Department for Education

Gloucestershire Healthy Living and Learning

Mental health and behaviour in schools

A localised look at the Departmental advice for school staff in Gloucestershire

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Summary

About this advice

This advice originated from the Department for Education and has been adapted to include relevant information for schools in Gloucestershire. All pupils will benefit from learning and developing in a well-ordered school environment that fosters and rewards good behaviour and sanctions poor and disruptive behaviour. The behaviour and discipline in schools advice sets out the powers and duties for school staff and approaches which they can adopt to manage behaviour in their schools. It also says that schools should consider whether continuing disruptive behaviour might be a result of unmet educational or other needs.

This non-statutory advice clarifies the responsibility of the school, outlines what they can do and how to support a child or young person whose behaviour, whether it is disruptive, withdrawn, anxious, depressed or other, may be related to an unmet mental health need. Schools say that this is a difficult area. They want to know what the evidence says, share approaches to supporting children at risk of developing mental health problems and be clearer on their own and others' responsibilities.

Nationally, one in ten children and young people aged 5 to 16 have a clinically diagnosed mental health disorder and around one in seven has less severe problems.

In Gloucestershire, we have seen a rise in young people's demand for mental health services in the last few years, and an increase in incidents of self-harm, as has been the case nationally.

The DfE have developed this advice and practical tools to help schools promote positive mental health in their pupils and identify and address those with less severe problems at an early stage and build their resilience. In using this advice, we at Gloucestershire County Council hope that schools will have more understanding of the referrals process and more confidence to refer pupils within the specialist support agencies we have within the county such as CYPS (Children and Young People Service). This is known nationally as CAMHS (Child and Adolescent Mental Health Service). The Gloucestershire Healthy Living and Learning team (GHLL) hope to be able to help schools evaluate the picture of Mental Health within their schools that pupils have reported through the Online Pupil Survey. This should enable schools to accurately pinpoint the specific needs within their school community and thereby introduce the necessary intervention work directly to those who need it.

Who is this advice for?

Primary and secondary school teachers, pastoral leaders, Special Educational Needs Coordinators and others working to support children who suffer from, or are at risk of developing, mental health problems.

Acknowledgements

- In developing this advice the Department has worked with:
  - a number of effective schools;
  - a team who developed the Department of Health's online mental health training for adults who work with children ('MindEd');
  - the DH Children and Mental Health team;
  - NHS England and the CYP IAPT (Children and Young People's Improving Access to Psychological Therapies) programme team;
  - Professor Mick Cooper and Professor Peter Fonagy;
  - behaviour and SEN colleagues within the Department for Education; and
  - the Department for Education's Primary and Secondary Heads' Reference Groups.

In Gloucestershire, we have also consulted:

- Public Health
- Public Health (School) Nurses
- Representatives across Gloucestershire County Council
- Gloucestershire Safeguarding Children's Board (GSCB)
- Members of the Gloucestershire Healthy Living and Learning team
- Foster and Brown Research
- Gloucestershire Schools
- Gloucestershire Partner organisations

1 Mental Health Problems in Children and Young People

Key points

- **In order to help their pupils succeed, schools have a role to play in supporting them to be resilient and mentally healthy.** There are a variety of things that schools can do, for all their pupils and for those with particular problems, to offer that support in an effective way.
- **Where severe problems occur schools should expect the child to get support elsewhere as well,** including from health professionals working in specialist Children and Young People Service (CYPS) locally, voluntary organisations and local GPs.
- **Schools should ensure that pupils and their families participate as fully as possible in decisions** and are provided with information and support. In Gloucestershire we have the Online Pupil Survey (OPS) which has been an invaluable tool to recognize where children and young people are reporting particular needs. We have epidemiological data across all settings and all age groups, the survey having been conducted biennially since 2006. It is an excellent early help tool but it is only useful if its results are responded to appropriately and quickly. The views, wishes and feelings of the pupil and their parents should always be considered. The surveys are anonymous and feedback to schools is given as percentages of the total, not as identifiable individual's data.
- **Schools can use the Strengths and Difficulties Questionnaire (SDQ) to help them judge whether individual pupils might be suffering from a diagnosable mental health problem** and involve their parents and the pupil in considering why they behave in certain ways.
- **MindEd, a free online training tool,** is now available to enable school staff to learn more about specific mental health problems. This can help to sign post staff working with children to additional resources where mental health problems have been identified. Counselling MindEd, which is part of MindEd, is also available to support the training and supervision of counselling work with children and young people.
- **There are things that schools can do – including for all their pupils, for those showing early signs of problems and for families exposed to several risk factors – to intervene early and strengthen resilience,** before serious mental health problems occur. The Gloucestershire Safeguarding Children's Board (GSCB) play an integral role in all educational settings, including during transition. They have resources, training and a helpline. They are contactable via www.gscb.org.uk with details of the Multi-Agency Safeguarding Hub. The Helpdesk is 01452 426565 for parents and/or professionals. Children are advised to phone Childline on 0800 1111. Here in Gloucestershire the GHLL team have devised a host of teaching resources, hopefully some of which may be relevant to the needs highlighted by the pupils within your school. Details of the resources produced and the training which they can provide can all be found on the GHLL website: www.ghll.org.uk.
- **Schools can influence the health services that are commissioned locally through their local Health and Well-being Board** – Directors of Children's Services and local Healthwatch are statutory members.
- **There are national organisations offering materials, help and advice. Schools should look at what provision is available locally** to help them promote mental health and intervene early to support pupils experiencing difficulties. It may be that some of the teaching resources listed on the GHLL website (www.ghll.org.uk) may be of help, or perhaps schools may like to consider an Mental Health First Aid training programme for staff (provided by funding from Public Health – available through Nicki.Wood@gloucestershire.gov.uk), carrying out staff surveys, and/or staff training in emotional resilience and handling emotional health issues with pupils, or perhaps working with some partner organisations, such as those listed on the GHLL website under 'Partnerships'. Help and information about evidence-based approaches is available from a range of sources (see Annex B). Work completed by Dr. Yvette Morey and her team at the University of the West of England, was recently shared at the 'Beyond Fed-Up' conference held in Gloucestershire, where a range of national evidence-based survey data was used to highlight key mental health issues for young people nationally, using similar questions to those in the Gloucestershire Online Pupil Survey. Gloucestershire County Council hope to be able to work with survey groups like these to compare our survey results with national results in order to identify county specific needs, and therefore channel specific intervention work accordingly.

❶ Promoting positive mental health

Factors that put children at risk

1.1. Certain individuals and groups are more at risk of developing mental health problems than others. These risks can relate to the child themselves, to their family, or to their community or life events. The risk factors are listed in table 1, on page 6.

1.2. Risk factors are cumulative. Children exposed to multiple risks such as social disadvantage, family adversity and cognitive or attention problems are much more likely to develop behavioural problems.[2] Longitudinal analysis of data for 16,000 children suggested that boys with five or more risk factors were almost eleven times more likely to develop conduct disorder under the age of ten than boys with no risk factors. Girls of a similar age with five or more risk factors were nineteen times more likely to develop the disorder than those with no risk factors.[3]

Factors that make children more resilient

1.3. Seemingly against all the odds, some children exposed to significant risk factors develop into competent, confident and caring adults. An important key to promoting children's mental health is therefore an understanding of the protective factors that enable children to be resilient when they encounter problems and challenges.

'Resilience seems to involve several related elements. Firstly, a sense of self- esteem and confidence; secondly a belief in one's own self-efficacy and ability to deal with change and adaptation; and thirdly, a repertoire of social problem solving approaches.'[4]

1.4. Research suggests that there is a complex interplay between risk factors in children's lives and promoting their resilience. As social disadvantage and the number of stressful life events accumulate for children or young people, more factors that are protective are needed to act as a counterbalance. The key protective factors, which build resilience to mental health problems, are shown alongside the risk factors in table 1, below. From the Gloucestershire Online Pupil Survey, direct correlations are repeatedly shown between certain aspects of the examined areas. For example, in the 2014 data, of the children who reported NEVER eating breakfast, almost 3 times more of them do not enjoy their school life. Similarly three times more students who reported feeling stressed also reported not liking school.

1.5. The role that schools play in promoting the resilience of their pupils is important, particularly so for some children where their home life is less supportive. School should be a safe and affirming place for children where they can develop a sense of belonging and feel able to trust and talk openly with adults about their problems.

2 Brown, E., Khan, L. and Parsonage, M. (2012) A Chance to Change: Delivering effective parenting programmes to transform lives. Centre for Mental Health.
3 Murray, J. J. (2010). Very early predictors of conduct problems and crime: results from a national cohort study. Journal Of Child Psychology & Psychiatry, 51(11), 1198-1207.
4 Rutter, M. (1985) Resilience in the face of adversity. Protective factors and resistance to psychiatric disorder. British Journal of Psychiatry. Vol. 147, pp. 598-611

Table 1: Risk and protective factors for child and adolescent mental health

	Risk factors	Protective factors
In the child [5 6]	• Genetic influences • Low IQ and learning disabilities • Specific development delay or neuro-diversity • Communication difficulties • Difficult temperament • Physical illness • Academic failure • Low self-esteem	• Being female (in younger children) • Secure attachment experience • Outgoing temperament as an infant • Good communication skills, sociability • Being a planner and having a belief in control • Humour • Problem solving skills and a positive attitude • Experiences of success and achievement • Faith or spirituality • Capacity to reflect
In the family [4 5]	• Overt parental conflict including Domestic Violence • Family breakdown (including where children are taken into care or adopted) • Inconsistent or unclear discipline • Hostile or rejecting relationships • Failure to adapt to a child's changing needs • Physical, sexual or emotional abuse • Parental psychiatric illness • Parental criminality, alcoholism or personality disorder • Death and loss – including loss of friendship	• At least one good parent-child relationship (or one supportive adult) • Affection • Clear, consistent discipline • Support for education • Supportive long term relationship or the absence of severe discord

	Risk factors	Protective factors
In the school	• Bullying • Discrimination • Breakdown in or lack of positive friendships • Deviant peer influences • Peer pressure • Poor pupil to teacher relationships	• Clear policies on behaviour and bullying • 'Open-door' policy for children to raise problems • A whole-school approach to promoting good mental health • Positive classroom management • A sense of belonging • Positive peer influences
In the community [4 5]	• Socio-economic disadvantage • Homelessness • Disaster, accidents, war or other overwhelming events • Discrimination • Other significant life events	• Wider supportive network • Good housing • High standard of living • High morale school with positive policies for behaviour, attitudes and anti-bullying • Opportunities for valued social roles • Range of sport/leisure activities

5 Young Minds risk handout
6 Young Minds resilience handout

Difficult events that may have an effect on pupils

1.6. Form tutors and class teachers see their pupils day in, day out. They know them well and are well-placed to spot changes in behaviour that might indicate a problem. The balance between the risk and protective factors set out above is most likely to be disrupted when difficult events happen in pupils' lives. These include:

- **loss or separation** – resulting from death, parental separation, divorce, hospitalisation, loss of friendships (especially in adolescence), family conflict or breakdown that results in the child having to live elsewhere, being taken into care or adopted;
- **life changes** – such as the birth of a sibling, moving house or changing schools or during transition from primary to secondary school, or secondary school to sixth form; and
- **traumatic events** such as abuse, domestic violence, bullying, violence, accidents, injuries or natural disaster.

1.7. Schools will often be able to support children at such times, intervening well before mental health problems develop. The report considers effective approaches in the classroom and more generally within the school in section 4.

How schools can promote their pupils' mental health

1.8. The culture and structures within a school can promote their pupils' mental health through:

- **a committed senior management team** that sets a culture within the school that values all pupils; allows them to feel a sense of belonging; and makes it possible to talk about problems in a non-stigmatising way;
- **an ethos of setting high expectations of attainment for all pupils with consistently applied support.** This includes clear policies on behaviour and bullying that set out the responsibilities of everyone in the school and the range of acceptable and unacceptable behaviour for children. These should be available and understood clearly by all, and consistently applied by staff [7];
- **an effective strategic role for the qualified teacher who acts as the special educational needs co-ordinator (SENCO)**, ensuring all adults working in the school understand their responsibilities to children with special educational needs and disabilities (SEND), including pupils whose persistent mental health difficulties mean they need special educational provision. Specifically, the SENCO will ensure colleagues understand how the school identifies and meets pupils' needs, provide advice and support to colleagues as needed and liaise with external SEND professionals as necessary;
- **working with parents and carers as well as with the pupils themselves**, ensuring their opinions and wishes are taken into account and that they are kept fully informed so they can participate in decisions taken about them;
- **continuous professional development for staff** that makes it clear that promoting good mental health is the responsibility of all members of school staff and community, informs them about the early signs of mental health problems, what is and isn't a cause for concern, and what to do if they think they have spotted a developing problem. This may include Mental Health First Aid courses (MHFA) offered for free through Gloucestershire County Council, funded by Public Health;
- **clear systems and processes to help staff who identify children and young people with possible mental health problems**; providing routes to escalate issues with clear referral and accountability systems. Schools should work closely with other professionals to have a range of support services that can be put in place depending on the identified needs (both within and beyond the school). These should be set out clearly in the school's published SEND policy;
- **a healthy school approach to promoting the health and well-being of all pupils in the school**, with priorities identified and a clear process of 'planning, doing and reviewing' to achieve the desired outcomes.[8] Gloucestershire Healthy Living and Learning offer a Review where schools appraise their health and well-being provision and then log baseline data for future intervention work where need has been highlighted. The success of the intervention work is then recorded in terms of the numbers of children and young people improving their behaviours or attitudes;
- **working with others to provide interventions for pupils with mental health problems that use a graduated approach to inform a clear cycle of support**: an assessment to establish a clear analysis of the pupil's needs; a plan to set out how the pupil will be supported; action to provide that support; and regular reviews to assess the effectiveness of the provision and lead to changes where necessary. As part of the Gloucestershire Healthy Living and Learning (GHLL) accreditation, schools can store the data relating to this intervention work securely, then use this data easily in reporting to interested parties such as staff, governors, Ofsted or even community-based projects.

7 For detailed information on school behaviour policy see: DfE (2014) Guide for heads and school staff on behaviour and discipline.

1.9. Schools with these characteristics mitigate the risk of mental health problems in their pupils by supporting them to become more resilient and preventing problems before they arise. In addition, schools should also have in place arrangements which reflect the importance of safeguarding and protecting the welfare of its pupils as set out in the latest safeguarding guidance[9].

Case study 1: Promoting positive mental health

For the last three years, Churchdown Parton Manor Junior School have been using the work of Dr. Tom Robson to empower pupils to become effective learners; the aim is to develop 'learning to learn' strategies in a way that is easily understood by primary school children, teaching them to grow their 'Gem Power'. This involves the acquisition and application of a range of attributes which are represented by a selection of gems.

During the first year of this project, the school reviewed their vision and values in order to promote the characteristics represented by the gems more explicitly. They now have three 'umbrella' values - self-belief, challenge and respect; each one of these has a number of associated characteristics to demonstrate what it looks like in practice.

The 'self-belief' umbrella includes the characteristics of courage, resilience, perseverance, hope and self-reliance. These are all facets of 'Emerald Power' which Dr. Tom defines for the children as follows:

'Emerald Power can make you feel excited, worried or anxious and because your blood is pumping faster, your cheeks might go a bit red. Emerald Power enables you to cope with disappointment and pressure, and take risks, and it gives you courage to try new things; these positive reactions make your brain work better so it is good to feel it. However, if it becomes uncontrolled, it produces anger; you lose Emerald Power if you lose your temper, moan or whinge.'

The children are taught that in order to acquire emerald power they must get into the habit of:
- having a go' even though they know they might make a mistake;
- understanding that mistakes help them to learn;
- 'bouncing back' from any mistakes they make;
- staying calm when they are upset or angry.

As time has gone on, however, the school have noticed that pupils find it very challenging to 'grow' this particular gem – they are inclined towards the very opposite tendencies, giving up at the first sign of difficulty, being reluctant to do anything that might result in failure and not understanding the potential to learn from a mistake. For many of them, the single biggest obstacle to progress in this area is a lack of resilience. As a result, the school is having a major focus on promoting the resilience aspect of emerald power.

There is no single 'catch-all' way of doing this, and it sometimes seems like a long, hard slog with very little gain. But looking back over a period of time, hundreds of gem stickers and many celebration assemblies later, the school can see the progress the children have made. The vocabulary of resilience has become embedded, understood and used regularly. An idea introduced by Dr. Tom has become a fundamental principle for the school – they do not allow a 'whopping whinge' or even a 'mini-moanette' as a response to any situation, however disappointing, as these denote a negative attitude. This has laid the foundation on which to build; pupils are now used to expecting a positive attitude as the default position.

Children regularly take risks and rise to new challenges even when they are afraid or anxious, and they experience the 'emerald' feeling of overcoming something they thought was beyond them. The school also has a very strong shared culture in which to tackle resilience difficulties with individual children; for example, in the case of a downwardly spiralling attendance problem, they were able to relate the child's feelings to the choices he had been making, and show him what the outcomes of changing his choices would be. And at PGL last summer, two girls conquered their fear of the zipwire, attributing their success to the fact they knew about emerald power.

One unexpected bonus of working to develop resilience in the pupils is that the adults in school felt that they became more resilient themselves. As they began to recognise their own development in this area, they also realised that there were many parents who were completely lacking in it. In addition, their attitude sometimes undermined the hard-won resilience of their children – they neither recognised nor understood it, and therefore didn't have the strategies to support the work being done in school. Some of them were upset by the idea that their children might experience something that was challenging, and many take the easy way out of any difficulty through avoidance. The school's current initiative, therefore, is to work on developing resilience with a group of parents. They have introduced this by holding regular coffee mornings, led by the Inclusion Manager, to give an opportunity to share thoughts and discuss ideas. This is obviously a work in progress and it will be a while before the impact is seen, but they are looking forward to seeing pupils and their parents experience the benefits of improving their resilience together.

8 For more information on a healthy school approach see Healthy Schools content in The National Archives: DfE (2011)
9 Working together to safeguard children safeguarding guidance (DfE, 2013)

❷ Identification

Identifying children with possible mental health problems

2.1. Behavioural difficulties do not necessarily mean that a child or young person has a possible mental health problem or a special educational need (SEN). Consistent disruptive or withdrawn behaviours can, however, be an indication of an underlying problem, and where there are concerns about behaviour there should be an assessment to determine whether there are any causal factors such as undiagnosed learning difficulties, difficulties with speech and language or mental health issues.

2.2. Only medical professionals should make a formal diagnosis of a mental health condition. Schools, however, are well-placed to observe children day-to-day and identify those whose behaviour suggests that they may be suffering from a mental health problem or be at risk of developing one. This may include withdrawn pupils whose needs may otherwise go unrecognised.

2.3. There are often two key elements that enable schools to reliably identify children at risk of mental health problems:

- **effective use of data** so that changes in pupils' patterns of attainment, attendance or behaviour are noticed and can be acted upon, as well as trends observed in reporting from pupil groups or school communities from the Online Pupil Survey in Gloucestershire; and
- **an effective pastoral system** so that at least one member of staff (e.g. a form tutor or class teacher) knows every pupil well and can spot where bad or unusual behaviour may have a root cause that needs addressing. The pastoral system or school policies should provide the structure through which staff can escalate the issue and take decisions about what to do next.

Case study 2a: monitoring and early identification of problems: Cheltenham College

The emotional health and well-being of all pupils at Cheltenham College is paramount and to this end the College has made a commitment to train key staff.

All Housemasters and Housemistresses at Cheltenham College, an Independent Boarding School, have undertaken the two-day MHFA youth course. They have also trained many of the resident tutors and matrons, all who have direct contact with boarders and day pupils. Pupils have many staff that they can turn to for help and support including two Counsellors, a team of doctors and nurses within the medical centre and a chaplaincy team.

The College also has a Director of Pupil Welfare (DPW), a senior member of staff, who chairs weekly team meetings to raise and discuss pupils with welfare concerns. Problems are raised and recorded through the use of Individual Welfare Plans, IWPs or via a Cause for Concern form, all of which are co-ordinated by the DPW.

Pupils have access to fully trained peer mentors in each of the houses and the use of an email account within the school to report bullying. These emails are forwarded to the DPW who will deal with matters raised. The school prefects also have key areas of responsibility and one of these areas is Anti-bullying.

Chapel forms an integral part of College life and themes are explored on a weekly basis with pupils regularly leading the service where there is a thought for the day and related readings followed by a short address.

Case study 2b: monitoring and early identification of problems: Elmbridge Junior School

Elmbridge Junior School has always had a good ethos towards emotional health and well-being, an ethos of high expectations for attainment and strong support systems to promote the emotional health and well-being of all our pupils. Amongst other things, they have a 'nurture room' where children can come and talk to our pastoral mentor, in a safe and supportive environment. Their 'Helping Hands' are on the playground during break and lunch times to help children resolve their disputes, or just to lend an ear. The PSHE curriculum teaches children about the significance of emotional health, building resilience and self-esteem and teaches the importance of personal responsibility.

In September 2014, Elmbridge Junior School was offered training for 12 members of staff about 'Mental Health First Aid (MHFA),' this training was to help staff recognise children with poor mental health, and look for early warning signs and symptoms.

The staff taking part in the training represented all areas of the school, from teachers, to midday supervisors, to pastoral support workers. The day was incredibly informative and relevant and school attitudes and practice have changed as a result. A number of staff commented on how therapeutic the day had been for them as individuals, as it had given them the opportunity to share feelings and support each other. They left the course feeling inspired, confident and keen to revise our current practices within school.

The first thing was to make sure that all staff felt confident and able to recognise the early signs and symptoms of poor mental health. Therefore, whole school continued professional development (CPD) was organised for the members of staff who had not attended the training. The school looked at, and revised key policies, i.e. behaviour, anti-bullying, e-safety and safeguarding. The school analysed their pupil data and looked for changing patterns of attainment of their pupils, focusing on certain vulnerable groups. Additionally, the pastoral support systems were revised to ensure that every pupil in the school knew people and places they could go to for help and support.

Elmbridge Junior School has an open door policy and parents have always been welcome to approach with any concerns or worries. But following the MHFA training the school looked for ways to increase parental involvement in school, especially for those 'hard to reach' parents. They personally targeted certain parents for meetings, re-advertised the 'Elmbridge Discussion Groups' and signposted, on the school website, external agencies that offer additional support to parents.

In class, as part of our PSHE curriculum, they used various techniques to build pupil resilience, for example, the 'stress bucket' activity, which gives pupils the opportunity to develop and share strategies for dealing with stressful situations. The training also highlighted the importance of the emotional well-being of staff; and they are keen to develop ways to further support all the members of their team.

In a short space of time, staff feel they have come a long way in applying MHFA, guided by the training and the MHFA handbook. The school believe that by identifying children with poor mental health at Primary school, they may be able to develop their resilience and self-esteem and offer strategies that will equip them for the challenges they may face later in life.

2.4. It is important that all those who work with children and young people are alert to emerging difficulties and respond early. In particular, parents know their children best, and it is important that all professionals listen and understand when parents express concerns about their child's development. They should also listen to and address any concerns raised by the pupils themselves.

2.5. Schools should be mindful that some groups of children are more vulnerable to mental health difficulties than others. These include, but are not limited to, looked after children, children with learning difficulties and children from disadvantaged backgrounds.[10]

2.6. If it is thought housing, family or other domestic circumstances may be contributing to the presenting behaviour, notifying and working with other agencies and professionals is likely to be necessary. In all cases, early identification and intervention can significantly reduce the need for more expensive interventions or sanctions at a later stage.

10 Full figures and data can be found in the 2004 Office National Statistics report 'Mental Health of Children and young people in Great Britian'

Strengths and Difficulties Questionnaire (SDQ)

2.7. If schools suspect that a pupil is having mental health difficulties then they should not delay putting support in place. This can happen whilst the school is gathering the evidence, and the pupil's response to that support can help further identify their needs. Schools looking for a simple, evidence-based tool to help them consider the full range of a child's behaviour, and balance protective factors and strengths with weaknesses and risks, can use the Strengths and Difficulties Questionnaire (SDQ). This can assist them in taking an overview and making a judgement about whether the pupil is likely to be suffering from a mental health problem. The questionnaire, scoring sheet and accompanying notes are available, for free, from www.sdqinfo.com or an online version with automatic scoring is available here.[11]

2.8. SDQ scoring sheets give overall scores considered normal, borderline and abnormal, both for the difficulties themselves and for the impact of those difficulties on a child's peer relationships and classroom learning.[12] SDQs may be completed by both parent and teacher, allowing comparison of the results and a fuller understanding of the situation. In addition, there is a version of the SDQ which those pupils aged 11 and above can complete themselves, although they should be advised what it is and how to use it.

2.9. An "abnormal" score identifies children who are struggling with high levels of psychological difficulties. In these cases it may be appropriate to refer the child either for a specific intervention or for a comprehensive assessment by specialist CYPS.

2.10. The SDQ is not always the right assessment tool for every pupil in each particular set of circumstances. Some schools prefer the Common Assessment Framework (CAF) for assessing needs and involving other professionals where there is a concern over the pupil's health, development, welfare, behaviour, progress in learning or any other aspect of their well-being[13].

2.11. Where teachers suspect a conduct disorder (see annex 3) after using the SDQ, the National Institute for Clinical Excellence (NICE) says that schools should always refer children for comprehensive assessment by local specialist CYPS if they are aware that they have another mental health problem (e.g. depression, post-traumatic stress disorder), a neurodevelopmental condition (e.g. ADHD, autism), a learning difficulty or disability or a substance misuse problem.[14]

11 To find the computerised SDQ within the Youth in Mind website select "UK English" then "Teachers and other education professionals" and then "What, if anything, should I be concerned about?"
12 For scores relating to the impact of difficulties, the versions of the questionnaire that include an "impact supplement" should be used.
13 More information on the CAF form is available in the Working Together to Safeguard Children guidance. 14 NICE guidance - Anti-social behaviour and conduct disorders in children and young people: recognition, intervention and management

Special educational needs (SEN)

2.12. Persistent mental health difficulties may lead to pupils having significantly greater difficulty in learning than the majority of those of the same age. Schools should consider whether the child will benefit from being identified as having a special educational need (SEN). Any special education provision should ensure it takes into account the views and wishes of the child and their family.

2.13. When deciding whether a pupil has SEN, schools should use the definition of SEN used in the SEND Code of Practice. This states:

"A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for him or her. A child of compulsory school age or a young person has a learning difficulty or disability if he or she:

- has a significantly greater difficulty in learning than the majority of others of the same age, or
- has a disability which prevents or hinders him or her from making use of educational facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions."

For children aged two or more, special educational provision is educational or training provision that is additional to or different from that made generally for other children or young people of the same age by mainstream schools, maintained nursery schools, mainstream post-16 institutions or by relevant early years providers.

2.14. A wide range of mental health problems might require special provision to be made. These may include problems of mood (anxiety or depression) or of conduct (oppositional problems and more severe conduct problems including aggression), self-harming, substance abuse, eating disorders or physical symptoms that are medically unexplained. Some children and young people may have other recognised disorders such as attention deficit disorder (ADD), attention deficit hyperactive disorder (ADHD), attachment disorder, autism or pervasive developmental disorder, an anxiety disorder, a disruptive disorder or, rarely, schizophrenia or bipolar disorder.

2.15. Where a school has identified that a pupil needs special educational provision due to their mental health problems, this will comprise of educational or training provision that is additional to or different from that made generally for others of the same age. This means provision that goes beyond the differentiated approaches and learning arrangements normally provided as part of high quality, personalised teaching. It may be as additional support from within the setting or require the involvement of specialist staff or support services. Typically in Gloucestershire, this would mean using support agencies, in all likelihood from the local offer (GCC). Information is available from www.glosfamiliesdirectory.org.uk.

2.16. Schools should identify clear means to support such children. Many schools offer pastoral support, which may include access to counselling sessions to help their pupils with social, mental or emotional health difficulties. Where more specialist provision is required, schools should have support from local health partners and other organisations. Additionally they will need to be clear when referrals to CYPS are appropriate. In Gloucestershire the CYPS advice line is the recommended first point of call if you are considering a referral as this would give you and them a greater understanding of the possibilities ahead in order to best meet the needs of the individual under discussion. Thereafter they may then be referred to specialists working for the 2gether NHS Foundation Trust's Children and Young People Service (CYPS). CYPS advice line, 9.00 – 5.00 tel . 01452 894272

2.17. The majority of children and young people with SEN will have their needs met through mainstream education providers and will not need Education, Health and Care plans (EHC plans) or Statements. The SEND Code of Practice sets out the steps that schools should take in identifying and meeting special educational needs.[15]

Working with local GPs

2.18. The identification of mental health problems will often be through a pupil's GP. Although medical practitioners cannot always share information, where possible the school should try to be aware of any support programmes GPs are offering that may affect the pupil's behaviour and attainment at school. Schools might consider asking parents to give consent to their child's GP to share information with the school in these circumstances.

15 The current SEN Code of Practice DfE (2001The latest draft of the new SEND Code of Practice, currently under review. DfE (2014)

❸ Interventions

Strategies to promote positive mental health

3.1. Poor mental health undermines educational attainment. Surveys suggest that disproportionately large numbers of pupils with conduct and emotional disorders fall behind in their overall educational attainment, missing school and/or being excluded.[16]

3.2. Schools offer important opportunities to prevent mental health problems by promoting resilience. Providing pupils with inner resources that they can draw on as a buffer when negative or stressful things happen helps them to thrive even in the face of significant challenges. This is especially true for children who come from home backgrounds and neighborhoods that offer little support. In these cases, the intervention of the school can be the turning point. Having a 'sense of connectedness' or belonging to a school is a recognised protective factor for mental health.[17] Activities that bolster mental health operate under a variety of headings, including 'emotional literacy', 'emotional intelligence', 'resilience', 'character and grit' 'life skills', 'violence prevention', 'anti-bullying', and 'coping skills'. Systematic reviews of this work show that the best of interventions, when well implemented, are effective in both promoting positive mental health for all, and targeting those with problems.[18]

3.3. Schools use various strategies, some of which are listed in more detail below, to support pupils who are experiencing high levels of psychological stress or who are at risk of developing mental health problems. This additional support may come from within the school or require the involvement of specialist staff or support services.

Personal, social, health and economic (PSHE) education

3.4. Schools have the flexibility to create their own PSHE curriculum and many use this to focus on developing children's resilience, confidence and ability to learn. Discussions or activities can also be used to identify pupils who require additional support. More information is available on GOV.UK and from the PSHE Association, which supports schools to develop their PSHE curriculums.

16 Green H., McGinnity A., Meltzer H., Ford and Goodman R. (2005) Mental Health of Children and Young People in Great Britain. Basingstoke: Palgrave.
17 Catalano, R. F., Mazza, J. J., Harachi, T. W., Abbott, R. D., Haggerty, K. P., & Fleming, C. B. (2003). Raising healthy children through enhancing social development in elementary school: Results after 1.5 years. Journal Of School Psychology, 41(2), 143-164 in Weare, K. (2011) Op. cit.
18 Weare, K. (2011) Thinking ahead: Why we need to improve children's mental health and well-being. Chapter 4: Improving mental health and well-being through schools. Pp33.

Case study 3: PSHE

Severn Vale has a well-established ethos of caring for its students and staff. Over the past ten years this has evolved from an implicit, unspoken approach to being kind, supportive and practical in ensuring that everyone in the school community is cared for. Over recent years however this has taken on a more explicit and focused approach.

Severn Vale has comfortably met the standards for Investors in People and has used this as the baseline for ensuring systems and procedures are in place. Work on well-being in more explicit terms began about five years ago through the CPD programme when Belinda Heaven, through GHLL, delivered training and highlighted the need for awareness on staff well-being, managing stress, work/life balance and some small group sessions with staff who were experiencing more challenging well-being situations. Staff both appreciated the content and delivery of these. Indeed through this work there came the opportunity to work with the University of Bristol on their WISE (Well-Being In Secondary Education) research programme led by Dr Judi Kidger. Severn Vale was part of the pilot project and as part of this participated in questionnaires for all of Year 9 and Year 10 students and their attitudes and experiences at secondary school as well as questionnaires for all staff both at the beginning of the year and the end.

Out of the staff questionnaire there came the formation of the Peer Support group. This is a group of staff (teachers, teaching assistants and support staff) who were nominated as being those who staff felt they could go to for support, guidance or information relating to their well-being rather than purely their professional development. This Peer Support group received intensive training on the MHFA course with Belinda Heaven – it was extremely well received and most supportive. It enabled the Peer Support group to feel a greater degree of confidence in signposting next step help for well-being or mental health issues. It has been used for a wide range of support – anything from tea and sympathy to emergency response to diagnosed depression or stress related "burn out" or "melt down".

Also from this work arose the offer of MHFA training for staff in their support of students. Out of a possible cohort of 90 teachers, teaching assistants and support staff, 45 are now trained to work with students on MHFA. The school has ensured that members of the Peer Support group have had access to further training by attending national conferences and local courses developing their skills. They are now at a point where they need to go to the next level in ensuring this is an even happier school.

The school have hosted a 400 strong CPD day with the key note address by Sir John Jones who explicitly promotes happiness in schools. They have appointed a Healthy Lifestyles co-ordinator who works on promoting well-being with students. The Assistant Headteacher oversees the Peer Support group and also the Go To team (a group of experienced teachers whose role is to help develop, support and nurture staff in professional terms) – it was clear that the cases of stress/depression/anxiety etc. were often closely linked to experiences or issues in the classroom and there clearly needs to be overlap between the two support groups. Severn Vale also has a coaching culture and a group of staff who actively promote this and use coaching strategies to support and develop staff – all NQTs are trained in this.

Severn Vale has also reviewed their CPD and now under the banner of "PLT" or Personalised Learning Time all staff have autonomy over their professional development with a wide range of strategies, approaches to this that they can select from. This means their PLT (latterly CPD) time can be spent in a way that best suits their needs and methods of acquiring training and support. So anything from being part of a reading group looking at pedagogical texts, to coaching, to action research or departmental reading/training on new specifications can be accessed in addition to carousel sessions designed to fit needs. This means staff can access the professional development that best suits them rather than the one size fits all/talk at them sessions prevalent in many schools. This can only have a positive impact on their professional well-being.

Latterly the school have been working with Roy Leighton – the starting point was two members of staff attending the Health, Harmony and Hamlet five day course with him, set up by the GHLL team. This has been combined with the work being done by the Associate Senior Leader (QLC, Year 7) on revolutionising the Year 7 curriculum and focusing Year 7 on life skills – managing change, resilience etc. The school is focusing on equipping the Year 7 students, explicitly, with independent life and learning skills. To that end all 240 have entry and exit points to each term and each new focus. This term they are working on Resilience after an introductory day lead by Roy Leighton – the student response to this less conventional approach has been overwhelmingly positive and evidence of their explicit understanding of Resilience is already evident in a range of subject areas. The next steps will be to further embed the existing approaches to well-being with more of the Peer Support training and input to PLT, more regular communication (whether that be the newsletter or carousel sessions or activities) related to well-being and ensuring they sustain their commitment to the systems and support networks already in place.

Positive classroom management and small group work

3.5. Evidence has shown that an effective approach to promote positive behaviour, social development and self-esteem is to couple positive classroom management techniques with one-to-one or small group sessions to help pupils identify coping strategies.

Case study 4: Approaches outside the classroom

The Croft Primary School teaches a six week unit of work on Mental Health entitled 'Sometimes my Brain Hurts' as part of their KS2 PSHE curriculum. It focuses on what mental health and mental illness look like, as well as looking at ways of promoting positive mental health. The structured programme introduces concepts gradually through separate plans for Years 3-6. It was introduced in response to the identification of increasing numbers of pupils who appeared to be very unhappy and anxious. Pupils, staff and parents have been extremely positive about the sessions, with pupils showing a much greater understanding and staff feeling much more confident about discussing and taking part in lessons on mental health and mental illness. In addition, parents have been overwhelmingly supportive with several reporting that it has helped open up communication at home about a wide variety of mental health issues.

In addition we have a Kindness group made up of children from different year groups who coordinate activities focusing on promoting positive mental health for example being kind, resilience and being a good friend. The group have run assemblies and have run a whole-school friendship day. The school have also employed Ben Sullivan from the Songwriting charity who came and worked with different year groups to produce a video and song which the pupils wrote themselves to celebrate the actions of children within the school in promoting kindness and positive well-being. Ben also did a whole-school assembly about taking care of each other and looking out for each other. This was really well-received by pupils.

The school have a team of 'Happy Helpers' recruited from Years 5 and 6 who are peer mediators in the playground. They help children who look lonely or sad, and they also become involved in conflict resolution in the playground. The number of playground incidents has definitely declined since the team were formed. This year all of the Year 5s and 6s have volunteered to help and they now do it on a rolling rota basis.

Counselling

3.6. School-based counselling is one of the most prevalent forms of psychological therapy for young people in the UK. Most secondary schools offer some form of counselling service. These services generally provide one-to-one supportive therapy, with pupils referred through their pastoral care teachers, and attending for three to six sessions. Non-directive supportive therapy[19] is recommended by NICE for mild depression[20] and there is emerging evidence to suggest that school-based humanistic counselling[21] is effective at reducing psychological distress and helping pupils achieve their goals. Both the pupils who use it and school staff believe school-based counselling to be an effective means of improving students' mental health and emotional well-being. They also believe it enhances pupils' capacity to study and learn.[22] A variety of resources and services are available to assist schools in establishing or developing counselling services, including from the British Association of Counselling and Psychotherapists (BACP) and various national and local voluntary organisations. BACP also have a Register of Counsellors and Psychotherapists which is accredited by the Department of Health. In addition, in March 2014 the Department of Health and BACP launched Counselling MindEd, a free programme of e-learning modules, to support the training and supervision of counselling work with children and young people.

19 Therapy involving the planned delivery of direct individual contact time with an empathic, concerned and skilled non-specialist...to offer emotional support and problem solving help (without specifically telling the pupil what to do) and to review the child or young person's state (for example, depressive symptoms, school attendance, suicidality, recent social activities) in order to assess whether specialist help is needed.
20 NICE (2005) Depression in Children and Young People: Identification and Management in Primary, Community and Secondary Care, in Clinical Guideline 282005, National Institute for Health and Clinical Excellence: London.
21 A family of psychological therapies that place particular emphasis on establishing a warm, understanding relationship with clients such that clients can come to uncover, and express, their true thoughts and feelings.
22 Cooper, M. (2013) School-based counselling in UK Secondary Schools: A review and critical evaluation, Lutterworth: BACP/Counselling MindEd.

3.7. In Gloucestershire we are lucky to have an Educational Psychologist Service (EPS) which is a partially traded service. This means that Gloucestershire schools and colleges have to subscribe to the service in order to purchase sessions of Educational Psychologist's (EP) work for non-statutory work. Statutory work is funded by the LA. Whether they are an independent school or an Academy they are treated in the same way. The EPS works closely with CYPS as part of the team around the child and this work should be coordinated through the new requirements of the Code of Practice Guidance Booklet. The EPS provides EP support for Early Years children (i.e. not on school role) and children in care as part of its core LA offer.

The EPS also is commissioned for other pieces of work, for example, monitoring Out of County placements or working on the SEND transformation of Statements and also working with children at risk of exclusion via the Educational Entitlement service.

There are also a range of voluntary organisations which would not charge for their counselling services such as Teens in Crisis, Footsteps, Winston's Wish, Hope and a range of other local services, frequently targeting particular needs of the children and young people. The school would need to ensure that these services would match the needs of the students concerned prior to referral.

Child and adolescent psychologist

3.8. Specialising in the mental health of young people, a clinical child psychologist may provide help and support to those experiencing difficulties. A CYPS team will include a clinical child and adolescent psychologist, but it may also be possible for schools to use the services of an LA educational psychologist or to commission one directly themselves, depending on local arrangements.

Developing social skills

3.9. Deficits in social skills and competence play a significant role in the development and maintenance of many emotional and behavioural disorders in childhood and adolescence. Helping children and young people to develop these skills, for example through Social Skills Training (SST), can be an effective element of multi-method approaches to bolstering the ability to perform key social behaviours that are important in achieving success in social situations.[23]

Working with parents

3.10. Evidence shows that if parents can be supported to better manage their children's behaviour, alongside work being carried out with the child at school, there is a much greater likelihood of success in reducing the child's problems, and in supporting their academic and emotional development. Many support services will work to support the family as well as the child that has be referred.

3.11. Whilst it is good practice to involve parents and families wherever possible, in some circumstances the child or young person may wish not to have their parents involved with any interventions or therapies they are receiving. In these cases schools should be aware that those aged 16 or over are entitled to consent to their own treatment, and their parents cannot overrule this. Children under the age of 16 can consent to their own treatment if it is thought that they have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment.

3.12. Otherwise, someone with parental responsibility can consent for them[24].

23 Spence, S.H. (2003) Social Skills Training with Children and Young People: Theory, Evidence and Practice. Child and Adolescent Mental Health (Volume 8), No. 2, 2003, pp. 84–96
24 Consent to treatement – children and teens

Case study 5: Working with Parents

Harewood Junior School is in an area of high social need on the outskirts of Gloucester. They have 24% of children on the SEN register and 47% on the vulnerable children's register, as well as 18 active CAFs and key working for a further 33 children and their families. Academic standards have risen significantly in the last four years to being significantly above the national average. Vulnerable children are now succeeding much more but the school still need to work increasingly with children and families to overcome mental health and emotional well-being issues before they can achieve effective learning and better engagement in education.

Three years ago, 3 staff were trained through the MHFA lite and then two full day courses, before looking at PSHCE to build children's resilience across the schools with specific elements being targeted in each year group. PSHCE activities were planned and delivered in each class to promote positive self-confidence, self-esteem and self-belief in solving their own problems:

- Year 6 children developed Happy Harewood Charters for use by other children in problem-solving
- Year 5 children made self-help cards in how to solve a simple problem before it escalates
- Some Year 5 and 6 children were trained as playground buddies
- The School Council wrote, performed and recorded an inspiring song to promote children's resilience.

Parents were trained in building resilience and as a follow-up, a working party of parents developed a help-list for use by all parents at home. The following year, more work was done on building resilience, as well as working on the dementia project with students from Newent on raising children's awareness. This helped many children whose grandparents were suffering from dementia.

The school have revisited positive touch through peer massage to help children with anxieties and have developed a 6-week programme on building positive friendships. They have piloted the Focused for Learning GHLL resource (based on mindfulness principles) in two classes and then rolled it out to all classes following staff training. Children have been taught relaxation techniques; how to achieve a moment of clam and how to focus their concentration on what's really important. Parent/Carer workshops on these techniques are also being run in the school.

Alongside the work across the school, a pastoral team composed of the Headteacher, SENCo and Learning Mentor has been developed so that they can work together to share the workload. Personalised support is therefore more cohesively available to the children and their families. The Learning Mentor has also worked specifically with individual children and families specifically to build their resilience and develop relaxation sessions for small groups. Play therapy was offered to targeted children to explore major issues which affected their emotional well-being. Therapeutic Writing groups were set up to enable children to explore their emotions through writing fiction.

Overall Impact:

- Standards have risen for the fourth year running and are now consistently above other schools nationally.
- The gap for FS and vulnerable children has been closed
- Pupils relish the challenge and have greater aspirations
- Parents are supportive and actively engage in their children's learning – attendance at Parents' evenings or structured conversations is now 99.5% in contrast to less than 50% four years ago.
- Children seem better equipped and more willing to solve problems for themselves.
- There are fewer recorded incidences of friendships impacting negatively on pupils' work.
- Pupil data (including the OPS) suggests the children are feeling happier and know who to go to if they have a problem.
- Parents of individual children report that they are experiencing less anxiety and have strategies to use to tackle bouts of anxiety when they do happen.

The Impact of Family Working:
Case studies for individual pupils show examples of:-

- significant improvement in attendance
- significant reduction in lateness
- 3 levels of progress over the key stage
- increased engagement in extra-curricular activities
- improved behaviour, motivation and engagement in learning
- reduced isolation for pupils and parents
- increased engagement of fathers in their child's care and education
- increased engagement of parents leading to volunteering in school and to training
- increased staff awareness of the impact of adult mental health on pupils
- improved support for pupils' mental health

The impact of working as a team:

- Shared workload
- Joint problem-solving
- Extensive knowledge of the children, their families and the problems they face as well as the support the school has put in place and its success
- Joined up thinking and better strategic planning and deployment of resources and commissioning of services
- Improved outcomes for children.

Next Steps:
In the spring term, the school will be delivering the Counting Sleep resource (GHLL) to improve bedtime routines and the quality of sleep for the children and families so they are better equipped to face challenges. In the summer term they will deliver Belinda Heaven's programme on Mental Health for primary schools.

Peer mentoring

3.13. Some schools also find peer mentoring to be an effective (and low cost) approach to supporting pupils.

Case study 6: Peer mentoring

The children in Year 5 at Kingsholm C of E Primary School were involved in the pilot of the new Facts4life project. Before the pilot, the school were questioned about their attitudes to health and well-being through class discussions and through a questionnaire.

The teacher lead the discussion in a calm and respectful environment, allowing the whole class to think together, without being judgemental or singling out the individuals involved. It was clear from the start of the project that children felt that 'health' was mainly physical and hardly any of the children mentioned mental health. The Facts4life project allowed children to look at being healthy through promoting positive mental health and the impact this has on our health. They were able to understand that there is a link between having good mental health and illness, and that they go hand in hand. Throughout the delivery of this resource, pupils are encouraged to think about their health in small groups and to share their experiences in relation to the topics discussed. In this way, students were working together in order to arrive at the 'right' conclusions, even when many of them were starting off the project with many misconceptions.

Through the project, the children also developed a better understanding of illness and the responsibility they have. At the start of the project the children felt that it was the doctor's responsibility to look after you when you were poorly. By the end of the project the children were able to understand that each individual has responsibility for their own health through taking care of themselves both physically and mentally.

Children with more complex problems

3.14. For children with more complex problems, additional in-school interventions may include:

- **support to the pupil's teacher**, to help them manage the pupil's behaviour within the classroom, taking into account the needs of the whole class;
- **additional educational one to one support for the pupil – to help them** cope better within the classroom;
- **one to one therapeutic work** with the pupil, delivered by mental health specialists (within or beyond the school), which might take the form of cognitive behavioural therapy, behaviour modification or counselling approaches;
- **medication** may be recommended by mental health professionals, school staff should be aware of any medication that children are taking;
- **family support and/or therapy** could also be considered by mental health professionals – to help the child and their family better understand and manage behaviour.

Case study 7: Supporting children with more complex problems

At the Milestone School, pupils have a wide range of complex physical, learning and emotional difficulties and as such are regarded as a high risk group in terms of vulnerability to mental health issues. It is therefore vital that our curriculum has a strong focus on providing opportunities for pupils to acquire skills and attitudes which improve the impact of these risks: a sense of belonging, a positive sense of self and a language to express their emotions. These in turn provide the building blocks for developing resilience and the motivation to survive and succeed.

Classes throughout the school create a sense of community through Class Charters. These were implemented as part of the SEAL initiative and are simple ground rules, written and agreed by the pupils. As well as providing students with autonomy over their learning and environment, they give each member of the group a sense of belonging and stability from which they can begin to explore and develop a positive sense of self.

Pupils at the school can have a severely impaired ability to understand and express their feelings and as such, they can become isolated and unable to articulate their needs. Teaching the language of emotions is therefore central to our Circle time and PSHE sessions. A wide range of strategies are used to meet the diverse needs of the young people. Such strategies include early intervention through the provision of a nurture group to support pupils who have suffered emotional trauma. Staff training is delivered to ensure appropriate distancing techniques are used, confidentiality observed and referrals for specialist interventions made as early as possible.

Pupil responses are positive and demonstrate emerging emotional literacy and self-awareness.

"My anger is like a red mist" (a former pupil with severe behaviour and learning difficulties).

"I'm trying to think but I just hurt my friends" (extract from song lyrics written and performed by a former pupil with learning and behavioural difficulties). Both are currently enjoying success at colleges – motivated, resilient and aware.

Approaches used by professionals to tackle mental health problems

3.15. Annex C outlines the main types of mental health disorder with brief descriptions and a summary of the interventions that evidence from the Targeted Mental Health in Schools (TaMHS) project suggests are most effective.

❹ Referral and commissioning

Involvement of schools in defining local services

4.1. The Health and Social Care Act 2012 established health and well-being boards as a forum for local councillors, the NHS and local communities (including schools when invited) to work together to identify the local priorities for children and young people. All health services used by children and young people are within the scope of the health and well-being board, including specialist CYPS.

4.2. The job of the health and well-being board is to collect and analyse information about current and future health and social care needs and develop a strategy for commissioning the right balance of services. Schools can influence this process by feeding in what they know about the needs of their pupils. This could include information on pupils with specific impairments (such as mental health problems) and more broadly, sharing their perspective, experience and knowledge of pupil needs to help shape a system that is better able to deliver for their pupils.

4.3. Local authority Directors of Children's Services and local Healthwatch[25] are statutory members on health and well-being boards. They will be critical in promoting the interests of all children and young people, including those with disabilities and SEN. Schools are not statutory members of health and well-being boards. It will be for local authorities and health and well-being boards themselves to use their discretion in shaping the wider membership in a way that reflects local priorities and encourages meaningful dialogue.

4.4. To get involved, schools should approach their Director of Children's Services (DCS) or local Healthwatch organisation, who are responsible for engaging children and young people, professionals and other stakeholders in the work of the board. Although schools are not required to become members, headteachers may be invited or could seek to join. In addition to approaching the Director of Children's Services individually, headteachers might also consider engaging with the DCS through a lead headteacher as part of local cluster arrangements. Other routes of involvement might include:

- Developing a relationship with other local managers of social care who may also take a lead on local multi-agency planning arrangements;
- Developing a good relationship with CYPS (perhaps through an existing multi- agency body or as a cluster of schools for example to request mental health awareness training) which can also promote effective referral and cooperation and validate the work of schools with young people with mental health problems; or
- Commissioning other voluntary and community sector organisations, as a cluster of schools, to play an advisory or assessment role in mental health issues which may also reduce inaccurate referrals to CYPS; provide quick response services and long term planning for the school population.

4.5. More information on the health and well-being boards can be found on the Department of Health website[26].

Referring serious cases to Children and Young People Service CYPS

In Gloucestershire, the 2gether NHS Foundation Trust's Children and Young People Service (CYPS) operates in two ways. A telephone advice line for teachers, general practitioners and others working with young people e.g. scouting. There is a team of Children and Young People staff who work in the community and in schools (Primary and Mental Health Workers) and a team working at a morespecialised level.

There is also a team of specialists who work locally on referral with one-to-one or small group work in a particular Mental Health specialism area.

4.6. The specific services offered by CYPS vary depending on the needs of the local area. The best way to influence those services overall is to get involved with your local health and well-being board, as detailed above.

4.7. Schools have told us, however, that several things can be helpful to them in referring pupils effectively to specialist CYPS and otherwise working well with the service for the benefit of their vulnerable pupils. These include:

- **consulting CYPS** about the most effective things the school can do to support children whose needs aren't so severe that they require specialist CYPS.
- using a **clear process** for identifying children in need of further support (such as the Strengths and Difficulties Questionnaire detailed at section 3);

25 Local Healthwatch: a strong voice for people – the policy explained

- **having a close working relationship with local specialist CYPS**, including knowing who to call – Advice Line 01452 894272.
- **to discuss a possible referral and allowing pupils to access CYPS professionals at school – see, for example, Case Study 8);**
- **documenting evidence** of the symptoms or behaviours that are causing concern (and including this with the referral);
- encouraging the pupil and their parents **to speak to their GP**, where appropriate;
- **working with local specialist CYPS** to make the referral process as quick and efficient as possible – for example by being clear who can refer, by ensuring schools have access to the relevant forms and by sharing information about when decisions will be taken and fed back;
- understanding the **criteria** that will be used by specialist CYPS in determining whether a particular pupil needs their services;
- **working with local specialist CYPS** to make the referral process as quick and efficient as possible – for example by being clear who can refer, by ensuring schools have access to the relevant forms and by sharing information about when decisions will be taken and fed back;

Schools commissioning services directly

4.8. Specialist CYPS, which are a limited resource, are not the only support available to children and young people who are experiencing, or at risk of, mental health problems. In addition to statutory services, some schools have found that their local voluntary and community sector (VCS), organisations offer valuable services, either working directly with pupils and their families, or offering support and advice to schools. In Gloucestershire...

4.9. Many individual schools are able to commission individual support and health services for pupils, which gives increased flexibility and provides an early intervention response. Schools therefore need to have a robust commissioning process that ensures that the services they choose are suitably accredited and can demonstrate that they will improve outcomes for their children and young people. Guidance on good commissioning, based on evidence from the DfE funded BOND programme is available online[27].

4.10. Schools may choose in some circumstances to commission specialist CYPS directly. It is best practice for CYPS to offer a 'triage' service to identify and provide for children and young people who need specialist provision very quickly. Where needs are less urgent, this service can signpost them to appropriate sources of support whether provided by CYPS or other services.

4.11. Schools considering commission services directly may find it helpful to ask for advice and assistance from commissioners of targeted and specialist CYPS in Clinical Commissioning Groups (CCGs) and Local Authorities. This will support the development of high quality services that meet the needs of the children and young people in the school which are also fully integrated into local systems.

4.12. All services that support children and young people with SEN should be part of the LA published local offer on SEN support, which should be available in all regions from September 2014. This will provide clear, comprehensive and accessible information about the provision available. Schools will be able to use it as a resource to help with the commissioning of support services, and by contributing to its development and review they will be able to ensure provision is targeted at local needs.

4.13. A selection of contacts available nationally is available in Annex B.

27 BOND consortium 'Learning from best practice review'

Case study 8: Working with partners

Infobuzz works in a variety of ways throughout the county, frequently working in partnership with schools. One of the projects run recently involved a group of students with social and emotional difficulties. The project included a programme of Equine Facilitated Learning, experiential learning using horses, addressing primarily the development of self-awareness of their own behaviours and emotional responses. All of the students rated higher levels of awareness and concern about their behaviours at the end of the project showing the development of greater self-understanding.

The students used reflective diaries to cover a range of activities with specific goals. Beginning with self-monitoring of emotional arousal using different techniques the students demonstrated an increased ability to use self-regulatory techniques around the horse activities. At the beginning of the programme all students demonstrated poor boundary awareness and assertion skills. There was a general improvement in these areas as they began to cooperate as a group and individual strengths came to the fore after confidence building activities. It was noted at the end of the programme that the group had begun to communicate more fluently and participate more readily in group exercises.

In another situation, Infobuzz worked on a one-to-one basis with a 15 year old female who had a very difficult history, under a mentoring placement. She was sexually groomed and exploited until being rescued from the house where she had been held for almost a year. During that time, she had been given drugs and developed an acquired brain injury as a result. While statutory and medical agencies are involved in her care, there were still needs that could not be met through those routes, including the most basic need for someone to give her individual time and offer emotional support, which the Infobuzz mentor was able to do.

One of the resulting issues was that she had been left with a complete inability to assess risk and keep herself safe. The Infobuzz mentor took time to teach her strategies to keep safe and help her understand how to identify risky behaviours, people, and places. The work undertaken also helped her boost her self-esteem and self-image so that she could understand that she is worth keeping safe.

Annex A – Facts about mental health problems in children and young people

Good mental health

5.1. Children who are mentally healthy have the ability to develop psychologically, emotionally, intellectually and spiritually; initiate, develop and sustain mutually satisfying personal relationships; use and enjoy solitude; become aware of others and empathise with them; play and learn; develop a sense of right and wrong; and resolve (face) problems and setbacks and learn from them.[28]

"Mental health influences how we think and feel about ourselves and others and how we interpret events. It affects our capacity to learn, to communicate and to form, sustain and end relationships. It also influences our ability to cope with change, transition and life events, having a baby, moving house, experiencing bereavement."
Dr. Lynn Friedl 2004

Mental health problems in children and young people

5.2. Some children experience a range of emotional and behavioural problems that are outside the normal range for their age or gender. These children and young people could be described as experiencing mental health problems or disorders.

5.3. Mental health professionals have defined these as:

- emotional disorders, e.g. phobias, anxiety states and depression;
- conduct disorders, e.g. stealing, defiance, fire-setting, aggression and anti- social behaviour;
- hyperkinetic disorders e.g. disturbance of activity and attention;
- developmental disorders e.g. delay in acquiring certain skills such as speech, social ability or bladder control, primarily affecting children with autism;
- attachment disorders, e.g. children who are markedly distressed or socially impaired as a result of an extremely abnormal pattern of attachment to parents or major care givers; often seen in children who are adopted or in care; and
- other mental health problems include eating disorders, habit disorders, post- traumatic stress syndromes; somatic disorders; and psychotic disorders e.g. schizophrenia and manic depressive disorder.[29]

5.4. Many of these problems will be experienced as mild and transitory challenges for the child and their family, whereas others will have serious and longer lasting effects. When a problem is particularly severe or persistent over time, or when a number of these difficulties are experienced at the same time, children are often described as having mental health disorders.

Numbers of children and young people with a mental health problem

5.5. 9.8% of children and young people aged 5 to 16 have a clinically diagnosed mental disorder. Within this group, 5.8% of all children have a conduct disorder (this is about twice as common among boys as girls), 3.7% have emotional disorders, 1.5% hyperkinetic disorders and a further 1.3% have other less common disorders including autistic spectrum disorder, tic disorders, eating disorders and mutism. 1.9% of all children (approximately one fifth of those with a clinically diagnosed mental disorder) are diagnosed with more than one of the main categories of mental disorder.[30]

5.6. Beyond the 10% discussed above, approximately a further 15% have less severe problems that put them at increased risk of developing mental health problems in the future[31].

28 Mental Health Foundation (2002) A bright future for all: promoting mental health in education, London: MHF.
29 DfEE (2001) Promoting Children's Mental Health within Early Years and School Settings, DfEE. 30 Green et al. (2004) Mental health of children and young people in Great Britain, Office of National Statistics
31 Brown et al. (2012) Delivering effective parenting programmes to transform lives Elena Rosa Brown, Lorraine Khan & Michael Parsonage Centre for mental Health

Annex B – Sources of support and information

Here are links to some national support and information services offering assistance for child mental health issues. We can only list national services but please remember to look around for local services too.

Childline – A confidential service, provided by the NSPCC, offering free support for children and young people up to the age of nineteen on a wide variety of problems.

Counselling MindEd – Counselling MindEd is an online resource within MindEd that provides free evidence-based, e-learning to support the training of school and youth counsellors and supervisors working in a wide variety of settings.

Education Endowment Foundation – The Sutton Trust-EEF Teaching and Learning Toolkit is an accessible summary of educational research which provides guidance for teachers and schools on how to use their resources to improve the attainment of all pupils and especially disadvantaged pupils.

HeadMeds – website developed by the charity YoungMinds providing general information about common medications that may be prescribed for children and young people with diagnosed mental health conditions.

MindEd –MindEd provides free e-learning to help adults to identify and understand children and young people with mental health issues. It provides simple, clear guidance on mental health to adults who work with children and young people, to help them support the development of young healthy minds.

National Institute for Health and Care Excellence (NICE) – NICE's role is to improve outcomes for people using the NHS and other public health and social care services, including by producing evidence-based guidance and advice. Some of this guidance had been drawn on to produce this document and much of it is provided in non-specialist language for the public. This can be useful in understanding social, emotional and mental health conditions and their recommended treatments.

Place2Be – Place2Be is a charity working in schools providing early intervention mental health support to children aged 4-14 in England, Scotland and Wales.

Relate – Relate offers advice, relationship counselling, sex therapy, workshops, mediation, consultations and support face-to-face, by phone and through their website. This includes children and young people's counselling for any young person who is having problems.

Royal College of Psychiatrists (RCPSYCH) – Provide specifically tailored information for young people, parents, teachers and carers about mental health through their Parents and Youth Info A-Z.

Women's Aid – Women's Aid is the national domestic violence charity that works to end violence again women and children and supports domestic and sexual violence services across the country. They provide services to support abused women and children such as the free 24hour National Domestic Violence Helpline and The HideOut, a website to help children and young people.

Young Minds – Young Minds is charity committed to improving the emotional well-being and mental health of children and young people. They undertake campaigns and research, make resources available to professionals (including teachers) and run a helpline for adults worried about the emotional problems, behaviour or mental health of anyone up to the age of 25. They also offer a catalogue of resources for commissioning support services.

Annex C – Main types of mental health needs

6.1. This annex provides a brief description of the main types of mental health needs and summarises which approaches other professionals might use if a mental health problem is diagnosed. The information draws on the evidence collected from the Targeted Mental Health in Schools (TaMHS) project and gives information about the kinds of treatments and approaches that are supported by the evidence reviewed in the new edition of *What Works For Whom? A Critical Review of Treatments for Children and Adolescents.*[32 33]

6.2. In all cases it is assumed that a supportive whole school framework will also be in place along with appropriate classroom management, anti-bullying and support strategies. Public Health England is developing a framework to support schools to understand better what is meant by a whole school approach (to be available April/May 2014). An important caveat in relation to therapeutic work, especially for children and young people with multiple needs, is that it should not take place in isolation and practitioners need to be working together towards a common set of goals with the child and family.

Conduct disorders

(e.g. defiance, aggression, anti-social behaviour, stealing and fire-setting)

Overt behaviour problems often pose the greatest concern for practitioners and parents, because of the level of disruption that can be created in the home, school and community. These problems may manifest themselves as verbal or physical aggression, defiance or antisocial behaviour. In the clinical field, depending on the severity and intensity of the behaviours they may be categorised as Oppositional Defiant Disorder (a pattern of behavioural problems characterised chiefly by tantrums and defiance which are largely confined to family, school and peer group) or Conduct Disorder (a persistent pattern of antisocial behaviour which extends into the community and involves serious violation of rules).[34]

Around 4-14% of the child and adolescent population may experience behaviour problems. Many children with attention deficit hyperactivity disorder (ADHD) will also exhibit behaviour problems. Such problems are the most common reason for referral to mental health services for boys, and the earlier the problems start, the more serious the outcome. There is, however, evidence to support the effectiveness of early intervention.

Intervention for primary school pupils

The strongest evidence supports prevention/early intervention approaches that include a focus on:

- the whole school environment, particularly addressing bullying;
- teaching social and emotional skills in combination with:

1. working with parents (families at risk may be difficult to engage) where possible in the school context as there is a high risk of dropout of families at greater risk. Individual child oriented interventions are less effective than ones which involve parents although programmes are available including the Coping Power Program: CBT Problem-solving skills training which involve parents to some degree; and
2. small group sessions for children with a focus on developing cognitive skills and positive social behaviour and staff training as part of a multi- system intervention. Interventions designed to change how teachers behave are not likely to produce clinically significant improvements in individual children in the absence of other concurrent interventions, notably parent reinforcement of classroom contingency management.

32 DCSF (2008) Targeted Mental Health in Schools Project: Using the evidence to inform your approach, a practical guide for headteachers and commissioners.
33 Fonagy, P, Cottrell, D, Philips, J., Bevington, D., Glaser, D. E., & Allison, E. (in press). What Works For Whom? A Critical Review of Treatments for Children and Adolescents (2nd ed.). New York: Guilford.
34 Brosnan and Carr, Adolescent Conduct Problems', in Carr (2000) What Works with Children and Adolescents. London: Routledge.

Where particular problems have been identified evidence supports starting as early as possible and giving a 'booster' intervention at the end of primary school, where possible. The strongest evidence supports:

- working with parents in a structured way to address behavioural issues through education and training programmes (these are particularly effective for younger children with less severe behavioural problems and include: The Incredible Years Program, Triple P-Positive Parenting Program and The Oregon Social Learning Centre (OSLC) Program); and
- parent training programmes combined with interventions with the child to promote problem-solving skills and positive social behaviours.

There is also evidence to support:

- well-established nurture groups to address emerging social, emotional and behavioural difficulties;
- play-based approaches to developing more positive child/parent relationships or for enabling a child to express themselves;
- specific classroom management techniques to support primary school pupils, including strategies using token systems for delivering rewards and sanctions (though the impact is limited to the period and context of the intervention itself) and changing seating arrangements in classrooms from groups to rows; and
- 'Self-instruction' programmes (programmes that children can learn to use on their own to manage their own behaviour) in combination with parental support may be moderately effective if accompanied by parental involvement.

In response to requests from primary schools in Gloucestershire several resources for targeted mental health have been created by the GHLL team and are now piloted and published ready for use. These include the Focused for Learning resource, Counting Sleep and a Primary Mental Health resource and training. These are all offered for free within the county. If your school is interested in attending the training sessions, please contact Nicola.Wood@gloucestershire.gov.uk

Intervention for secondary school pupils

The strongest evidence supports prevention/early intervention approaches that include a focus on:

- Multi-component school-based prevention programmes for older children – targeted at students at high risk– though their impact is greater with younger children. There are targeted universal US programmes (e.g. 'The Family Check-Up' targets adolescents and their families) which have had some successes but these have not yet been introduced in the UK.

Where particular problems have been identified the strongest evidence supports:

- Working with the family is preferable as therapeutic approaches are most effective when they look at the young person in the context of their family structure and work with all family members, even while intervening in the school. Where this is impossible, individual work focusing on thoughts and behaviour can also be helpful. The more social systems engaged in a coordinated fashion by the intervention, the more effective the intervention is likely to be;
- For more severe and entrenched problems, a range of tailored, multi component interventions. In multi-systemic therapy, therapists have multiple contacts each week and deliver a range of different evidence-based services according to each family's individual needs. While effective, this approach involves high levels of professional resources; and
- For chronic and enduring problems, specialist foster placement with professional support, within the context of an integrated multi-agency intervention. Multicomponent interventions without integration by an overarching organisational focus and shared set of principles are ineffective

Anxiety

Anxiety is normal and everyone experiences it at some stage. It exists on a continuum and can range from a mild sense of uneasiness right through to a full blown panic attack. It is very common, often undiagnosed and the full impact of it and how debilitating it can be is also not fully acknowledged. It becomes a disorder when it is more severe, problematical, ensuring and interferes with school relationships and work.

Many young people are predisposed to developing an anxiety disorder as being a "worrier" can run in families. Additional factors include unrealistic expectations, bullying, relationship difficulties both at home and school, changes in family structure, (this affects many young people who do not develop anxiety) and many more.

Warning signs

These may be divided into three categories, physical, psychological and behavioural.

- **Physical** - increased pulse rate, dizziness, aches and pains, flushing, sweating, dry mouth, nausea and shaking.
- **Psychological** - excessive fear, mind racing or going blank, irritability, confusion, impatience, anger, tiredness and unwanted repetitive thoughts.
- **Behavioural** – avoidance of situations, distress, urges to escape and compulsive behaviour.

Anxiety problems can significantly affect a child's ability to develop, to learn or to maintain and sustain friendships, but they tend not to impact on their environment.

Children and young people may feel anxious for a number of reasons – for example because of worries about things that are happening at home or school, or because of a traumatic event. Symptoms of anxiety include feeling fearful or panicky, breathless, tense, fidgety, sick, irritable, tearful or having difficulty sleeping. If they become persistent or exaggerated, then specialist help and support will be required.

Clinical professionals make reference to a number of diagnostic categories:

- separation anxiety disorder (SAD) – worry about being away from home or about being far away from parents, at a level that is much more than normal for the child's age;[39]
- generalised anxiety disorder (GAD) – a long-term condition which causes people to feel anxious about a wide range of situations and issues, rather than one specific event;[35]
- panic disorder – a condition in which people have recurring and regular panic attacks, often for no obvious reason; 36
- obsessive-compulsive disorder (OCD) – a mental health condition where a person has obsessive thoughts (unwanted, unpleasant thoughts, images or urges that repeatedly enter their mind, causing them anxiety) and compulsions (repetitive behaviour or mental acts that they feel they must carry out to try to prevent an obsession coming true);[37]
- specific phobias – the excessive fear of an object or a situation, to the extent that it causes an anxious response, such as panic attack (e.g. school phobia);[38]
- social phobia – intense fear of social or performance situations;[40] and
- agoraphobia – a fear of being in situations where escape might be difficult, or help wouldn't be available if things go wrong.[41]

While the majority of referrals to specialist services are made for difficulties and behaviours which are more immediately apparent and more disruptive (externalising difficulties), there are increasing levels of concern about the problems facing more withdrawn and anxious children, given the likelihood of poor outcomes in later life.

35 Anxiety
36 Panic disorder
37 Obsessive compulsive disorder

What schools can do to help

It is vitally important for staff in schools to look behind the behaviour that might be presenting to them. Whilst this might not be acceptable in terms of disruption and aggression it is often masking anxiety. Growing up is a complicated business for everyone and so therefore those experiencing additional difficulties and trying to work out who they are present a challenge for schools. It is important for young people to realise that everyone gets anxious sometimes and we as professionals should not be so quick to label a person with a problem. There are agencies to support young people and is also helpful for them to learn coping strategies and learn how to take better care of their own emotional wellbeing. It would be most beneficial for schools to discuss mental health more openly and acknowledge that it is something we all have and it is not fixed.

The strongest evidence supports prevention/early intervention approaches that include a focus on:

- regular targeted work with small groups of children exhibiting early signs of anxiety, to develop problem-solving and other skills associated with a cognitive behavioural approach; and
- additional work with parents to help them support their children and reinforce small group work. Such work is likely to be especially effective when the parents are themselves anxious and the children are younger.

Where particular problems have been identified the strongest evidence supports:

- Therapeutic approaches focusing on cognition and behaviour for children with specific phobias, generalised anxiety and obsessive compulsive disorder (in some cases doctors may consider using medicines alongside therapy if therapy alone is not working but this does not include anxiety related to traumatic experiences). This should include parents where the child is under 11 or where there is high parental anxiety;
- Specific individual child focused programmes which show recovery in 50-60% of C&YP include Coping Cat and FRIENDS. On the other hand, group based interventions are likely to be almost as effective. The programmes have been shown to be effective when delivered by different professionals, including teachers;
- Education support, training in social skills and some behaviour focused interventions are highly effective for social phobia (e.g. Social Effectiveness Therapy).;
- For obsessive compulsive disorders professionally administered Exposure and Response Prevention (ERP) and cognition focused interventions are most effective; and
- Trauma related problems require special adaptations of therapy (e.g.Trauma - focused CBT) including sexual trauma. Trauma and grief component therapy is effective for trauma and can be delivered in school (e.g. Cognitive Behavioural Intervention for Trauma in Schools).

There is also evidence to support:

- for anxiety, the use of play-based approaches to develop more positive child/parent relationships or to enable the child to express themselves; and
- psychoanalytic family psychotherapy (focusing on the 'internal' world of family members and their unconscious processes) has reported some positive outcomes especially when trauma is involved.

Other avenues for support and guidance

Public health in Gloucestershire in collaboration with GHLL are delivering mental health first aid training for staff to learn more about what to do and how to best support young people www.mhfaengland.org www.ghll.org

Little Red Books available from http://www.gloshp-resources.nhs.uk/

Children and Young People's Service

Headspace app (https://www.headspace.com)

Rethink (www.rethink.org) – Telephone contact 0300 5000 927.

38 Anxiety disorders
39 Separation anxiety
40 Anxiety disorders
41 Agoraphobia

Depression

Feeling low or sad is a common feeling for children and adults, and a normal reaction to experiences that are stressful or upsetting. There is much confusion over what constitutes depression and it is not about feeling low or sad. Everyone experiences the blues in the short term.

Whilst most people can and do recover, some go on to develop a longer term condition often know as clinical depression this occurs in around 5 in every 100 teenagers and interferes with their ability to study, work and have successful relationships. Depression is common but serious and affects a young person physically, emotionally, cognitively and behaviorally. When these feelings dominate and interfere with a person's life, it can become an illness. According to the Royal College of Psychiatrists, depression affects 2% of children under 12 years old, and 5% of teenagers.

Factors which might increase the likelihood for a young person to develop depression include, bullying, relationships difficulties, poor achievement at schools, bereavement, abuse, being a long term carer. For some young people whilst they might have several of the factors affecting them due to their own resilience and or support they remain well. It is a very individual consideration.

Depression can significantly affect a child's ability to develop, to learn or to maintain and sustain friendships, but tends not to impact on their environment. There is some degree of overlap between depression and other problems. For example, around 10% to 17% of children who are depressed are also likely to exhibit behaviour problems.

Clinicians making a diagnosis of depression will generally use the categories major depressive disorder (MDD – where the person will show a number of depressive symptoms to the extent that they impair work, social or personal functioning) or dysthymic disorder (DD – less severe than MDD but characterised by a daily depressed mood for at least two years).

The strongest evidence supports prevention/early intervention approaches that include a focus on:

- Regular work with small groups of children focusing on cognition and behaviour – for example changing thinking patterns and developing problem- solving skills – to relieve and prevent depressive symptoms.

Where particular problems have been identified the strongest evidence supports:

- therapeutic approaches focusing on cognition and behaviour (Cognitive Behaviour Therapy), family therapy or inter-personal therapy lasting for up to three months (in severe cases these interventions are more effective when combined with medication);
- psychoanalytic child psychotherapy may also be helpful for children whose depression is associated with anxiety;
- family therapy for children whose depression is associated with behavioural problems or suicidal ideation; and
- for mild depression, non-directive supportive counselling.

Warning signs

There may not be anything specific initially as young people get very good at hiding their feelings and masking underlying problems. Staff need to be mindful of those who put on a brave face and even provide humour. The key is noticing changes in behaviour that are not usual for a particular individual. Outward signs could include crying, risk taking, lack of emotional response, expressions of hopelessness and or helplessness, confusion, indecision guilt anger and sadness.

What schools can do to help

It is vitally important for staff in schools to look behind the behaviour that might be presenting to them. Whilst this might not be acceptable in terms of disruption and aggression it is often masking anxiety. Growing up is a complicated business for everyone and so therefore those experiencing additional difficulties and trying to work out who they are present a challenge for schools. It is important for young people to realise that everyone gets down sometimes and we as professionals should not be so quick to label a person with a problem. There are agencies to support young people and it is also helpful for them to learn coping strategies and learn how to take better care of their own emotional well-being. It would be most beneficial for schools to discuss mental health more openly and acknowledge that it is something we all have and it is not fixed. Perhaps if young people were reminded that just because today is bad, tomorrow has potential to be much better. This is a key message from Mental Health First Aid in terms of hope and recovery.

Other avenues for support and guidance

Public health in Gloucestershire in collaboration with GHLL are delivering Mental Health First Aid training for staff to learn more about what to do and how to best support young people www.mhfaengland.org www.ghll.org

Little Red Books available from http://www.gloshp-resources.nhs.uk/

Children and Young People Service

Headspace app (https://www.headspace.com)

Rethink (www.rethink.org) – Telephone contact 0300 5000 927.

Hyperkinetic disorders

(e.g. disturbance of activity and attention)

Although many children are inattentive, easily distracted or impulsive, in some children these behaviours are exaggerated and persistent, compared with other children of a similar age and stage of development. When these behaviours interfere with a child's family and social functioning and with progress at school, they become a matter for professional concern.

Attention Deficit Hyperactivity Disorder (ADHD) is a diagnosis used by clinicians and sometimes described as Hyperkinetic Disorder. It involves three characteristic types of behaviour – inattention, hyperactivity and impulsivity which must all be present and occur before the age of seven, evident in two or more settings. There is also a related group of children who suffer from Attention Deficit Disorder where the core symptom is inattention.

The strongest evidence supports:

- Parent education programme and individual behavioural management is the first line of approach. Behaviour management needs to be provided in school as well as at home as they do not appear to generalise across settings;
- Use of medication, where ADHD is diagnosed and other reasons for the behaviour have been excluded. These treatments have few side-effects and are effective in 75% of cases when there is no depression or anxiety accompanying ADHD. High doses can be avoided if behavioural treatments accompany medication;
- For children also experiencing anxiety, behavioural interventions may be considered alongside medication; and
- Some children have complex presentations with neuro developmental disorders such as learning disability, autism and Tourette's Syndrome. others may have severe conduct disorder. Psychosocial treatments may also be considered by CYPS teams.

Evidence also supports:

- Making advice about how to teach children with ADHD-like behaviour in their first two years of schooling widely available to teachers, and encouraging them to use this advice.

Attachment disorders

Attachment is the affectionate bond children have with special people in their lives that lead them to feel pleasure when they interact with them and be comforted by their nearness during times of stress. Researchers generally agree that there are four main factors that influence attachment security: opportunity to establish a close relationship with a primary caregiver; the quality of caregiving; the child's characteristics and the family context. Secure attachment is an important protective factor for mental health later in childhood, while attachment insecurity is widely recognised as a risk factor for the development of behaviour problems.

The strongest evidence supports:

- Video feedback based interventions with the mothers of pre-school children with attachment problems, with a focus on enhancing maternal sensitivity.

Evidence also supports:

- Use of approaches which use play as the basis for developing more positive child/parent relationships.

Eating disorders

Eating disorders involve a disturbance in eating habits and weight control behaviour. It affects physical health as well as psychological and social functioning for a young person. There are a number of different types including anorexia nervosa, bulimia, binge eating, food avoidance emotional disorder and eating disorders not otherwise specified. Whilst eating disorders are more common in certain age groups, most specifically young women, there has been a significant increase in disorders affecting young men.

There are many factors that might contribute to a young person developing an eating disorder. Despite that fact that some young people have several factors it depends upon their individual vulnerability along with biological and other predisposing factors. Contributory factors include, bereavement, relationship difficulties, perfectionist tendencies, low self-esteem, bullying and this is not an exhaustive list. Eating disorders can emerge when worries about weight begin to dominate a person's life.

Someone with anorexia nervosa worries persistently about being fat and eats very little. They lose a lot of weight and if female, their periods may stop. Someone with bulimia nervosa also worries persistently about weight. They alternate between eating very little, and then binging. They vomit or take laxatives to control their weight. Both of these eating disorders affect girls and boys but are more common in girls.

Eating disorders vary often go unnoticed as the young person experiencing it becomes very good at avoiding mealtimes with very plausible excuses and dresses in a way to conceal weight loss. It might be possible to notice a preoccupation with food, excessive exercise and increased anxiety if prevented from doing so.

The strongest evidence supports:

- In anorexia nervosa the primary aim of intervention is restoration of weight . This involves therapeutic work with the family to support the young person eating, taking a family based approach based on behavioural principles and/or structural systemic principles. These may be helpful even when there is family conflict, for a few, inpatient treatment may be required, and
- For young people with bulimia nervosa, individual therapeutic work focusing on cognition and behaviour, for example to change thinking patterns and responses.

Evidence also supports:

- Early intervention because of the significant risk of ill-health and even death among sufferers of anorexia;
- School-based peer support groups as a preventive measure (i.e. before any disordered eating patterns become evident) may help improve body esteem and self-esteem; and
- When family interventions are impracticable, cognitive-behavioural therapy may be effective.

What schools can do to help

Share concerns with other key members of staff and talk to the young person involved. Gloucestershire has invested in improving a service for young people with eating disorders. They are a group very seriously at risk who very often require specialist support as indeed do their families. Early intervention is key here to ensure recovery and the disorder is often associated with other complication such as self-harming behaviour and anxiety or depression.

Other avenues for support and guidance

Gloucestershire Eating Disorders Service www.2gether.nhs.uk/eatingdisorders
Telephone 01242 634242 Monday- Friday 8-5pm

BEAT Eating Disorders Helpline 08456347650 http://www.b-eat.co.uk/
This used to be the Eating Disorders Association for the UK.

Anorexia Bulimia Care www.anorexiabulimiacare.org.uk Telephone 03000 111213

Substance misuse

Experimentation with drugs and alcohol might be considered by some as quite usual for adolescent behaviour. There is evidence to suggest that normal development in brain chemistry leads young people to take risks as part of the maturation process. That being said, many parents and those who work in education have concerns regarding young people's use of drugs and alcohol. Substance misuse can result in physical or emotional harm. It can lead to problems in relationships, at home and at work. It should be highlighted that it might be difficult to spot signs as many of the behaviours associated with adolescent development involve changes in sleeping and eating patterns etc. However, if a young person becomes more secretive and is spending more money than usual or shows a deterioration in school work, has difficulty concentrating or falling out with friends and not engaging in activities they previously enjoyed, this may indicate there is a problem. School staff are ideally placed to notice subtle changes in young people. They can then ask what is going on for that young person and assess the level of risk. If additional support is required they may access more information from specialist agencies such as Infobuzz. It is helpful for schools to deliver sessions for pupils on substance misuse as part of their PSHE programme. Specialist advice is also available from the Primary Mental Health workers in the Substance Misuse team based in Youth Support Services, seconded from the Children and Young People Service.

In the clinical field, a distinction is made between substance abuse (where use leads to personal harm) and substance dependence (where there is a compulsive pattern of use that takes precedence over other activities). It is important to distinguish between young people who are experimenting with substance and fall into problems, and young people who are at high risk of long-term dependency.

This first group will benefit from a brief, recovery oriented programme focusing in cognitions and behaviour to prevent them to move into more serious use. The second group will require ongoing support and assessment, with careful consideration of other concurrent mental health issues.

The strongest evidence supports:

- Therapeutic approaches which involve the family rather than just the individual; this assists communication, problem-solving, becoming drug-free and planning for relapse prevention. These approaches are especially helpful with low-level substance users, and when combined with cognitive- behavioural therapy or treatments focusing on motivation;
- A variation of family therapy known as 'one-person family therapy', where families cannot be engaged in treatment; and
- Multi-Systemic Therapy , Multidimensional Family Therapy and the Adolescent Community Reinforcement Approach and other similar approaches (which consider wider factors such as school and peer group), where substance misuse is more severe, and part of a wider pattern of problems.

Evidence also supports:

- The introduction of programmes, delivered in community settings or schools and which focus on developing skills that enhance resilience, as a preventative measure as substance abuse is connected to other problems that can be addressed within these settings.

Other avenues for support and guidance

Frank www.talktofrank.com Telephone 0800776600

Drugscope www.drugscope.org.uk

National Drugs Helpline 0800776600 (24 hours)

The Site - http://www.thesite.org

Infobuzz- www.infobuzz.co.uk

Self-harm

Self–harm is often misunderstood. It is a behaviour not an illness. It is not about attention seeking as often it is a private act. It has many functions including relief from emotional pain, communicating feelings of distress, regaining feelings of control or punishment for feelings of guilt or shame. The clinical definition includes attempted suicide, though some argue that self-harm only includes actions, which are not intended to be fatal. It is often described by young people as a coping strategy and is not necessarily linked with suicidal thoughts although in some cases it might be. It exists on a continuum ranging from minor injuries to life threatening behaviour. Self–harm is so much more than young people cutting themselves and whilst this is probably the most common form it takes according to the Gloucestershire OPS, it can also involve other methods including taking risks, provoking fights, hair pulling, hitting, cutting or burning oneself, picking skin, overdosing (self-poisoning) or self-strangulation. Risk factors would include bullying, family breakdown, fear of failure amongst high achievers, concerns over sexuality, homelessness, isolation, and multiple other factors although it is not an exhaustive list. Self-harm significantly increases the risk of suicide.

As self-harm is frequently concealed, it is unlikely there would be any outer signs. That being said, for professionals who work with young people on a regular basis they may notice subtle changes in their behaviour. These might include poor performance at school, loss of interest in hobbies they previously enjoyed, friendship problems falling out with people, unexplained accidents and avoidance of situations where undressing might be required such as PE. The strongest evidence supports:

- Brief interventions engaging the child and involving the family, following a suicide attempt by a child or young person;
- Assessment of the child for psychological disturbance or mental health problems which, if present, should be treated as appropriate. At times, brief hospitalisation may be necessary; and
- Some individual psychodynamically influenced therapiese.g. Mentalisation Based Treatment or specialist Dialectic Behaviour Therapy involving infividual and group therapy.

Other avenues for support and guidance

Gloucestershire Healthy Living and Learning website www.ghll.org a guidance pack for schools may be downloaded from the resources for mental health section and also training can be provided from leading teachers.

Rethink 0121 522 7007 Supporter care (general enquiries) open 9am to 5.00pm Mon to Fri

Children and Young People Service (previously CAMHS) Advice Line 01452 894272

Bristol Crisis Centre for Women www.selfinjurysupport.org.uk

Harmless www.harmless.org.uk

Post-traumatic stress

If a child experiences or witnesses something deeply shocking or disturbing they may have a traumatic stress reaction. This is a normal way of dealing with shocking events and it may affect the way the child thinks, feels and behaves. The Home Office revised its definition of harm in 2004, it now therefore include witnessing the harm of another, possibly a parent or friend. If these symptoms and behaviours persist, and the child is unable to come to terms with what has happened, then clinicians may make a diagnosis of posttraumatic stress disorder (PTSD).

The symptoms might include flashbacks, intrusive memories, avoidance behaviour, emotional numbing changes in mood and level of sadness which may continue for months or even years.

The strongest evidence supports:

- Therapeutic support which is focused on the trauma and which addresses cognition and behaviour especially regarding sexual trauma and some can be delivered in schools such asTrauma and grief component therapy and Cognitive Behavioral Intervention for Trauma in Schools (CBITS). Trauma focused CBT should be adapted appropriately to suit age, circumstances and level of development.

The evidence specifically does not support:

- prescription of drug treatments for children and young people with PTSD; or
- the routine practice of 'debriefing' immediately following a trauma.

Other avenues for support and guidance

Local safeguarding board – GSCB

24 hour NSPCC Helpline 0808 8005000

Children and Young People Service (CYPS).

Department for Education

Gloucestershire Healthy Living and Learning

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