear cost/resource implications, they can identify universal themes on which to base whole class or year group work on child and adolescent mental health. Topics might include psycho-education on bullying, sleep hygiene, managing exam stress, healthy eating habits, self-harm and eating disorders. They can also identify children or young people with or at risk of developing mental health difficulties who need targeted interventions from school staff (such as school counsellors or Learning Mentors) or specialist mental health services (such as school-based psychologists and CAMHS).
- Universal groups for children (Stallard, 2013; Stallard et al., 2016). These can be groups using specific evidence-based therapeutic approaches (for example, mindfulness-based approaches (Weare, 2013) or can be groups focusing on specific topics (such as transitions, promoting good mental health, anxiety management, bullying, friendship). Although these groups function as a universal intervention, they can also provide signposting information for young people about where to get targeted help.
- Workshops and training: These may be offered to parents on universal topics such as separation anxiety, managing behavioural difficulties, sleep difficulties, managing exam stress, managing access to technology.
- Pre-referral or 'drop in' sessions for parents: These allow parents to discuss worries about their child's needs and facilitate early identification of mental health difficulties.

Selective and indicated provision

Indirect provision

This aims to improve early identification of mental health difficulties and increases the 'reach' of psychological and mental health services, to benefit a greater number of pupils. It can include:

- Attendance at school Pastoral Care or Team Around the School (TAS) meetings, ensuring a psychological and mental health perspective to school and/or multi-agency discussions about children, young people and families identified as being of concern to the school.
- Sharing the formulation and understanding of a child's difficulties and recommendations with those best placed to intervene in a positive way on a day-to-day basis.
- Signposting to CAMHS and other services for children and families with identified difficulties and acting as a 'bridge' between Health and Education services.
- Regular consultation to, or supervision of, school staff focusing on students or groups of students who are of concern to staff. These informal discussions are easier and more productive if the psychologist has a regular presence in the school and staff feel comfortable to approach him/her. Gowers, Thomas and Deeley (2015) surveyed schools and found that over 50 per cent of respondents reported dissatisfaction with referral systems and many teachers valued the opportunity to discuss concerns and ask advice from CAMHS clinicians on an informal basis and with a named person.
- Contributing to Education, Health and Care (EHC) plans. The Special Educational Needs and Disability Regulations, (HM Govt., 2014) supported by a Code of Practice (Department for Education, 2015) provides statutory guidance on duties, policies and procedures relating to Part 3 of the Children and Families Act 2014, and applies to England. It came into force in September 2014 and was last revised in January 2015. EHC plans will replace statements and Learning Difficulty Assessments over three years. The legal test for an EHC plan remains the same as for a statement and there are new duties on education, health and social care to jointly plan and commission support. The code says that local clinicians, such as community paediatricians, will participate where relevant in the development of a child's or young person's EHC plan. CCGs must ensure that commissioned services are mobilised to participate in the development of EHC plans.

Direct provision

Psychological assessments and interventions with children, young people, parents/carers and family work in schools can include:

- Screening and assessment of developmental and neurodevelopmental conditions where observation of the child or young person within the school context forms a key part of the assessment.
 - Early assessment and treatment of school-based difficulties where there is a social, emotional and/or behavioural component, where intervening in school is clinically relevant and evidence-based.
 - Assessment and ongoing therapy for an often complex population that has been or would be unable to access traditional clinic-based service. Parents accessing a school-based psychology service
- give positive feedback (Picciotto, 2014). One commented that the professional they worked with ‘Explained everything and talked me through different solutions to the problem. I think all schools should have this service.’ Another said that their clinician ‘has worked tirelessly with the school and [child] to ensure a positive outcome.’
 - Preventative work for children and young people likely to struggle with an educational transition, for example from early years provision to primary school, or from primary to secondary school or college. This may be group or individual work.
 - Evidence-based group work for specific difficulties or diagnoses, such as CBT for anxiety.
 - Targeted parenting groups located in schools (e.g. The Incredible Years, Webster-Stratton, 1998).

Case example

A primary school had a general focus on how to improve the transition from the Early Years/Foundation Stage to Key Stage 1. The aim was to narrow the gap between the stages so children were more prepared for the learning demands of Year 1, and to identify difficulties the children might have as early as possible.

At the beginning of the autumn term, the Year 1 teacher, in discussion with the inclusion manager and the clinician, identified the children most benefit from this intervention. The clinician then met with parents to think about their concerns and what might realistically be achieved. She co-ran the group with an assistant child psychotherapist from CAMHS – weekly sessions over the autumn and spring terms. Some children flourished in the group, with growing emotional maturity and a new focus and engagement in the classroom. Others remained quite stuck but the group was useful in pinpointing the nature of their difficulties and providing information for the school about where best to concentrate resources to support them.

The CAMHS clinician started providing some individual sessions for the parent of a child with serious difficulties to support his thinking about his child. She offered occasional sessions to another of the parents to think about the impact of recent adverse life events on her child.

Working with schools as communities

Whilst there are many advocates for and examples of whole school approaches to promoting psychological wellbeing in schools, most do not take a whole community approach and this is an area which is worth further exploration, using the evidence base of Community Psychology.

Such an approach aims to help the whole community of the school, including families, to develop support systems that can begin to build resilience at a wider level. These interventions should be evidence-based, where evidence is available, and should contribute to research and building better practice-based evidence where the evidence is lacking.

Community psychology is not just ‘psychology in the community’ (like therapy based in GP practices) but takes a wider view of mental health and wellbeing. The focus is not on changing individuals, although this

does occur, but on transforming social conditions and contexts to enable better mental health and wellbeing. Community psychologists take a facilitative, non-expert role within such interventions, appreciating that they may have a different set of lived experiences than the community members they hope to serve. They take a partnership approach, mapping and harnessing the resources and strengths in a community and equally valuing other ways of knowing (e.g. the importance of lived experience). Many tools and models exist to support the mapping and exploring of resources present in communities that can be adapted for use in schools. NICE guidelines on community engagement recommend such co-production and asset-based approaches, amongst others, to foster community-led change.

For more information and ideas see Chapter 6 ‘Working with whole communities: Delivering commu-

nity psychology approaches with children, young people and families' in 'What good looks like in psychological services for children, young people and families' and 'What good could look like in integrated psychological services for children, young people and their families: Preliminary guidance and examples of practice'

A significant issue when considering the capacity of schools to support the psychological wellbeing of children is the psychological wellbeing of the staff. Many surveys and studies report high stress levels in teachers themselves. The Health and Safety Executive analyses show that teachers come into the highest stress category, with only nurses and social workers having higher levels (Health & Safety Executive, 2016). Many recent surveys, although not necessarily fully representative of the profession, indicate significant problems with excessive workloads and high levels of concern that teachers have about the impacts of their job on their mental and physical health. One example is a survey conducted for *The Guardian* (Lightfoot, 2016) of over 4000 teachers that found that 98 per cent described themselves as under increased pressure, 82 per cent found their workload unmanageable, 73 per cent said this was having an impact on their physical health and 75 per cent on their mental health.

The stress on staff is a significant issue in its own right both in terms of its impact on them and their families but also on their ability to support their students. It can be addressed directly in a number of ways, for example, Nottingham's Education Improvement Board's Fair Workload Charter (http://www.nottinghamschools.org/wp-content/uploads/2016/09/53683_EIB-FAIR-WORKLOAD-CHARTER-2PP_6.pdf) but this type of approach tends to lead to only partial and piecemeal solutions rather than developing the school into a psychologically healthy workplace

A community approach would consider the psychological wellbeing of staff, students, families and the local community together. All would be equal partners in developing a school strategy, supported by more specialist staff. Harnessing the energy, creativity and ideas of the young people in particular can lead to very positive change that would not be achieved in more conventional models.

This type of approach also opens the possibilities of new resources to help support increased wellbeing. Young people and parents, with training and ongoing support, can develop and deliver help to others through schemes like peer mentoring and parent befriending.

Thrive framework

Another relatively recent development in the conceptualisation of children's mental health services is the THRIVE Framework. It is a conceptual model for ensuring needs-led service planning and review for children and young people's mental health services.

'The framework outlines groups of children and young people, and the sort of support they may need, and tries to draw a clearer distinction between treatment on the one hand and support on the other. It focuses on a wish to build on individual and community strengths wherever possible, and to ensure children, young people and families are active decision makers in the process of choosing the right approach.'

The THRIVE framework below conceptualises five needs-based groupings for young people with mental health issues and their families. Each of the five groupings is distinct in terms of the:

- needs and/or choices of the individuals within each group;
- skill mix required to meet these needs;
- dominant metaphor used to describe needs (well-being, ill health, support);
- resources required to meet the needs and/or choices of people in that group.

This approach is potentially attractive to policymakers, and may prove to be influential in the design of services in future because it describes services in a less rigid way, and might create new opportunities to overcome traditional barriers between service providers. This could allow for more integrated working across different parts of the system.

In addition, THRIVE's authors hope that describing services in this way will support better coordination in the commissioning of services, and a more even distribution of funding across different parts of the system.

Figure 1: The Thrive model.



Recommendations

Recommendation 14: Psychological intervention should be a critical part of the ways in which schools and colleges deliver Public Health England's (2015) whole school approach to promoting emotional health and wellbeing.

Recommendation 15: The research base on the effectiveness of primary prevention and schools-based approaches is relatively new and development of it should be a priority both for psychologists developing new models on the basis of psychological theory and for practitioners who are implementing these. This could be a priority area for key research funders such as the Economic and Social Research Council. In addition the important role of practitioner research should be supported by employers and commissioners.

Recommendation 16: Whilst enhanced training for teachers is recommended, commissioners, service providers and employers should recognise it is essential that it is not seen as a stand-alone solution. Effective training requires adequate follow up in terms of ongoing access to consultation, support and supervision from more highly trained and experienced staff.

Recommendation 17: The development of psychologically healthy schools which support the wellbeing of staff and students should be a priority for all including commissioners, service providers and employers. Use of community psychology models and methods would be a positive way to approach this jointly with staff, students, families and local communities.



In conclusion

The provision of psychological services in schools presents an exciting opportunity to develop innovative services that support the psychological wellbeing of children and young people thus helping to prevent mental health problems, improve and facilitate early intervention and provide an increased reach of psychological services. This is supported by guidance from government that places the emotional health and wellbeing of pupils in school as a high priority.

Psychological knowledge can be shared more widely in schools through training, contributing to collaborative plans developed with young people, and maximising the use of existing resources in the education, health and voluntary sectors. Consultation and promoting whole school approaches can help build capacity in the school and surrounding community and systems.

In a climate of limited resource, there is clear and growing evidence that embedding psychological services in schools is an effective way of identifying and working with children and young people's mental health needs.

A deputy head teacher of a secondary school commented:

'What stands out is the girls' readiness to come and see [the CAMHS clinician] and their acceptance of the support. There is no stigma or avoidance, they feel heard and that they have a voice. It has an impact on the individuals and they are more positive about school. Their resilience is growing and they are more hopeful about their futures.'

Appendix A: The roles of the educational and clinical psychologists

Access to specialist input from qualified applied psychologists is an important part of a whole school approach to wellbeing (Public Health England, 2015). Two disciplines of applied psychology, clinical and educational, provide most specialist mental health input to schools. The availability of these professionals to schools is currently limited and variable between and within local authorities.

Educational psychologists provide a broad portfolio of services that contribute to the education and wellbeing of children and young people. The role and function of educational psychologists varies across the country. Following the development of academies and free schools, many educational psychologists are employed independently, though some remain directly contracted to local authorities. Educational psychologists typically serve many schools on a sessional basis, rather than being based in a single school. Educational psychologists vary in how much they become involved in mental health provision but all will have a focus on the educational impact of children's difficulties, and helping the school to manage teaching and learning. They support vulnerable groups of children and young people, both through developing whole school approaches and through more targeted work at a group or individual level. Educational psychologists have played a strong role in developing evidence-based strategies and practice-based evidence to promote resilience and wellbeing in partnership with other colleagues, and in providing support to schools to develop positive learning environments.

Clinical psychologists in schools and colleges work to reduce psychological distress in children and young people affected by mental or physical health prob-

lems. They often provide specialist assessment, using observation, clinical interviewing or psychometric testing. From the assessment and their formulation of the difficulties, clinical psychologists may then offer advice, consultation, individual or group therapy, interventions for parents or carers or onward referral to other clinical and community services. Clinical psychologists in schools are typically employed in the NHS through CAMHS, but an increasing number work independently and are commissioned directly by schools.

Clinical and educational psychologists working in schools share some common skills and approaches and contribute different specialist skills, so their work is most effective if it is integrated. Both groups emphasise the importance of training, support and consultation for school staff". The common factor in applied psychologists' work with schools is understanding a child's problems or symptoms in context, rather than solely at an individual level. In schools and colleges, relevant contexts, which can maintain psychological problems or support positive change, often include a child's classroom environment, peer group, parental mental health, poverty and a great range of other possible influences. Psychological interventions may target one or more of these contexts with little or no individual work with the child (so-called 'indirect interventions'). When direct work with the child is indicated, significant engagement with the child's school and family network is the norm. A flexible approach to different levels of intervention often means that a school-based psychology service will be offering more than one of these interventions simultaneously.

Appendix B: The recent policy context

There is no shortage of guidance and reviews from government and non-governmental organisations in recent years, relating to mental health in schools, as the following selective potted history shows.

2015

Future in Mind encourages schools to promote the wellbeing of their young people and staff by using ideas and interventions from applied psychology (Department for Education, 2015; National Institute for Health and Care Excellence [NICE], 2008a, 2009;). This report builds on the CAMHS Review (DfE, 2008). Future in Mind recommends that schools continue 'to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.'

Public Health England publish 'Promoting children and young people's emotional health and wellbeing: A whole school and college approach'. Based on eight principles, the guidance draws together NICE guidance and the Ofsted Inspection Framework, signposting school leaders to the evidence and useful resources.

2016

Based on a review of the evidence (Weare, 2015) NCB published 'A whole school framework for emotional wellbeing and mental health: A self-assessment and improvement tool for school leaders' (see Figure 2). The tool is intended to help school leaders to identify and address how to respond systematically to individual mental health problems and build resilience, influence attitudes and behaviours and create a culture that promotes and protects wellbeing across the school.

The Department for Education produce two pieces of departmental advice to schools:

- *Counselling in schools: a blueprint for the future* sets out the Government's expectation that all schools will provide access to counselling services, provides practical help for setting up or improving existing counselling services, and 'explains how counselling fits within a whole school approach to mental health and wellbeing, covering issues such as improving wellbeing and resilience, raising awareness of mental health issues through the curriculum, reducing the stigma around mental health, effectiveness of the pastoral system and the role of leadership.'
- *Mental health and behaviour in schools* collates a summary of the appropriate role of schools in relation to mental health, and the school's key role in influencing health services that are commissioned locally.

2017

The *Five Year Forward View for Mental Health: A Government Response* (2017) emphasises the school setting as important for mental health promotion and the delivery of psychological services, noting that schools should continue 'to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education's current work on character and resilience, PSHE and counselling services in schools.'

In January 2017, Prime Minister Theresa May committed to provide **Youth Mental Health First Aid** training to at least one member of staff in every state secondary school in the country over the next three years. Mental Health First Aid (MHFA) is an internationally recognised training course, designed to teach people how to spot the signs and symptoms of mental ill health and provide help on a first aid basis. Youth MHFA is a version of this course tailored towards supporting young people experiencing a mental health issue. Following this announcement, the Youth MHFA in Schools programme was launched in April 2017. In the first year of the programme 100 Youth MHFA One Day Courses will be delivered, which equates to over 1000 places available. A similar number of courses will be delivered in years two and three of the programme.

Recent government proposals suggest integrating quality audit of mental health provision for young people across health and education systems by joining the functions of Ofsted and Care Quality Commission.

Figure 2: Eight principles to promoting a whole school and college approach to emotional health and wellbeing.



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