



Promoting Children's Mental Health within Early Years and School Settings

**LEAs, Schools,
Pre-School Settings
Child and Adolescent
Mental Health Services
(CAMHS)**

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Foreword

BY THE PARLIAMENTARY UNDER SECRETARY OF STATE FOR EARLY YEARS
AND SCHOOL STANDARDS, BARONESS CATHERINE ASHTON

The Government is committed to promoting children's mental health within schools.

A positive school experience – in which children are able to develop a sense of achievement, learn new skills, develop friendships and relationships with significant adults is important for all children. It can also make a real difference to the long-term outcomes for children who are experiencing mental health problems.

There is increasing evidence that schools can promote all children's mental health, and intervene effectively with those children experiencing problems. There is also evidence that strategies to promote mental health impact on individual children's learning and behaviour, staff performance and morale, and the overall ethos and success of the school.

It used to be believed that many children's mental health problems could be left largely to mental health professionals to deal with. However, school-based interventions can offer great potential for helping children. Many children reached through such programmes would not otherwise have obtained help. The school may be better placed to support and maintain progress achieved by children with mental health problems, than may contact with a health professional seen solely for specific problems and for the duration of that problem.

Schools can play a vital part in ensuring that mental health problems are quickly recognised and treated. If mental health problems are not recognised early they can lead to school or home breakdown, or both, with significant costs for education or social services. On the other hand, unrecognised learning difficulties can themselves lead to emotional and conduct problems.

There is often a poor long-term outcome for children who have disruptive behaviour problems if their difficulties go untreated, with a greater likelihood of these children becoming involved in crime, alcohol and drug-related problems and having severe relationship difficulties in adulthood

This guidance provides a useful tool for local education authorities, schools and others who are striving to ensure that the mental health needs of children are met, and that all children enjoy a positive school experience.



Catherine M. Ashton.

Introduction

This guidance has been written for Local Education Authorities, schools, early years settings and Child and Adolescent Mental Health Services. It has been produced as a result of increasing recognition of the importance of promoting all children's mental health and emotional well-being and the importance of working together to promote this.

Increasing numbers of children are experiencing mental health problems. A recent ONS survey showed that 10% of children aged between 5–15 experience clinically defined mental health problems. This guidance offers pointers and examples of good practice in the area of the early identification and interventions for children and young people experiencing mental health problems in pre-school and school settings.

Mental health is about maintaining a good level of personal and social functioning. For children and young people, this means getting on with others, both peers and adults, participating in educative and other social activities, and having a positive self-esteem. Mental health is about coping and adjusting to the demands of growing up. It does not all happen at one point in time, and appears to result from an interactive process to which we can all contribute, based on the child's environmental, social and cultural contextⁱ.

This guidance is designed to help teachers and others, working alongside mental health professionals, to promote children's mental health and to intervene effectively with those children experiencing problems. It forms part of a joint approach with the Department of Health to promote health issues in schools and other mainstream settings. It is part of a wider strategy currently being developed through the NHS plan, the Children's Taskforce and the cross-cutting Children and Young People's Unit. This will improve the services to children and young people and their families and ensure that all children have the opportunity to fulfil their potential.

The case studies referred to in the text are taken from interesting examples of work that have come to our attention. Some, but by no means all, of the case studies have been evaluated. Nevertheless, they provide a range of models, which are being developed to address the mental health needs of children within early years and school settings. The examples within the text of individual children who are experiencing difficulties, do not relate to particular children, but are intended as helpful illustrations of the type of difficulties that children may encounter.

Questions about Mental Health

1.1 What is Mental Health?

Children who are mentally healthy have been defined as having 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 themⁱⁱ.

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.

Mental health professionals have defined the problems that children and their families can be faced with as follows:

- emotional disorders, e.g. phobias, anxiety states and depression that may be manifested in physical symptoms;
- 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 and those with pervasive development disorders;
- 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;
- eating disorders, e.g. pre-school eating problems, anorexia nervosa and bulimia nervosa;
- habit disorders e.g. tics, sleeping problems, soiling;
- post-traumatic stress syndromes;

- somatic disorders e.g. chronic fatigue syndrome; and
- psychotic disorders e.g. schizophrenia, manic depressive disorder, drug-induced psychosisⁱⁱⁱ. (For a fuller description of these terms see Section 4)

Many of these problems will be experienced as being mild and transitory nuisances to 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.

1.2 Mental Health or Emotional and Behavioural Difficulty?

The terms mental health problems and mental health difficulties are not precise – with definitions ranging from the highly categorised still employed by some health service professionals, to those based on more descriptive terms which are prevalent in schools and school-support services.

Children experiencing problems (and predominately externalising problems) in schools have tended to be defined as having emotional and behavioural difficulties. EBD is a term to be understood within an educational context, to describe a range of difficulties that children might experience as a result of adverse experiences in the early years, difficult family relationships or ineffective behaviour management or means of engaging children effectively within the school.

Such a definition will include many children who experience or are at risk of experiencing mental health problems; such as those who are so withdrawn and anxious that it is significantly impacting on their ability to learn, or those whose behaviour is so extreme they are not able to sit and concentrate. However, not all children with mental health problems will necessarily have special educational needs. Some children, for example those who are extremely anxious and isolated, may be in need of additional help and support within the school in order to help them overcome their difficulties. Other children, for example a child with an eating disorder, may be in need of support outside school, but which the school with an effective pastoral and/or counselling service can help the child access.

For other children however, their behavioural difficulties, which often have a significant emotional element to them, may be so intertwined with their inability to concentrate, to learn and to get on with their peers, that an approach which does not include attention to the educational alongside their emotional, social and behavioural needs will fail to provide the range of support that they need. Such children may be defined as having an emotional and behavioural problem when seen within an educational context. By a medical practitioner, however, the same child may be defined as having a conduct disorder, a mental health term used to describe children with overly oppositional or defiant behaviour.

The challenge is to find ways in which the different approaches and frameworks and professionals can operate effectively together. In many pre-schools and schools there is currently a great deal of positive practice in developing such work – this is often not without difficulties and compromises amongst all those involved – often requiring the development

of new understandings and ways of working between the different professionals. The gains for all, however – those children experiencing problems, their peers, teachers and other school staff, often the school as a whole – ultimately outweigh the difficulties in initially developing this work.

1.3 What are the Causes of Mental Health Problems in Children and Young People?

Evidence has shown that it is possible to identify the factors that have an impact on children's mental health. Certain individuals and groups are more at risk of developing mental health problems than others, and these risks are located in a number of areas – risks specific to the child, to their family, their environment and life events. There are a range of factors in children's and young people's lives which can result in them being at increased risk of developing mental health difficulties:

- loss or separation – resulting from death, parental separation, divorce, hospitalisation, loss of friendships especially in adolescence, family breakdown that results in the child having to live elsewhere;
- life changes, e.g. birth of a sibling, moving house, changing schools; and
- traumatic events – abuse, violence, accidents, injuries, war or natural disaster.

Other children, against all the odds, 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.

RISK FACTORS

Risk factors are those which increase the *probability* of a child developing a mental health problem. There is a complex interplay between the range of risk factors in the child's life, their relationship with each other and more positive resilience factors. Risk factors are cumulative. If a child has only one risk factor in their life, their probability of developing a mental health problem has been defined as being 1–2%. However, with three risk factors it is thought that the likelihood increases to around 8%; and with four or more risk factors in their life this increases to 20%.

We know therefore that the greater the number of risks, and the more severe the risks, the greater the likelihood of the child developing a mental health problem.

RISK FACTORS IN THE CHILD

Certain children have particular vulnerabilities, which have to be understood in relation to their 'assets' – their resiliences. For example, children who have a 'difficult temperament' and who are less likely to be able to adapt themselves to new social situations are more at risk of developing mental health problems than their peers.

Risk Factors in the Child:

- Specific learning difficulties
- Communication difficulties
- Specific developmental delay
- Genetic influence
- Difficult temperament
- Physical illness especially if chronic and/or neurological
- Academic failure
- Low self-esteem

Risk Factors in the Family:

- Overt parental conflict
- Family breakdown
- 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

Risk Factors in the Community:

- Socio-economic disadvantage
- Homelessness
- Disaster
- Discrimination
- Other significant life events

RESILIENCE FACTORS

'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',^{iv}

Research suggests that there is a complex interplay between risk factors in children's lives, and promoting their resilience, and that as disadvantage and the number of stressful life events accumulate for children or young people, more protective factors are needed to act as a counterbalance.

As with risk factors, those features that serve to reduce the impact of risk or promote resilience relate to characteristics within the child, family or wider community and can include any combination of these factors.

RESILIENCE FACTORS IN THE CHILD

Children who are able to establish a secure attachment to their parents in the first year of life are better able to manage stressful events later in life. Also those children who have effective communication skills, can problem-solve and have the ability to reflect tend to be more resilient.

Resilience Factors in the Child:

- Secure early relationships
- Being female
- Higher intelligence
- Easy temperament when an infant
- Positive attitude, problem-solving approach
- Good communication skills
- Planner, belief in control
- Humour
- Religious faith
- Capacity to reflect

Resilience Factors in the Family

- At least one good parent–child relationship
- Affection
- Clear, firm and consistent discipline
- Support for education
- Supportive long-term relationship/absence of severe discord

RESILIENCE FACTORS IN THE COMMUNITY

Support outside the family, e.g. close friendships or having access to a network of kin and neighbours, peers and elders for counsel and support, is an important factor in promoting resilience. Alongside this, schools that have a positive ethos, high morale and which support pupil’s academic and non-academic achievement play an important role in promoting resilience.

Resilience Factors in the Community:

- Wider supportive network
- Good housing
- High standard of living
- High morale school with positive policies for behaviour, attitudes and anti-bullying
- Schools with strong academic and non-academic opportunities
- Range of positive sport/leisure activities

As disadvantage and the number of stressful life events increases, more protective factors are needed as a counter-balance. Individuals are often able to cope, so long as the balance among risks, stressful life events and protective factors is manageable. But when risk factors and stressful life events outweigh the protective factors, even the most resilient individual can develop problems.

What is important is that protective processes are put in place for all children and young people. These include:

- reducing the likelihood of negative chain reactions arising from the risk;
- promoting self-esteem and self-efficacy through the availability of secure and supportive personal relationships, or success in achieving tasks; and
- opening up new and positive opportunities and offering turning points, where a risk path may be rerouted^v.

Whole School Approaches to Promoting Children's Mental Health

2.1 Good Practice in Schools

Promoting children's mental health within schools has important educational payoffs. A number of studies have been carried out on the impact of social and emotional learning for children. In addition to the positive impact of these schemes – children having better conflict resolution skills and being more co-operative – such programmes also improve children's academic achievement scores and school performance.

2.2 Early Years Settings

Early childhood education may be viewed as an innovative mental health strategy that affects many risk and protective factors^{vi}

There are important characteristics shared by Early Years Settings that actively promote the emotional well being of children. These include:

- stable childcare arrangements so that children interact with just a few primary care givers in any one day;
- low staff turnover so that children are cared for by the same individuals over several years;
- good staff training in child development;
- adequate staff to child ratios; and
- positive behaviour management.

Alongside this is the importance of the delivery of an effective pre-school curriculum for children. An effective pre-school curriculum must do more than instil a few facts or simple cognitive skills.

In the much praised High Scope curriculum, 'children learn to be self-critical, without shame, to set high goals while seeking objective feedback...Its programme aims to help children acquire resources for dealing with the stress of failure and the belief that achievement is not God-given but achieved through effort.'^{vii}

The DfEE and Qualifications and Curriculum Authority publication *Curriculum guidance for the foundation stage* helps practitioners plan activities which will contribute to most children achieving early learning goals by the end of the school reception.

It states that practitioners should work closely with parents and carers to build on children’s previous experiences, knowledge, understanding and skill, and provide opportunities to develop:

- personal, social and emotional development;
- communication, language and literacy;
- mathematical development;
- knowledge and understanding of the world;
- physical development; and
- creative development.

It also sets out what most children will have achieved in each of these areas by the time they enter Year 1 of primary education. The Curriculum Guidance for the Foundation Stage has set out key principles for early years practitioners in relation to children’s personal, social and emotional development.

Amongst other important issues, these include that practitioners should give special attention to:

- establishing constructive relationships with children, with other practitioners, between practitioners and children, with parents and with workers from other agencies, that take account of differences and different needs and expectations;
- planning activities that promote emotional, moral, spiritual and social development alongside intellectual development; and
- providing support and a structured approach to achieve the successful social and emotional development of vulnerable children and those with particular behavioural and communication difficulties.

The Rebecca Cheetham Nursery Centre is an early years excellence centre based in Stratford, East London. The Centre actively promotes the emotional and social well being of the pupils and their parents through a range of policies and practice. It actively engages with parents through running groups, drop-ins and parenting courses, and works towards promoting the emotional, social and cognitive development of all the children through all aspects of its work.

(For a fuller description see Case Study 1)

2.3 Primary and Secondary School Settings

There are key characteristics which schools that promote their children’s and young people’s mental health share:

- a committed senior management team, creating a culture within the school in which the importance of trust, integrity, democracy, equality of opportunity and each child being valued regardless of their ability is seen as being vital;

- a culture within the school which values teachers, lunchtime supervisors, and all those engaged in the care and supervision of children;
- clear policies regarding such vital issues as behaviour and bullying – ‘whole school behaviour’ policies which set out the range of acceptable behaviour for children, what is and what is not acceptable;
- the range of sanctions that will result and the acceptance and implementation of the policies throughout the school;
- high professional standards (efficient planning, setting, marking, punctuality);
- skilful teaching which arouses pupil interest and motivates; and
- proactive work with parents.

The importance of a value system within the school, which embraces all children, is particularly important. Such schools, particularly primary schools are often also engaged in a whole range of work to actively promote emotional and social learning amongst the staff, parents and pupils; from emotional literacy programmes, parenting programmes, circle time and specific initiatives for vulnerable children. Examples of such schools are Thurnby Lodge Primary School in Leicester and St. Marylebone School for Girls in Westminster.

Thurnby Lodge Primary School in Leicester works to actively promote the school as a ‘caring environment’ through a range of ways of involving and supporting school staff, parents and children in all aspects of the school’s life.
(For a fuller description see Case Study 2)

St Marylebone School for Girls in Westminster

St Marylebone School is an all girls comprehensive school in central London. The school actively promotes the mental health of its pupils through a number of initiatives, including a commitment to including the promotion of self-esteem, confidence, independence and responsibility throughout the PSHE curriculum, and where relevant in all aspects of the school life. *(For a fuller description see Case Study 3)*

The National Healthy School Standard takes a whole school approach to supporting schools become healthier schools, since this is likely to have a greater impact on pupils’ health, learning opportunities, experience and achievements. The Standard emphasises the importance of ensuring that school activities reflect pupils’ needs, including those with special educational needs and specific health conditions, as well as disaffected pupils, young carers and teenage parents. For further information on this, visit the Wired for Health Website at www.wiredforhealth.gov.uk.

There is a whole range of specific initiatives that schools can become involved in to promote children’s mental health. Whilst this area has not yet been comprehensively evaluated, as a result of a number of studies which have been carried out internationally, we are able to pull out important information about the types of interventions in schools which are more likely to be successful in promoting children’s mental health, particularly for those children who are more vulnerable than their peers.

WHAT DO WE KNOW?

- The importance of work in schools that is positively aimed at promoting the mental health of all children, rather than an approach which is solely focused on work with those children already displaying difficulties. Such an approach has been shown to have very real pay-offs for those children who are most at risk of developing problems.
- Work in schools can promote ‘caring school environments’ for all children and parents and school staff. A number of schools are currently working with external facilitators to help them address issues of the broader school culture and classroom management. This can include such issues as: the stability of class groups, students relationships with their class teachers, helping teachers devise behaviour management techniques, and helping schools develop community-based projects for students and social activities.
- Programmes through the curriculum can promote mental health. In particular, the use by schools of curriculum materials which promote examples of positive behaviour (being concerned for and trying to understand other people’s feelings), and the use of role-play, games and stories to enhance students’ understanding of others. Important characteristics of such programmes include those that enable children to correctly identify and regulate one’s feelings e.g. understanding how anger is different from sadness and developing positive attitudes and values that guide behaviour. A whole class approach to teaching these skills through the curriculum which has been effectively evaluated is the PATHS curriculum.

The PATHS curriculum has 50 lessons on different emotions, teaching the most basic, such as happiness and anger, and touching on more complicated feelings such as jealousy, pride and guilt. Emotional-awareness lessons within the curriculum include how to monitor what they and those around them are feeling, and how to recognise when someone is actually hostile as opposed to when the attribution of hostility comes from oneself. *(For a fuller description see Case Study 4)*

- Schools that actively teach children the use of pro-social resolution strategies, which they can practise both within the classroom and throughout all aspects of their school life. Examples of effective programmes in this area, which operate at either a whole class or a whole school level, and which have been evaluated are the Interpersonal Cognitive Problem-Solving programme and the Seattle Social Development Project.

Seattle Social Development Project

This is a comprehensive universal prevention programme that addresses multiple risk and protective factors within the child, school and family. The programme has a strong emphasis on creating and maintaining strong school and family bonds, with its combination of helping teachers to manage the behaviour of children within the class and training for parents in children's behaviour through a 6-year intervention period. An evaluation of the programme revealed that students who had taken part in the full programme reported greater attachment to school, improved self-reported achievement and less involvement in school misbehaviour. *(For a fuller description of this example and the ICPS programme see Case Studies 5 and 6)*

Interventions to Support Individual Children who Are Experiencing Difficulties

3.1 Understanding Individual Children's Needs

Understanding an individual child's needs is essential in helping school staff to decide what help and support might be most useful for the child.

Ahmed is a quiet boy and does not make friends easily. He is a poor attendee at school, and often appears to be very anxious about starting new projects or learning new subjects. He has a slight stutter. He is an academically able child, yet the quality of his schoolwork has recently begun to deteriorate slightly. His class teacher, being concerned about his attendance and his academic progress, invited Ahmed's parents into school to discuss her concerns with them. They reported that Ahmed often experiences stomach problems in the morning – and that he has told them that children in the class are teasing him.

Michelle is 8 and has recently started at a new primary school. Her mother has started a relationship with a new boyfriend, and has moved into the area with Michelle and her four stepbrothers and sisters in order to live with him. He has two children by a previous relationship, who occasionally visit at weekends. Michelle initially appears to be a quiet, shy and anxious child. She is very small for her age. However she is quick to lose her temper, and can on occasion be very aggressive with other children in the class. Michelle has problems with reading and writing, which are not helped by the difficulties that she has in concentrating for any length of time. Michelle's attendance at school is erratic, as is that of her stepbrothers and sisters, two of whom are at the same school. After being at the school for a term, it is clear that Michelle's behaviour is deteriorating. Her attendance is more erratic than ever – and she is increasingly isolated from other children in the class. She regularly gets into fights with other children – and is occasionally rude to school staff. Her behaviour is causing great concern for her class teacher.

Schools can play an important role in helping children such as Ahmed and Michelle access and manage the help and support that they need, whether this is support from other professionals within school or for children with more severe problems, alongside work within the school, help in more specialist settings. What is important is that pre-schools and schools are able to assess whether children require help and support, and what form this might most usefully take.

There are a series of questions that are useful to consider when thinking about the help that children and young people might need. These include:

- **What sort of problem is the child presenting with?** The difficulties experienced by many children with mental health problems, can sometimes be seen as being naughtiness or wilful disruptiveness. However, if close attention is given to the child's behaviour, it may be possible to assess the underlying causes of their problems and develop appropriate ways of supporting them to develop emotionally, behaviourally and academically.
- **What is the impact of the child's problem?** In order to develop a range of strategies to support children, it is important to consider how much distress the child's problems are causing for them and for those around them. It would not be valuable to develop a year's programme of support for a child who is showing signs of anxiety over a number of weeks, but who is soon able to respond positively to all aspects of school life. However, a child who displays difficult and challenging behaviour consistently over time, may well be in need of additional help and support, as described below.
- **Risks. What factors have initiated and maintained the problem?** As we have seen, there is a range of risk factors in relation to children's mental health. It is important in thinking about the causes of children's difficulties, and any possible solutions, to consider all those aspects of the child's life which may have contributed to the child's difficulties; whether within the child, school, home or wider community.
- **Strengths. What assets are there to work with?** All children and their families have strengths, which can be worked with in order to promote the education of the child. For example, a strong-willed child who displays defiant and disruptive behaviour in school may show a great determination to succeed in the face of adversity – if their energy can be effectively harnessed.
- **Are there wider perspectives?** Many parents and professionals define children's problems differently, dependent on their cultural and professional backgrounds. It is therefore important in considering the causes of and approaches to supporting children experiencing problems in schools, to share your understanding and approach with others involved in the child's life.

Schools will already be involved in a great deal of practice in relation to these issues. The Code of Practice for Special Educational Needs sets out clear guidance for meeting children's needs, particularly in relation to those children who have emotional and behavioural difficulties. This includes children with mental health problems. The Code sets out a clear assessment process for children who may require additional support as a result of a range of difficulties. In many schools, it will be the SENCO who takes lead responsibility for this, in co-ordination with the class, form or year tutor.

For the majority of children who experience mental health problems, it will be appropriate for the extra support that they need to be met within the school setting, often with support from more specialist professionals such as educational psychologists or other child and adolescent mental health professionals. For some children, particularly children experiencing such problems as Autism, Asperger's Syndrome, Obsessive Compulsive Disorder and in some cases ADHD and severe conduct disorder, in addition to this, it may be appropriate

for the child to have a statutory assessment of their special educational needs, in order to ensure that a full range of specialist support is available within the school for as long as the child requires it.

The SEN Code of Practice sets out the procedure for carrying out statutory assessments. For children who are experiencing severe mental health problems, it is important that these assessments are where possible, multi-agency in nature. It is also important to ensure that strategies to support these children and their families, both within school and that provided outside school, are fully co-ordinated across the professionals involved.

In their contribution to the assessment of children’s needs under the Children Act, schools should also be working with the Framework for the Assessment of Children in Need and their Families. This Framework sets out important principles to consider in assessing children’s needs, along with clear guidance and tools in order to assist professionals in assessing need. The questionnaires and scales, designed to assist social services staff in this area of their work, may also be useful for schools. Copies of the Framework and questionnaires are available on website www.doh.gov.uk

3.2 Early Interventions in Early Years Settings

Certain practice within early years settings is particularly important for children, like Nathan and Gemma, who are at risk of developing emotional and behaviour problems.

Nathan is 3, and has been attending his local nursery class for the last three months. He is an active child, and seems keen to please those adults who are working with him. Yet his enthusiasm often boils over into frustration and tears, if he begins something that he cannot immediately grasp. He is unable to concentrate on any activity for periods of time, even sitting in front of his favourite video at the end of the day. He is easily distracted and is often very aggressive with other children, who tend to avoid him if possible. Nathan has been asked to leave a previous child-minder, who found Nathan too demanding and his behaviour extremely difficult to deal with. She reported that he had on occasions bitten and hit the other children that she was looking after, and that he expressed no remorse or understanding of what he had done. This behaviour has also been observed within the nursery. Nathan’s parents have expressed their concerns to the nursery about his behaviour, saying that they do not know what to do. They do not understand why he is behaving in this way, as his older sister’s behaviour is fine and they have brought them up in the same way.

Gemma is 3½, and attends her local Early Excellence Centre. She is an extremely anxious child, who clings to her mother when brought to the Centre every morning. Gemma is very quiet, and often appears quite fearful of expressing her needs. Gemma spends a great deal of time playing alone – even when warmly encouraged to join in activities with other children. She is easily distressed in these situations. Gemma’s mother lives with a new partner, and has recently had another child. She often appears to be harassed when she brings Gemma to the Centre, and has said that she doesn’t have the time to join a new parenting class that has been set up at the Centre. A couple of weeks ago, she arrived at the Centre with a bruised face, but said that she had fallen down when one of the nursery staff expressed concern. She has said that she doesn’t want anyone ‘messing about in her business’.

Effective engagement with parents and children, especially those parents who are particularly hard to reach and who may be experiencing mental health problems themselves, could be developed through:

- home visiting, parent ‘drop ins’, courses run for parents in such areas as literacy and computing skills;
- parenting classes which enable parents to build on their strengths and learn new ways of engaging with their children;
- work with small groups of vulnerable children or vulnerable children individually around strategies to promote positive behaviour, social development and self-esteem;
- the teaching of interpersonal problem-solving skills to young children; and
- compensatory nurturing experiences for vulnerable children.

An area of great concern for many mental health practitioners however, is the low take-up of support services by parents with young children experiencing emotional and behavioural problems. This may be the result of a number of factors:

- parents not recognising that their child is experiencing problems;
- parent’s belief that it is inappropriate to seek help for young children’s emotional or behavioural problems – that they should be able to manage by themselves; or
- lack of knowledge about where to go for help, who to ask – alongside the stigma and fear associated with revealing family difficulties to professionals.

Research has shown the important role that early years practitioners can play in assisting parents to recognise when their child may be experiencing difficulties outside of the norm, to help them and the child address some of the problems they may be experiencing and where appropriate refer them on to more specialist help.

For some very young children, the difficulties that they experience are such that even with input from skilled early years practitioners, they and their parents may still require additional help to maximise their emotional and social development. It is important if practitioners are concerned about a child’s behaviour, to contact their local support service (whether this is

within the LEA or the local CAMHS) in order to gain the support that they need. Such action can be part of the statementing process under the Code of Practice for SEN, or outside, dependent on the child’s needs.

An exciting way of gaining this support is through the provision of a specialist service within an early years centre, which can also be accessed by other local parents. An example of a service offering parents and their children such specialist help within mainstream early years provision is the Nippers Project.

The Nippers Project – Nursery Intervention for Parents and Education Related Services

The Nippers project was set up as a response to the high rate of emotional and behavioural problems presented by young children in the boroughs of Camden and Islington. The project, run by the local Clinical Psychology Team is run in three Early Years Settings. Its aims are to engage with parents in ways and settings that they find appropriate; developing parenting classes for all parents, drop-in clinics within the settings for parents who may be experiencing problems and work with children to promote their emotional well-being. As a result of the non-stigmatising approach of the service, there is a 96% take-up rate by parents of the services. *(For a fuller description see Case Study 7)*

Another model for the provision of support and advice to pre-school settings, parents and children is that provided by LEA Early Intervention Teams.

Camden Early Years Intervention Team offers a multi-disciplinary resource for the Borough, providing support and advice to all providers of nursery education in Camden other than maintained schools. *(For a fuller description see Case Study 8)*

3.3 Early Intervention in Primary Schools

As with Early Years Settings, there are a number of simple but important strategies that all teachers can implement in order to support children, such as Sasha (described overleaf), who may be experiencing mental health problems.

Sasha is 6, and has been described by her parents as being a difficult child ‘from the word go’. She attended her local nursery school, between the ages of 3 to 5, but did not appear to thrive well within it. On a number of occasions, she was sent home from nursery for biting and hitting other children, behaviour which has improved slightly as she has got older – but she is still prone to losing her temper easily. She does not find it easy to play with other children, and can be extremely defiant with school staff. Her behavioural problems are causing problems for her teacher – who feels that Sasha takes up a great deal of her time. Sasha’s behaviour is having an impact on her learning, and on her ability to make friends. She often appears to be unhappy.

WITHIN THE CLASSROOM

Useful strategies that can be implemented within the classroom include:

- first, to assess what Sasha’s difficulties may be. In particular, does the child have learning problems and if so how can these be addressed? (see Section 3.1. on understanding individual children’s needs);
- set short, achievable targets and give immediate rewards when the child completes a task;
- keep classroom rules clear and simple;
- encourage children to verbalise what needs to be done – first to the teacher and then silently to themselves; and
- use teacher attention and praise to reward positive behaviour.

WITHIN THE PLAYGROUND

Many children with emotional and behavioural problems experience difficulties engaging with other children at playtimes. There are a range of interventions that schools can implement – Circle of Friends, Play Assistants, Pyramid Trust type schemes to assist such children at these potentially difficult times.

Stoke Primary School in Coventry, is an example of a school which is working hard at promoting the well being of all the children in its care. Alongside developing whole school policies and programmes to promote mental health, the school has been involved in developing a range of projects for children who are vulnerable and at risk of developing mental health problems. *(For a fuller description see Case Study 9)*

EFFECTIVE LINKS WITH PARENTS

Many children with behavioural or emotional problems, experience problems at home as well as at school. Evidence is demonstrating that if parents can also 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.

For children, such as Sasha therefore, there is a range of important early interventions that schools themselves can implement. Often, these interventions are carried out with input from a range of external agencies: LEA Psychological support services, Behaviour Support Teams, voluntary agencies with expertise in developing particular schemes e.g. National Pyramid Trust, The Place to Be and in some areas the local Child and Adolescent Mental Health Service. Such interventions can include Circle Time, Circle of Friends, Nurture Groups, and Social Skills Groups etc. *(For a further discussion of these, see Intervening Early, How primary schools can help children get the best from school. DfEE In press)*

Hexthorpe Primary School in Doncaster is located in a multiethnic, mainly working class area of high unemployment, and caters for over 400 pupils aged between 4 to 11. In the school, an increasing number of pupils with emotional and behavioural problems seemed to be struggling to cope with confusion in their personal lives. The school developed an integrated whole school policy based on a multi-agency approach in order to respond more effectively to the needs of these pupils. *(For a fuller description see Case Study 10)*

For some children, on assessing their needs, it is clear that they and their families require much more help and support, inside and outside of school, than the school alone is able to provide. Children such as Ewan, described below, may require a fuller assessment of their needs from educational psychologists, or other child and adolescent mental health specialists, often working in partnership with other professionals such as social workers who may be involved with the child and their family.

Ewan is 10, and has been described as being difficult for most of his school life. He is academically a very able child, yet he does not appear to understand basic classroom rules. Teachers often describe his behaviour as being ‘wilfully naughty’, especially when he fails to respond to their requests, and carries on completing his own projects or games when expressly told not to. He can become very distressed in these situations. He sometimes appears to have a slight nervous tick, finds it difficult to maintain eye contact with teaching staff and always prefers to work alone – being shunned by and shunning others when requested to become involved in joint project work. Ewan always seems to play alone at break times – and spends hours playing complex computer games in the school library. His parents have visited the school on a number of occasions and expressed concern about Ewan’s difficult behaviour at home and at school. They say that they have run out of ways of trying to discipline Ewan – and are keen to find new ways of trying to improve his behaviour. They are concerned that Ewan often appears to be unhappy – and that his isolation at school often causes him real distress.

An effective approach to supporting Ewan might be to:

- implement a range of classroom management techniques as outlined in Section 4;
- ensure that a full assessment of his needs is carried out;
- work with other professionals to ensure that a strategy to support Ewan, both within and outside school is in place. This might include:
 - support to Ewan’s teacher, to help them manage Ewan’s behaviour within the classroom, taking into account the needs of the whole class;
 - additional educational one-to-one support for Ewan – to help him cope better within the classroom;
 - one-to-one therapeutic work with Ewan, delivered by mental health specialists outside or sometimes inside school. This may take the form of cognitive behavioural therapy, behaviour modification or counselling approaches. See Section 4 for a further description of these;
 - the use of medication might be considered appropriate by mental health professionals. It is important that schools are aware of the medication that children are taking; and
 - family support and/or therapy could also be considered by mental health professionals – to help Ewan and his family better understand and manage his behaviour.

Many Child and Adolescent Mental Health Services (described in Section 5.7) are currently working with schools, to support them in assessing children’s needs and providing support for those children, their families and the school who require it.

CHILD BEHAVIOUR INTERVENTION INITIATIVE IN LEICESTER, LEICESTERSHIRE AND RUTLAND

The Child Behaviour Intervention Initiative is an innovative multi-agency initiative in Leicester, Leicestershire and Rutland. The work includes supporting schools to develop programmes to promote psychological well-being, supporting them to identify children at risk of developing problems, and holding drop-ins within schools for parents who are concerned about their children’s behaviour or emotional well-being. *(For a fuller description see Case Study 11)*

Another interesting project is the **Rochdale Excluded Children’s Project**

The aim of the project in Rochdale was to develop a multi-agency team to intervene with children under 12 at risk of and experiencing school exclusion. The team is based within the Child and Adolescent Mental Health Services in Rochdale – and comprises a team leader, practice nurse, family support worker and educational psychologist. The project’s main focus is to work with the child and family, outside the school environment – offering a range of behavioural and therapeutic interventions. The team also works with the school, helping them further develop their skills and practices in relation to working with the excluded child.

(For a fuller description see Case Study 12)

3.4 Early Intervention in Secondary Schools

Natalie is 14 and attends her local comprehensive school. Natalie has always appeared to be a popular child, however recently she has become isolated from her peers within her form group, and has been mixing with much older girls. Her form teacher has noticed that Natalie is sometimes aggressive with her peers, and is very quick to lose her temper. At other times, she appears to be withdrawn and anxious. Her attendance at school is becoming increasingly erratic, and the standard of her work is noticeably deteriorating. Natalie has a number of cuts on her arm, but on questioned about these insists that ‘they are nothing’. Natalie’s parents have recently separated, and she is currently living with her mother and visiting her father at weekends.

The majority of children within secondary schools manage to cope with the increasing stresses placed upon them, which, for example, include earlier puberty, family breakdown and reformations and the increasing demands for academic success. However, an increasing minority of young people, like Natalie, are experiencing psychological problems, which have a significant impact on their lives: on their ability to make and sustain friendships, on their family relationships and on their ability to learn. There are a range of psychosocial disorders which tend to rise or peak during the teenage years; suicide and suicidal/self-harming behaviour, depression, eating disorders (anorexia nervosa and bulimia) and abuse of alcohol and psychoactive drugs.

ASSESSING YOUNG PEOPLE’S NEEDS

Just as with children, in working with young people like Natalie who are at risk of developing mental health problems, it is important to be able to build up a full picture of the young person’s life, and their particular strengths and vulnerabilities in relation to these. Often such work is carried out within school by the form tutor, Year Head or other pastoral staff. However, sometimes access to an ‘external agency’; non-teaching staff, based within the school, who have the time to listen and offer support within the school setting can be particularly important. Adults who are able to build up trusting, supportive relationships using counselling skills or approaches can enable young people to discuss issues, which

may be of concern in confidence. These could comprise a mentor, counsellor, youth worker, school nurse, or a personal adviser.

An effective approach to supporting Natalie, after holding initial discussion with Natalie and her parents regarding her behaviour, attendance and issues that may be affecting these might be to:

- persuade Natalie to attend a social skills group, which is currently being run at the school, in order to help her develop her self-esteem and confidence;
- support Natalie within school and enable her to discuss any worries that she may have in confidence, through the use of a mentor, personal adviser, or if the school employs them, a school-based counsellor;
- develop an Individual Education Plan for Natalie, in order to help her improve her attendance and academic work; and
- for Natalie and her parents to contact their local GP, with regard to Natalie's self-harming behaviour. As a result of this, Natalie is referred to her local Child and Adolescent Mental Health Service as an out-patient, and is referred for cognitive behavioural therapy.

Dudley Local Education Authority runs a counselling service in primary and secondary schools in the Dudley area. A team of professional counsellors, all with teaching qualifications, work with around 160 secondary aged pupils and 30 primary pupils at any given time. *(For a fuller description see Case Study 13)*

Another way of enabling young people to express their worries confidentially to health professionals working within schools, has been developed in Huddersfield.

Nurse-led Project in Huddersfield

In Huddersfield NHS Trust, school nurses have developed, with the help of the CAMHS team, an effective method of screening Year 9 pupils' health needs in school. This looks at the young people's general health needs and pays specific attention to emotional and psychological well being. *(For a fuller description see Case Study 14)*

SUPPORTING YOUNG PEOPLE IN SECONDARY SCHOOL

There are a range of initiatives that secondary schools can implement in order to assess and support young people who are at risk of developing mental health problems. As part of a wider strategy to support young people, many schools are developing peer support projects. Peer support can take a number of forms.

As well as being effective for young people who are anxious and isolated, peer support projects can be extremely effective for children or young people who have disruptive behaviour problems. In such schemes, young people can act as pro-social models for the

young person experiencing problems, and as a way of providing the young person with opportunities to practice new skills in actual social interactions. It can also counter the alienation experienced by many young people with extreme behaviour problems that makes them vulnerable to the influence of more disreputable peers.

PEER COPING SKILLS TRAINING

In such projects, groups of young people who are coping well and young people experiencing behaviour problems are set up. The teams progress through different skills and levels of difficulty, with new skills being introduced when the group has demonstrated mastery over the previous skill. This format encourages and reinforces peer support. An evaluation of the scheme showed that young people who took part in these schemes were rated by teachers as being less aggressive, and significant improvements were also noted in the young person’s pro-social coping and teacher-rated social skills. *(For a fuller description see Case Study 15)*

Some schemes within schools, such as counselling services, school nurse services, pastoral systems, can provide effective supports for young people who are experiencing emotional problems, but other young people experiencing more pronounced mental health problems will require input from more specialist services either within the school setting or to be referred on to more specialist agencies.

An example of a project which has developed a range of responsive ways of working with young people on mental health issues has been developed within a **Secondary School in York**.

A multi-agency initiative to support vulnerable pupils within a secondary school has been developed in the City of York. Whole school approaches to promoting the young people’s mental health are being developed through the PSHE curriculum and a peer support programme. *(For a fuller description see Case Study 16)*

Many young people in secondary schools will present with largely externalising behavioural problems, underlying which they may be extremely anxious, depressed or experiencing a range of other difficulties. For many of these young people, Local Education Authorities in some areas are developing a more ‘holistic’ approach to supporting the range of needs they may be presenting with through their Behaviour Support Services, which include attention to and support around the young person’s mental health.

YOUNG PEOPLE WITH MORE SEVERE MENTAL HEALTH PROBLEMS

Mohammed is thirteen, and has always been a slightly anxious child. On entering a large comprehensive school, he seemed to withdraw totally into himself, finding it increasingly difficult to communicate with other children and with teaching staff. His parents have visited the school on numerous occasions to discuss their worries about Mohammed with his form teacher and Year Head, and a range of strategies have been put in place in order to support Mohammed in school. These have included peer support schemes, a social skills programme and a mentoring programme to help Mohammed develop confidence within school and attend after-school activities. Yet, Mohammed is increasingly reluctant to attend school, preferring to remain alone within his room. He is withdrawn and unable to communicate to anyone what is worrying him. On occasions, he can be extremely aggressive.

For some children like Mohammed, their mental health problems will be such that may require intensive support in the community or periods of in-patient treatment. These may be young people experiencing, for example, long term and severe anxiety, depression, severe eating disorders or early onset of psychotic illness. For these young people it is important that they are able to continue their education or when appropriate to be supported in their reintegration. Academic achievement is an important source of self-esteem and resilience for all children and particularly so for those with mental health problems. Effective liaison between the different agencies working with children experiencing such problems is the key to meeting the needs of these children.

Middlesbrough LEA's Hospital Teaching Service is an established service, which offers support to children and young people experiencing the full range of clinically defined mental health problems. Within the service the LEA works collaboratively with the local CAMHS to provide education support for both in-patients and community day-patients (out-patients) of the Tees and North-East Yorkshire NHS Trust. *(For a fuller description see Case Study 17)*

Specific Mental Health Problems and Useful Approaches that Schools Can Implement

Below is a section which outlines some of the more common mental health problems amongst children and young people, the terms that mental health professionals use to describe the problems, and useful approaches that schools can implement to support children and young people who may be experiencing such difficulties.

4.1 Conduct/Anti-social Disorders

Conduct disorder is a term used by mental health specialists to describe a syndrome of core symptoms, which are characterised by *the persistent failure to control behaviour appropriately within socially defined rules*.

Conduct problems involve three overlapping domains of behaviour: *defiance* of the will of someone in authority; *aggressiveness*; and *anti-social behaviour* that violates other people's rights, property or person. None of these are in themselves abnormal – and many children as part of the process of developing and maturing engage in disobedient, destructive and challenging behaviour. However, for some children, the variety and severity of their conduct problems **can significantly impact on their lives**.

WHAT ARE THE ISSUES, AND CAN DESCRIBING CHILDREN'S EMOTIONAL AND BEHAVIOURAL PROBLEMS IN THIS WAY BE USEFUL?

The majority of children will display some form of oppositional, defiant or challenging behaviour at various points in their lives. However, for some children, the regularity and persistence of their behaviour along with the range of emotional and academic problems that they often experience alongside their behavioural problems – result in their life chances and experiences being at risk of being severely reduced. Such children are:

- often rejected and unpopular with their peers;
- often have poor social skills, and many experience significant emotional problems, most commonly unhappiness and misery; and
- a third of children assessed as having conduct disorder have specific reading difficulties, which because of their behaviour can often go undetected.

Some people consider that use of the term 'conduct disorder' implies that behavioural problems in children are being 'medicalised': the focus on diagnosis and classification somehow linking such problems to disease and illness. This is not what the term implies and so should not be used as a reason for denying children help that may be of benefit to them.

- A number of children with conduct disorders have additional problems such as hyperactivity or depression and would benefit from referral to and input from mental health professionals.
- Many disruptive children lack social skills. Not only do they show physical and verbal aggression, but they also show less pro-social behaviour than other children. Work in schools that can assist children in learning such behaviours can be particularly effective.
- Many disruptive children also have difficulties reading the behaviour of other children and adults around them – with a tendency to believe, often wrongly, that this is hostile or negative, and responding accordingly. Work in schools which enables children to examine those situations involving conflict or frustration, and to understand how to read the signals of people around them and respond in a more positive manner has been shown to have long-term preventive effects for such children.
- It is important that learning problems which could benefit from referral to specialist educational services are recognised as soon as possible.

Issues for teachers to consider in determining whether children might require additional support, or a fuller assessment of their needs include:

- the severity and frequency of defiant, aggressive and antisocial acts in the last month;
- the child's ability to concentrate and sit still, especially as hyperactivity is a common and easily overlooked accompaniment of conduct problems;
- whether the child has any positive peer relationships;
- whether the child might be experiencing emotional difficulties;
- whether the child is also experiencing difficulties within their home setting; and
- academic attainments including test results – there are times when children's troublesome behaviour in class can take up so much of the teacher's time that significant reading difficulties can be overlooked or simply regarded as a consequence of the bad behaviour.

APPROACHES TO WORKING WITH CHILDREN WITH CONDUCT PROBLEMS

Structural causes (i.e. socio-economic factors such as poor housing, inner-city deprivation and alienation) are important in the development of conduct disorders and cannot be ignored. However, there are important interventions at different levels, which can be useful. At a classroom level:

- the importance of proactive classroom management methods, which are important for all children, but particularly for those children who experience conduct problems/behavioural difficulties;
- the teaching of social and problem-solving skills to all children. An example of such work in schools is the PATHS curriculum. The PATHS curriculum has 50 lessons on different emotions, teaching the most basic, such as happiness and anger, and touching on more complicated feelings such as jealousy, pride and guilt. Emotional-awareness lessons

within the curriculum include how to monitor what they and those around them are feeling, and how to recognise when someone is actually hostile as opposed to when the attribution of hostility comes from oneself. [See Leicester model for another example of such work]

For children who have behavioural problems which are significantly impacting on them and other children around them, the first step is for the class teacher to provide special teaching arrangements and materials. For example, they might rearrange the classroom to ensure that the child is sitting nearer to them, being mindful, however, of not isolating the child or of placing them in too extreme a position, which has been shown to encourage negative teacher responses to the child.

Other strategies, which are useful for children with conduct problems, are:

- to set short, achievable targets and give immediate rewards when the child completes the task;
- keep classroom rules clear and simple;
- use teacher attention and praise to reward positive behaviour;
- give the pupil special responsibilities so that they and other children can see them in a positive light;
- set up within the school small structured training groups for children experiencing such problems, which focus on improving self-monitoring and self-control through using cognitive behavioural techniques. An example of such work is the Webster-Stratton ‘Dinosaur Games’, which has been shown to be effective in reducing aggression and anti-social behaviour amongst children experiencing such problems; and
- implement within schools anger-management workshops for aggressive children/young people, in order to help children/young people control their impulsive behaviour, generate alternative solutions in social situations and learn to use problem-solving techniques when angry.

Parent training programmes can also be very effective in improving outcomes for children with conduct problems, especially when these are carried out alongside work in school. A number of projects are currently working with parents to support their children’s learning alongside their behaviour, and may show particularly fruitful results.

Medication is not usually used for children with conduct problems, except where ADHD might be present. *(See section on ADHD)*

For many children who experience conduct problems, their needs can be adequately met within the school, however, for some children their needs will be such that they will require additional help within the school, and may require a referral for a statutory assessment under the Code of Practice for SEN (see section 3.1).

4.2 Attention Deficit/Hyperactivity

ADHD stands for Attention Deficit Hyperactivity Disorder. It is normally used to describe children who have three main kinds of problems.

- overactive behaviour (hyperactivity);
- impulsive behaviour;
- difficulty in paying attention and distractibility.

Some children have significant problems in concentration and attention, but they are not necessarily overactive or impulsive. These children are sometimes described as having Attention Deficit Disorder (ADD) rather than ADHD. Children with ADHD have a short attention span. They find it hard to concentrate and therefore to learn new skills, both academic and practical. Research from the USA suggests that 90% of children with ADHD underachieve at school and 20% have reading difficulties.

Children with ADHD are also often rejected and disliked by their peers, because they disrupt their play or damage their possessions. In the UK, the diagnosis of children having ADHD is based on quite a narrow set of symptoms. And about 0.5–1% of children are thought to have attention or hyperactivity problems. About 5 times more boys than girls are diagnosed with ADHD – this may be because of the particular ways in which boys and girls express their difficulties. Boys and girls both have attention problems, but boys are more likely to be overactive and difficult to manage.

Diagnosis of children with ADHD can be difficult because:

- there is no clinical test for ADHD;
- there are other disorders which can present a similar profile of behaviours, e.g. anxiety states, attachment disorders;
- all children have problems with self-control, and it can be hard to decide where to draw the line and give a diagnosis of ADHD; and
- other problems can result in behaviour similar to ADHD, for example language or hearing difficulties, dyslexia, major disruptions in a child's life. Over half of the children with ADHD will have other areas of difficulty, such as these, in addition to ADHD.

The kinds of symptoms professionals look for in diagnosing ADHD:

- difficulty following instructions or completing tasks;
- difficulty 'sticking to' an activity;
- easily distracted and forgetful;
- often doesn't listen when spoken to;
- fidgets, is restless and can't sit still in class;
- can't stop talking, interrupts others;
- runs about when it is inappropriate;

- blurts out answers without waiting for the question to be finished; and
- difficulty in waiting or taking turns.

In order for a child to be diagnosed with ADHD some of these problems would have been apparent before the age of 6 or 7 years. These behaviours must also normally have occurred in more than one setting (for example, at home as well as at school) for ADHD to be diagnosed.

As a result of being overactive and impulsive, children with ADHD often find it very hard to fit in at school. They may also have problems getting on with other children. These difficulties can continue as they grow up.

As with children experiencing conduct problems, when a school has identified that a child has behavioural problems, the first step is for the class teacher to provide special teaching arrangements and materials. For example, they might re-arrange the classroom to ensure that the child is sitting nearer to them and away from distractions such as the window.

Other strategies that teachers could implement are:

- to set short, achievable targets and give immediate rewards when the child completes the task;
- use large type, and provide only one or two examples per page. Avoid illustrations which are not directly relevant to the task;
- use checklists for each subject, outlining the tasks to be completed, and individual homework assignment charts;
- keep classroom rules clear and simple;
- encourage the pupil to verbalise what needs to be done – first to the teacher and then silently to themselves;
- use teacher attention and praise to reward positive behaviour; and
- give the pupil special responsibilities so that other children can see them in a positive light.

(Adapted from Hampshire County Council, ADHD: Information and guidance for schools (1996))

If this is not sufficient, the SENCO within the school should carry out a more detailed assessment and draw up an Individual Education Plan. Many children with ADHD may require a referral for a *statutory assessment*.

Many children with ADHD are prescribed medication, such as Ritalin or Dexedrine. It is important to work out exactly how this will be taken during school hours. Teachers are not obliged to administer medication, but if they agree to do so, they must have clear instructions from the doctor who has prescribed it. Teachers can play an important role in monitoring the effects of medication and looking out for any side effects.^{viii}

4.3 Emotional Disorders

Emotional disorders refer to the whole range of emotional problems that are experienced by children. The majority of children are miserable on occasions, and the ability to understand and resolve minor setbacks or difficulties is a central part of a child's psychological development.

However, for some children, their experience of depression or anxiety can significantly impact on their ability to develop, to learn or to maintain and sustain friendships. Many children who experience other mental health problems, those with conduct problems for example, are also often miserable and anxious.

In children, depression can impact on cognitive development, socialisation, family relationships and behaviour. Associated symptoms include: reduction or loss of ability to experience pleasure; low self-esteem, guilt, helplessness, hopelessness, suicidal thoughts and acts; loss of energy; poor concentration; restlessness; and changes in appetite, weight and sleep.

In childhood the range of depressive symptoms may include refusal or reluctance to attend school, irritability, abdominal pain and headache. Children who are depressed often present with non-specific symptoms such as physical complaints, irritability, withdrawal, or they may express feeling unhappy or miserable.

In adolescence, young people who are depressed may appear to:

- be overly irritable;
- have insomnia or sleep excessively;
- lose their appetite or have a noticeably increased appetite;
- have a noticeable weight change, usually loss;
- experience suicidal thoughts or self-harming behaviour;
- have poor concentration and loss of interest in previously enjoyed activities;
- experience fatigue and negative thoughts of being useless, inadequate, ugly, guilty and hopeless about the future;
- be aggressive; and
- show a marked decline in educational performance.

Such feelings may affect the young person in that they will:

- have difficulties in getting on with friends or family;
- experience a loss in confidence and difficulty in making decisions;
- be unable to study or perform such tasks such as taking exams; and
- experience difficulty in getting up each morning and facing the day.

Those factors which make children and young people vulnerable to depression include: family breakdown, death or loss of a loved one, neglect, abuse, bullying and other adverse life events.

HOW CAN SCHOOLS IDENTIFY CHILDREN WHO ARE DEPRESSED OR ANXIOUS?

Being able to ascertain whether a child is depressed or anxious is an area that is quite complex – and many mental health practitioners are currently working towards developing effective instruments in order to be able to do so themselves.

However, there are ways in which teachers and schools can play an important role in assessing whether children might require initial or more specialist help and support.

Anxiety and depression in children and young people is often missed. This may be due to a number of factors:

- a belief that children do not experience anxiety or depression and a consequent lack of awareness of the symptoms that the child is presenting with;
- symptoms that may alert us to depression can be dismissed as being ‘part of adolescence’. Irritability can be mistaken for ‘difficult behaviour’;
- sometimes professionals judge the child or young person’s presentation as understandable under the circumstances, for example, if a child has been bereaved or abused;
- the belief that if the stressful situation is relieved, the problems will subside;
- if the child or young person is displaying somatic problems, the focus may be fully focused on the physical rather than the emotional signs or symptoms; or
- professionals may not be sure of what to do next, and consequently do not ask relevant questions for fear of upsetting the young person.

It is therefore important that teachers and schools are able to initially assess whether a child or young person is experiencing emotional problems which are severely impacting on them.

CAN SCHOOLS HELP CHILDREN WHO ARE DEPRESSED OR ANXIOUS?

The following approaches are effective in working with children and young people who are depressed:

- working with the child/young person to help manage any underlying school problems. Many children and young people may become anxious or depressed as a result of bullying within school, or due to worries about school work or exams, for example. Schools which have strong policies to prevent bullying, and strong pastoral systems where children can discuss any worries that they may have and which can be acted upon promptly, can be particularly effective in helping prevent long-term problems from developing.

- Schools can implement social skills training for pupils, which can improve self-esteem and interpersonal relationships. Such work is particularly important for building resilience amongst those children and young people more at risk of experiencing anxiety and depression than their peers.
- Counselling approaches to working with children and young people. Many schools currently offer counselling type services for children and young people. These are held to be particularly important for those children who are anxious or depressed. Whilst research has failed to show the long-term benefits of counselling type approaches for children and young people who are depressed, many children and young people themselves have reported the benefits of such approaches. What appears to be important for many young people is having someone to talk to, being properly listened to and having their difficulties taken seriously.
- For many children and young people who are depressed, short-term cognitive behavioural therapy (CBT) can be effective. Mental health professionals, such as child psychiatrists, or psychologists often outside school, can deliver such an approach. This approach helps the child/young person in the following way – the cognitive component is designed to alter negative thoughts, improve self-esteem and enhance coping skills, whilst the behavioural aspect of the therapy is designed to increase the child or young person's involvement in normal and rewarding activities. Often such treatment may be undertaken during school hours, and schools can play an important role in destigmatising help of this kind.
- The use of medication for children and young people experiencing depression is controversial. There has been generally negative evidence on the effectiveness of drug therapy for children and young people.

4.4 Obsessive Compulsive Disorder

Obsessive compulsive disorder in children has been described as 'troublesome and distressing rituals and ruminations' outside the criteria of 'normal' childhood rituals. For example, most 2 year olds develop rituals around bedtime, which rarely last beyond the age of 8; rule-bound play increases from 5 years and around 7 years old children often start collecting. OCD has some resemblance to these normal rituals; however there is no age trend to OCD rituals, and 'symptoms interfere with, rather than enhance, socialisation and the growth of independence'.^{ix}

TREATMENT

- Behaviour therapy in conjunction with medication can be effective in children.
- Behaviour therapy for children with OCD involves keeping a diary, with the child drawing up a hierarchy of compulsions, and, starting with the easiest to tackle, being encouraged to try to avoid carrying out the compulsion.

4.5 Anorexia Nervosa and Bulimia Nervosa

Anorexia has a peak age of onset in the mid teens and a male/female ratio of about 1:10. The prevalence is around 0.1% in 11–15 year old girls and 1% in 16–18 year olds.

The core features of anorexia are:

- self-induced starvation and weight loss;
- a strong desire to be thinner, with a marked fear of weight gain;
- a distorted body image;
- determined food avoidance;
- weight loss or failure to gain weight in the absence of physical or other mental health problems; and
- a pattern of eating that is designed to avoid weight gain. This includes: avoidance of fatty foods, self-induced vomiting, self-induced purgation, over-activity in order to lose weight, and excessive use of laxatives.

BULIMIA NERVOSA

Bulimia consists of periodic bouts of ‘binge-eating’ over a brief period. These are followed by self-induced vomiting, purging, periods of starvation or other means. Body weight is usually close to normal, but concern about body weight is heightened. The peak age for bulimia is usually a few years later than anorexia, but there is the same over-preponderance of females to males.

TREATMENT

The severity of the conditions will vary widely amongst children and young people. For some children with severe difficulties, they will require specialised intervention and even in-patient treatment. For these children and young people, an important issue is that of their continuing education in the various in-patient settings where they may be placed, and their transition to and support within mainstream school if and when they are well enough to return. Most children and young people will however present with mild and transient eating problems, and will remain within the school setting during the course of their treatment.

GENERAL PRINCIPLES IN WORKING WITH CHILDREN/YOUNG PEOPLE EXPERIENCING EATING DISORDERS

- Schools can play an important role in helping young people develop confidence and self-esteem, all vital elements in helping young people with eating disorders manage the way in which they think about themselves. (See example of the PATHS curriculum)
- It is important that children/young people are encouraged to eat regular meals. Schools can play an important role in helping to ensure that the young person does not skip meal times.
- It is important where there is rapid weight loss, for the young person to be referred for a medical assessment. Schools can liaise with parents in relation to this.

4.6 Deliberate Self-harm/Suicidal Behaviour

Both attempted suicide and completed suicide are rare in children under 12 years old. However, girls outnumber boys by 4:1 in those attempting suicide, with the number of boys attempting suicide gradually increasing after the age of 14. Many young people who deliberately self-harm – who overdose on analgesics, anti-depressants or other medication, or who cut themselves or inflict other lacerations – do so after arguments with family, friends or partners.

Many young people's self-harm is associated with other mental health problems such as depression, alcohol or drug misuse. However, other self-harm episodes are not related to mental health problems.

It has been stated that young people may self-harm because:

- they feel sad and lonely;
- they feel that no-one really understands or likes them;
- they feel that they are a failure;
- they feel trapped and want to escape from the situation;
- they are angry but are unable to say so, leaving them feeling hopeless about the future;
- of difficult social/environmental circumstances; or
- it is a way of coping.

For many young people the decision to attempt suicide may be taken quickly and without warning. The young person may soon regret their action, but any attempt must be taken seriously. There is a high risk of eventual suicide in up to 10% of young people who attempt suicide and they are likely to have further suicidal attempts.

MANAGEMENT ISSUES

In working with young people who are self-harming, the following strategies have been put forward as being useful:

- the importance of taking a non-judgmental attitude towards the young person, if not the act. Many teachers and other professionals who work with young people find the reality of young people self-harming very difficult; however, it is important that the young person does not feel rejected as a result of the adults around them finding their behaviour unsettling or bizarre.
- It is important that the young person feels that they are listened to effectively. Evidence shows that teenagers are most likely to make a repeat suicide attempt when no one has really listened, or when no help has been offered. (Trust for the Study of Adolescents leaflet in press).
- It is important that all attempts of suicide or deliberate self-harm are taken seriously. All mention of suicidal thoughts should be noticed and the young person listened to carefully and if appropriate referred for more specialist help.

- If a child states that they have taken any medication or made any other attempt to harm themselves, it is important to listen to the child. In the case of children taking medication, or taking any significant risk to their health, it is important that they are referred to a doctor for an assessment.
- After a medical assessment, it may be appropriate to involve the Child and Adolescent Mental Health Service in order to provide ongoing support for the child/young person.

4.7 Asperger’s Syndrome/Autistic Spectrum Disorders

ASPERGER’S SYNDROME AND AUTISM

Autism is a developmental disorder. Classic autism and Asperger’s syndrome are amongst a group of Pervasive Developmental Disorders now commonly grouped together as autistic spectrum disorders (ASD). Prevalence rates vary. The National Autistic Society cites a prevalence figure of 91 per 10,000. This includes a total of 20 per 10,000 for people with autism and learning difficulties and 71 per 10,000 with autism and average or high abilities, including those with Asperger’s syndrome and high functioning autism.

Children with classic autism and learning difficulties are likely to be educated in special schools or autism specialist schools or units. However, many children with ASD, particularly those with Asperger’s syndrome, are educated in mainstream schools and many of those with success. Whilst many children with Asperger’s syndrome thrive within mainstream schools, some children are at increased risk of encountering difficulties at school because of the poor social skills which are a central feature of autistic spectrum disorders. This is particularly so when they get to secondary education.

Diagnostic criteria or guidelines for autism and Asperger’s syndrome are given separately. All autistic spectrum disorders are said to be characterised by a ‘triad of impairments’ – impairments of social interaction, social communication and imagination. It has been said that a diagnostic definition of Asperger’s is difficult in practice as core syndromes for the condition are ‘almost always bound up with other symptoms which are reactions to it’. And many of these secondary syndromes may be present in children and young people who do not have Asperger’s syndrome.

The range of behaviours that a child with ASD is likely to exhibit include:

- abnormal non-verbal communication – either a failure to use non-verbal expression or a failure to respond to it. A child who has difficulties reading other people’s facial expressions, avoids mutual gaze, lacks gesture and has a diminished facial gesture themselves;
- engages in repetitive or ritualistic activities – these are an almost universal response to anxiety in people with Asperger’s syndrome and anxiety is an almost universal concomitant of Asperger’s syndrome; and
- naïve, inappropriate, one-sided interactions, a lack of empathy and little or no ability to form friendships. Asperger’s syndrome sufferers will have pedantic, repetitive speech and intense absorption in certain subjects. Adolescents experiencing severe social phobia

(extreme shyness) will not necessarily mean they have developed Asperger's – socially phobic adolescents may also have marked abnormalities of non-verbal communication, with extreme gaze avoidance and lack of emotional expression – and may also be socially clumsy.

The problems that some children with Asperger's have can often be experienced by school staff as being wilful bad behaviour. Classroom problems are especially likely to occur for children and young people with Asperger's, as they often find the social situation within classrooms very hard to understand. Very often, this lack of social understanding is compounded by attentional problems. The National Autistic Society's report *Inclusion and autism* found that school exclusion was significantly more likely for pupils with Asperger's syndrome or high functioning autism. Head teachers should always consider whether a child's behavioural difficulties are caused by special educational needs before deciding whether to exclude them or not.

Many children with ASD may also experience psychological problems – emotional difficulties as a result of the ASD, which can significantly impact on their ability to develop friendships, and to learn. For example, many children and young people with Asperger's syndrome/high functioning autism, have a sufficient level of social awareness to realise how isolated their communication difficulties have made them. These children and young people are also more prone to being bullied at school. Not surprisingly, this results in young people with ASD being more at risk of depression, and thus requiring additional emotional support and advice in order to help them. Problems with low self-esteem and social isolation can sometimes be addressed with the aid of the pupil's obsessional interests. For example, a pupil's intense absorption and expertise in computer technology can put them in a position to help other pupils with computer work and give the child some social standing.

It can sometimes be difficult for those working with children with Asperger's to know whether the child is experiencing particular psychological problems as a result of their condition. For example, it may be difficult to ascertain when a child or young person with Asperger's is particularly anxious, as their behaviour may appear as a more extreme form of their usual pattern of behaviour. For example, rituals may increase, and in times of particular anxiety such as threats of substantial life change, the child or young person may reveal particularly unpredictable behaviour.

What can schools do to support children with ASD? There are a number of important measures that schools can implement in order to support the emotional well being and learning of children with Asperger's. These include:

- Having clear communication systems in place to ensure that children are clear what they have to do, where, with whom, when, for how long, what next and how.
- To ensure that children with Asperger's or high functioning autism have access to ways of learning that are appropriate for them – for example one-to-one teaching and instruction through asocial means (for example, as described above through computer-assisted learning).
- The development of pro-social learning within the school – this is particularly important for children with ASD, to enable them to understand how to communicate and interact with others.

- The development of Peer Supports e.g. buddy systems and circle of friends – in order to help children with ASD manage free times and develop strategies to deal with potential bullying.
- Counselling-type approaches can also be very effective in helping children/young people with Asperger’s identify and sort out misinterpretations of events or statements in the past – and so alleviate them dwelling and fixing on these.

(For a fuller description of how schools, local education authorities and others can support children with ASD, the DfEE’s Autism Working Group will be producing guidance in this area) The Mental Health Foundation has produced three booklets on autism, which contain useful information for schools.

Support for Schools

There is a range of support that schools can draw upon, both internally and externally, in order to meet the mental health needs of children and young people. Some will be very familiar, others may be less so.

5.1 Education Staff Working in Schools

SENCO. All Schools must have a special educational needs co-ordinator, whose role is to co-ordinate the provision of support for children with special educational needs. Given the links between the needs of children with SEN and those with mental health problems, it may be appropriate for the SENCO to co-ordinate the provision of support for this group.

Learning Support Assistants. LSAs can provide extremely valuable in-class behavioural and learning supports for children experiencing emotional and behavioural problems, especially when these are linked with effective whole class behaviour policies.

Peer Support. For a discussion of the role of peer supports for young people experiencing mental health problems see Section 3.4.

Home-school Link Workers. The effectiveness of home-school links in fostering better individual achievement and behaviour in school, particularly for those children who are more at risk than their peers, has been well documented. Many schools have found the appointment of a co-ordinator or specialist workers to set up and run programmes to develop home-school links extremely valuable.

Pastoral Staff. The role of pastoral staff in supporting vulnerable children, children more at risk of developing behaviour problems and other teaching staff remains extremely important. For many children, it is class teachers in the primary school or form tutors in secondary schools who become aware of children's difficulties and offer initial support to the best of their and their school's ability. In many cases, advice will be sought from SENCOs, pastoral staff such as heads of year and senior staff such as deputy head or head teacher.

Learning Mentors/Mentors. Learning Mentors help young people overcome barriers to learning, both inside and outside school. Their key functions include developing a one-to-one mentoring relationship with children who need particular support; to maintain regular contact with families/carers of children receiving support; and to encourage positive family involvement in the child's learning. Learning Mentors have been introduced through our Excellence in Cities initiative and can contribute towards addressing the emotional and mental health needs of pupils in these schools.

5.2 Other Professionals Working in Schools

Personal Advisers. Personal Advisers are being introduced as a result of the Connexions Service, to provide one-to-one support for young people and to oversee the effectiveness of interventions for them. Their role is to ensure that young people aged between 13–19 receive a ‘seamless service’ to support and manage their transition to further learning and adult life which is appropriate to their needs. Personal Advisers have an important role in supporting young people at risk of or who are experiencing mental health problems; ensuring they are able to engage effectively with young people who are at risk, carrying out initial assessments of young people’s needs, developing ways of offering initial support and interventions with young people experiencing mental health problems and their families, and referring young people on to more specialist help when appropriate.

5.3 Specialist Educational Support

Education Social Workers. Educational social workers can play an important role in supporting those families who are experiencing problems in ensuring the attendance of their children at school – offering support, guidance and sometimes advocating on the family’s behalf in relation to the provision of support and help.

Behavioural Support Staff. Many LEAs offer a behaviour support service, to support schools in developing whole school approaches to behaviour alongside interventions for children experiencing particular problems. Schools could usefully bring in such support before children require a statement of special educational needs.

Educational Psychologists. Their role has been defined by a recent report^{vi} as being:

‘To promote child development and learning through the application of psychology by working with individuals and groups of children, teachers and other adults in schools, families, other LEA officers, health and social services and other agencies’.

This report says that all educational psychology services should:

- *‘be delivered in school settings as well as in local authority and family settings;*
- *focus on assessment, intervention and consultation;*
- *develop multi-agency approaches to support schools and parents; and*
- *be accessible to users independently of schools.*

The core activity of all educational psychologists is assessment and intervention work at a number of levels with children and young people aged 0–19. These interventions can include work with the individual child or family, or advice on intervention strategies that the teacher/SEN co-ordinator/early years co-ordinator might employ.

It has been recommended that each school is to have access to one nominated educational psychologist in order to offer it a range of support, and can expect at least one visit per term from the psychologist for this purpose.

It has also been recommended that educational psychologists seek to maximise the time they spend in schools to ensure they are providing effective support at the whole range of levels that the school requires, which can include work:

- *with groups of children or at a whole class level on particular issues – including social and friendship skills, inclusion, managing exam stress, behaviour management, bullying issues, pupils at risk of exclusion;*
- *at whole school level, applying their knowledge of systems and organisational psychology to support schools/early years providers in their overall approach to learning and development i.e. approaches to discipline and behaviour management; pastoral schemes and work with other agencies;*
- *with other agencies. It is the responsibility of the LEA to establish a framework for joint planning and intervention for children requiring support from a range of agencies, and for involving educational psychology services as appropriate in this. For children and young people experiencing mental health problems, it is important that effective links have been developed between the individual schools, the LEA and Child and Adolescent Mental Health Services.'*

5.4 Health Professionals Working in Schools

School Nurse. School nurses have an important role to play in the early assessment and increasingly in assisting schools in delivering effective early interventions for children and young people experiencing mental health problems. For an example of school nurses carrying out an effective screening and early intervention for young people see Case Study 14.

Primary Mental Health Workers. Some areas have employed primary mental health workers, (either through the General Practitioner or the Child and Adolescent Mental Health Service) to offer initial help and advice to children, young people and their families experiencing mental health problems and where appropriate refer young people onto more specialist help. There is no clear job description or management arrangement for primary mental health workers, with workers having different remits in different areas.

5.5 Social Services Staff with a Remit to Support Children in Need

Children and Family Teams, Section 47 Child Protection Fieldwork and Family Units.

Whilst these professionals and social work teams do not have direct responsibility for children experiencing mental health problems, many children who are experiencing mental health problems may have a range of other problems that have brought them to the attention of the social services department. It is therefore important that schools are aware of the range of professionals that children are involved in, as are the specialist services in developing supports to meet children and families needs.

5.6 Health Staff Operating outside School

Health Visitors, Practice Nurses, General Practitioners. Along with schools, many of these, particularly general practitioners and health visitors, have important roles in assessing whether children and young people may be experiencing mental health problems. Often specialist services, particularly CAMHS, will require that a referral is made from the GP or health visitor for an appointment, rather than from the parent, young person or the school.

Speech Therapists. The role of language difficulties in the development of some children’s emotional and behavioural problems has been well documented. The role of speech therapists in highlighting at-risk children’s needs and providing supports is therefore particularly important.

Community Paediatricians. Community paediatricians play an important role in assessing children’s needs and referring on to more specialist help where appropriate.

5.7 Specialist Mental Health Professionals

Clinical Psychologists, Psychiatrists, Educational Psychologists, Community Psychiatric Nurses. Many of these specialist mental health professionals will be located within Child and Adolescent Mental Health Services (CAMHS).

CAMHS (Child and Adolescent Mental Health Services) – what and who are they?

Child and Adolescent Mental Health Services (CAMHS) is a term used to describe the range of services and professionals working in the field of child and adolescent mental health.

In some areas, there are fully staffed specialist child and adolescent mental health teams, who are able to offer a range of supports and help for individual children, their families and schools.

There has recently been a commitment by the Department of Health (1998) to ‘improve the provision of appropriate, high quality care and treatment for children and young people by building up locally based Child and Adolescent Mental Health Services’.

In many areas, Child and Adolescent Mental Health Services have been organised into four different tiers. CAMHS should be available for each level of need, and the following sets out ways in which they could be organised within areas and, for more specialist services, districts*.

Tier One. This level is a primary level of services and can include interventions by:

- GPs
- health visitors
- school nurses
- social services
- voluntary agencies
- teachers
- residential social workers
- juvenile justice workers

CAMHS at this level are provided by non-specialists who are in a position to:

- identify mental health problems early in their development
- offer general advice and in certain cases treatment for less severe mental health problems
- pursue opportunities for promoting mental health and preventing mental health problems

Tier Two. A level of service provided by uni-professional groups, which relate to each other through a network (rather than a team)

These include:

- clinical child psychologists
- paediatricians, especially community
- educational psychologists
- child psychiatrists
- community psychiatric nurses/nurse specialists

CAMHS professionals should be able to offer:

- training and consultation to other professionals (who might be within Tier 1)
- consultation for professionals and families
- outreach to identify severe or complex needs which require more specialist interventions but where families are unwilling to use specialist services
- assessment which may trigger treatment at a different tier

Most children and young people with mental health problems will be seen at Tiers 1 and 2.

Tier Three. A specialist service for the more severe, complex and persistent disorders. This is usually a multi-disciplinary team or service working in a community mental health clinic or child-psychiatry out-patient service, and including:

- child and adolescent psychiatrists
- social workers
- clinical psychologists
- community psychiatric nurses
- child psychotherapists
- occupational therapists
- art, music and drama therapists

The core CAMHS in any area should be able to offer:

- assessment and treatment of child mental health disorders
- assessment for referrals to Tier 4
- participation in R and D projects
- contributions to the services, consultation and training to Tiers 1&2

Tier Four. Access to infrequently used but essential tertiary-level services such as day units, highly specialised out-patient teams, and in-patient units for older children and adolescents who are severely mentally ill or at suicidal risk

The most specialist CAMHS may provide for more than one district or region, and should be able to offer a range of services, which might include:

- adolescent in-patient units
- secure forensic adolescent units
- eating disorder units
- specialist teams for sexual abuse
- specialist teams for neuro-psychiatric problems

Case Studies on Promoting Children's Mental Health in Early Years Settings, Primary and Secondary Schools

Case Study 1

Rebecca Cheetham Nursery Centre

The Rebecca Cheetham Nursery Centre is an early years excellence centre based in Stratford, East London. The Centre actively promotes the emotional and social well being of the pupils and their parents through a range of policy and practice.

The Centre sets out five rules for behaviour, which apply to all those who use the centre.

- Be caring: no hurting, bodies or feelings.
- Look after our nursery and the people in it.
- Work together (playing, tidying up, co-ordinating).
- Be safe.
- Be responsible (for yourself, other people and things, and what you do).

The Centre uses a key worker system, with each key worker working closely with seven children and their parents/carers. All workers are encouraged to develop 'close attachments' with individual children, alongside close relationships with the parents.

WORK WITH CHILDREN

The centre promotes the emotional, social and cognitive development of all the children through delivering a curriculum which:

- promotes active learning amongst the children, with an emphasis on children planning their own activities, carrying them out and evaluating what they have done;
- ensures that children have access to a range of adult/child interactions – including small group time, circle time and other activities aimed at promoting children's emotional and social development such as parachute games; and
- ensures that children have access to a variety of environments – inside, outside, field trips, various work areas.

The centre works closely with the local family resource centre, particularly with health visitors, social workers and speech therapists attached to the centre – who are able to work with vulnerable families and/or children. It is also in the process of appointing a social worker, to offer further effective early intervention work for vulnerable families from the centre itself.

WORK WITH PARENTS

The centre’s ethos is one of developing an effective partnership with parents. Alongside open access drop in classes for all parents, it runs a number of parenting groups/classes – through which it hopes to engage with parents in an empowering way, building on their strengths, alongside providing opportunities for parents to discuss issues that may be causing them concern. The centre runs a ‘drop-in’ for all local parents and a parenting course run by a social worker and a health visitor. An initial home visit is made for each child attending the nursery. This hour long visit enables parents to discuss anything they might feel is relevant, and enables the worker to assess the child ‘in situ’. If at this stage, the worker feels there are areas of concern, they are able to refer this on to the head teacher.

Case Study 2

Thurnby Lodge Primary School, Leicester

Thurnby Lodge Primary School in Leicester works to actively promote the school as a ‘caring environment’ through a range of ways of involving and supporting school staff, parents and children in all aspects of the school’s life. For example, the school is involved in the following: it is taking part in the Healthy Schools Award and within this has a specific focus on promoting children’s mental health and well being. In order to involve children in the school, a Children’s Council is held regularly, along with Circle time approaches to involve children, extra-curricular clubs, a Pyramid Trust style 10-week after-school club, big brothers and sisters for children experiencing problems, Circle of Friends for isolated children, story club, home-school links, mentors/support for new children and staff, and a clear focus on promoting well-being through PSHE throughout the school. For those children who are at increased risk of developing problems the school works closely with the school nurse and school medical staff, and also with the local Child and Adolescent Mental Health Service (see Section 5.7. for a fuller description of this). The school is committed to involving parents, and achieves this through running such initiatives as parent and tots pre-nursery groups, literacy and numeracy projects/SHARE projects for parents, ‘drop ins’ for parents, ‘bridge building’ for children at risk and a parents/carers support group, and a home-school links project to facilitate effective communication, liaising and involvement between children’s homes and the school.

Case Study 3

St Marylebone School for Girls in Westminster

St Marylebone School is an all girls comprehensive school in central London. The school actively promotes the mental health of its pupils through a number of initiatives, including a commitment to including the promotion of self-esteem, confidence, independence and responsibility throughout the PSHE curriculum, and where relevant in all aspects of school life. For example, aspects of personal, social and emotional education are taught throughout the curriculum, in English, drama as well as RS and science i.e. sex education and drugs education within the National Curriculum. Aspects of PSHE are also addressed in the tutorial programme within the school, and close liaison takes place between learning co-ordinators and the PSHE Department in order to facilitate this. In addition to this work, the school runs a Feel Good Factor Project: a peer support project that aims to raise self-esteem and self-

worth amongst students, to create a positive atmosphere and a 'can do' culture. The project enables younger pupils to seek advice and support from older pupils who may have experienced the same problems or issues as themselves. The Feel Good Factor also raises awareness of mental health issues through teaching, presentations, interviews, counselling sessions and the production of age-related and accessible information in a variety of forms. The Feel Good Factor is a whole school project aimed at Key Stage 3 but also involves the talents and experience of Key Stages 4 and 5, who have also gained a great deal from the project.

Case Study 4

PATHS curriculum

The PATHS curriculum (Promoting Alternative Thinking Strategies) is an American programme designed to promote emotional and social competencies, and reduce aggression and behaviour problems in school-age children. It is a universal, school-based intervention implemented by teachers to whole classes. The generalisation of skills learnt in the classroom to children's everyday lives is a major component in each unit. Curriculum units include self-control, emotional understanding, positive self-esteem, relationships and interpersonal problem-solving skills.

There have been four clinical trials of PATHS. Two have involved special needs students and two have involved 'mainstream' children. Across these trials, PATHS has been shown to improve protective factors (social cognitions, social and emotional competencies) and reduce behavioural risk (aggression and depression) across a wide range of primary school aged children. Effects have also been found on some cognitive skills. (Greenberg and Kusch, 1998)

Case Study 5

Seattle Social Development Project.

This is a comprehensive universal prevention programme that addresses multiple risk and protective factors within the child, school and family. The programme has a strong emphasis on creating and maintaining a strong school and family bond. It combines helping teachers to manage the behaviour of children within the class and training for parents in children's behaviour through a six-year intervention period. Classroom teachers are trained in proactive classroom management, interactive teaching and cooperative learning. These teaching approaches are used in combination with:

- (a) classroom-based cognitive and social skills training in the 1st grade (the ICPS Curriculum) and in the 6th grade (refusal and life skills); and
- (b) parent training which emphasises child behaviour management in the 1st and 2nd grade, academic support in the 2nd and 3rd grade, and preventing drug use and antisocial behaviour in the 5th and 6th.

An evaluation of the programme revealed that students who had taken part in the full programme reported greater attachment to school, improved self-reported achievement and less involvement in school misbehaviour.

Case Study 6

Interpersonal Cognitive Problem-solving Programme (ICPS)

Within the programme, it is the class teacher who implements the ICPS programme with small groups of children. The programme begins by teaching children fundamental skills related to language, thinking and listening and progresses to practising more complex interpersonal problem solving through dialogues and role playing. ICPS has been implemented in a number of schools through the US. In trials with both pre-school and primary school pupils, it has been shown that ICPS can significantly improve cognitive problem solving abilities and reduce inhibition and impulsivity in children, with effects lasting through one-year follow-up.

Case Study 7

The Nippers Project – Nursery Intervention for Parents and Education-Related Services

This service was set up as a response to the high rate of emotional and behavioural problems presented by young children in the boroughs of Camden and Islington.

The ethos underlying the project’s development is:

- the importance of effective engagement with parents, and the necessity of developing interventions in informal community settings in order to achieve this;
- the need for considerable time to build up trust and relationship with parents whose children have significant behavioural problems, in order for the parents to feel respected and safe enough to agree to participate;
- for parents to be able to have chosen to participate rather than feel that they have been coerced into doing so; and
- the importance of a range of interventions aimed at parents and their children.

The project is run in three settings; New River Green Early Years Centre, the Rosedale Under 5s Education Centre and Coram Early Years Centre.

Previous to the project being formally developed in each centre, parenting skills courses are set up. These are aimed at all parents, in order to ensure that they are established as a positive resource for all parents, and not as a stigmatised service for parents who are perceived as failing.

After this, in each centre, weekly clinic sessions, staffed by a member of the Clinical Psychology team, are offered which serve both the early years centre and private and voluntary sector playgroups. Parents are able to book themselves an appointment with this clinic, without having had a formal referral, after which if appropriate the psychologist carries out a formal assessment – this involves gathering information relating in detail to the child’s development alongside a detailed family history.

The family will then be a number of options, which include:

- six to ten sessions working with the psychologist with a brief solution focused intervention;

- the parents skills course. A great deal of effort is placed on working with parents to encourage them to take part in classes; with meetings taking place with parents at home. However, for those parents who do not want to take part in a class, as described above, individual sessions with the psychologist are made available; or
- a more psychodynamic approach. It may also be agreed at this stage that a referral onto another service is required e.g. speech and language therapy for the child, or adult mental health services. The psychologist facilitates any necessary referrals. As a result of the non-stigmatising approach of the service, there is a 96% take-up rate by parents.

Alongside work with parents, children are offered pro-social behaviour teaching. This is delivered by the nursery staff, and supported by the clinical psychologist as a whole class programme.

Case Study 8

Camden Early Years Intervention Team

Camden Early Years Intervention Team offers a multi-disciplinary resource for the Borough, providing support and advice to all providers of nursery education in Camden other than maintained schools. The team is made up of an educational psychologist, a speech and language therapist, two behaviour support teachers and an EAL adviser.

The team works with children from 2–5 years of age presenting with more than one of the following:

- behavioural/emotional difficulties;
- difficulties accessing the curriculum;
- language difficulties (not EAL);
- at risk of developing more long term special needs;
- difficulties participating in nursery activities as a result of family/environmental change e.g. relocation/bereavement.

The team may work with any child who is:

- not on the Code of Practice but who is raising concerns; or
- on the Code of Practice at any stage 1–3.

The team offers a range of services to all providers of early years education in Camden. This work involves:

- a. offering support and advice to staff in developing programmes and strategies which enable children with emotional/behavioural/language difficulties to access the curriculum more easily; and
- b. direct work with individuals, pairs and groups of children who have been referred to the team, for negotiated amounts of time.

This work may include planning and writing Individual Education Plans with staff; jointly monitoring a child's progress; devising strategies and activities with staff for individuals

or groups of children; and support in reviewing structures and routines that promote positive interactions between children and staff.

An important role of the team is the assessment of individual children’s needs. This assessment can be carried out by any of the team members, and may include:

- observation of the child in the nursery setting;
- discussion with the child’s parents;
- an assessment of the key worker’s interaction skills and the child’s response;
- an assessment of the child’s strengths and areas of need in individual/group/paired settings; and
- an assessment of the impact of routines and environment on the child alongside a consideration of other potentially contributing factors, such as gender or refugee status.

This work is carried out through observation of the child in the early years setting and at home, though the use of screening tools and checklists – for example the Strengths and Difficulties Questionnaire.

The team offers training centrally, or in response to the needs of individual providers. Training is offered in positive behaviour management, social development and self-esteem; language impairment and interaction difficulties; early literacy; and the identification of special needs. In addition, training on the Code of Practice (stages of assessment, intervention); writing of IEPs, including target setting; child development and curriculum planning to support children with special needs e.g. effective use of areas within under 5 provision, outdoor play space, rooms etc. are also delivered.

The team sees its work with parents as being very important. The team runs workshops and drop-in sessions for parents and carers, in addition to support groups for parents/carers of children with special educational needs. It also offers a range of information and advice to parents who request it.

Case Study 9

Stoke Primary School, Coventry

Stoke Primary School is in a fairly deprived area of Coventry. The school has been working hard at promoting the well being of the children in its care. Alongside ensuring that whole school policies around behaviour are effectively implemented, the school has a programme of Circle Time across all year groups alongside PSHE. It also employs a pastoral care worker, who supports the social and emotional work throughout the school: observing children’s behaviour during Circle Time sessions and during playtime in order to discuss with class teachers those children who might be showing signs of concern, working with small groups of children individually or in groups who are vulnerable.

With funding from an external organisation, the school developed a Home/School project, the focus of which was to improve access to the educational system for young children who are failing to thrive at school and who exhibit signs of depression, isolation, behaviour and emotional problems.

The project ran for two years and employed a half-time link worker, who was also half-time nursery teacher. The first year of the project developed the work with the parents and in the second year the focus moved to work in the classroom.

WORK WITH THE PARENTS

In addition to setting up a room for parents, where parent and toddler groups were run for all parents, the link worker and community nursery nurse targeted families requiring additional support. Two ten-week courses were run with these parents, one on “Handling children’s behaviour” and one to train parents as Befrienders in the Special Needs Parental Partnership. In the second year of the project, activities and courses for parents continued, as did the toddler groups. The link worker developed more individual work with parents.

WORK WITH CHILDREN

In the second year of the project emphasis was placed on working with the children in years 1, 2 and 3 who gave the most cause for concern. The children were identified by their class teachers backed up by a self-esteem and friendship survey and a locus of control questionnaire, which measures whether children feel they have control over their behaviour and events. Children with few friendships or who were actively unpopular were targeted for help and support. They received support through individual and small group work, using artwork and discussion and some Circle Time ideas to develop confidence, self-esteem and social skills.

Whilst many class teachers were initially doubtful about the usefulness of the project, on seeing the impact of the project many were keen to see follow-up courses.

- children whose parents took part in the reading workshops showed an improvement in reading skills and confidence;
- there was an improvement in the quality of parental involvement in the school;
- Circle Time was also rated as useful or very useful by all the staff, despite the fact that they had been very resistant initially. The children also found it beneficial and speaking and listening skills improved. Although it helped with relationships, in some classes it was felt that in many cases it would take longer to improve the children’s behaviour to each other.

Since this project, with additional funding the school has appointed a pastoral care worker, who has extended the work to include all year groups. The school is now registered in the Coventry pilot scheme of the Healthy Schools Initiative.

Case Study 10

Hexthorpe Primary School – Doncaster

Hexthorpe Primary School is located in a multiethnic, mainly working class area of high unemployment, and caters for over 400 pupils aged between 4 to 11. In the school, an increasing number of pupils with emotional and behavioural problems seemed to be struggling to cope with confusion in their personal lives. This manifests itself in low

self-esteem, an inability to develop positive relationships with peers and feelings about being ‘picked on’ by those with whom they come into contact.

The school developed an integrated whole school policy based on a multi-agency approach in order to respond more effectively to the needs of these pupils. A combination of Circle Time approaches, circle of friends, the setting up of play therapy/nurture groups and a programme aimed at the development of parenting skills helped to encourage an atmosphere of mutual trust and respect, leading to improved co-operative and supportive relationships between pupils, parents and staff.

The multi-agency group carried out a careful evaluation of the impact of the interventions. They found that although all interventions were only in place for a short period, the Circle of Friends and the Nurture Group (despite being a watered down version of the Enfield Nurture Group model), revealed the greatest impact.

In relation to the Circle of Friends – for the two children selected for the intensive support (who were assessed as having low self-esteem and who were socially withdrawn) using sociograms and ‘B/G steem’ measures, there was much subjective evidence and some quantifiable evidence to show that the Circle of Friends strategy was effective in promoting their inclusion. The strategy also had a positive impact for the other children involved in the groups. Staff in the school were committed to continuing the development of Circle of Friends approaches for other isolated children.

The Nurture Group – set up to address the needs of Reception and Year 1 children demonstrating adjustment difficulties in the classroom, was by far the most successful of the project’s interventions. Children were selected for involvement in the group by discussion with their class teachers; the primary criterion for selection was the child’s difficulties in coping with the social demands of the classroom environment e.g. mixing with peers, responding to adults, conforming to rules. In addition to this the Boxall diagnostic profile was used. Significant improvements were registered for two-thirds of the children involved in the nurture group, and it was felt possible that others would have benefited from a longer involvement – providing a clear indication of the value of this kind of intervention for young children who present emotional and behavioural difficulties in the classroom.

All of the strategies employed by the school, except for Circle Time, involved the joint working of different professionals:

- **Circle Time:** The head teacher undertook the delivery of Circle Time in 3 classes – a Y2, a mixed Y1 and Y2 and a Y1 class;
- **Circle of Friends:** head teacher, class teacher, educational psychologist;
- **Parenting Skills Group:** nursery teacher, educational welfare officer, educational psychologist; and.
- **Nurture Group:** nursery nurse, two clinical nurse therapists

The school reported of their experiences of this multi-agency working – ‘Where professionals shared an educational philosophy it was easy to develop complementary ways of working. Problems arose when educational and clinical professionals worked together because they favoured the use of different methods. However, most difficulties were resolved and effective ways of working together were established’.

Case Study 11**Leicester, Leicestershire and Rutland Child Behaviour Intervention Initiative**

The Child Behaviour Intervention Initiative is an innovative multi-agency initiative in Leicester, Leicestershire and Rutland. The initiative has been pump-primed through the Department of Health Child and Adolescent Mental Health innovation grant, and through Department for Education and Employment Standards Funding and Single Regeneration Budget. A thorough evaluation of the project is underway, the results of which will be used to make a decision regarding the continuation of the initiative. The Initiative is operating slightly differently in each area. The work of the Leicester team is expanded below.

- Within Leicester City, the initiative has established three teams. Each team works within an area that has been deemed to be a high priority by Social Services, Health and Education. Each of the three teams comprises a primary mental health worker, a senior family support worker, two family support workers and a senior practitioner educational psychologist. There is an additional family support worker who is working between two of the teams. One of the teams is located within a primary school – Thurnby Lodge Primary school.

After careful negotiation with the head teachers and heads of pre-schools within each area, the following work is being developed:

- carrying out assessments of children's mental health where they have been requested by the parents. Schools work closely with families to support their requests for help with children seen by parents or carers as having early signs of mental health problems;
- supporting schools in the early identification of children at risk of developing emotional and behavioural difficulties and in developing programmes to promote psychological well being;
- holding 'drop ins' in schools where parents can come and chat about any issue of child behavioural management with members of the team;
- running parent workshops in primary schools;
- running social growth projects in schools at Key Stage 1. This is a project drawing upon techniques previously piloted in the USA and Birmingham, which aims to improve social skills and competencies and increase psychological resilience in children aged 6 and 7. Four schools in the city are currently engaged in this work, which is being rigorously evaluated; and
- emotional literacy at Key Stage 2. The focus of projects in this age group is to contribute and collaborate in helping pupils achieve a sound psychological foundation for the later introduction for the citizenship curriculum at Key Stages 3 and 4. The skills include: promoting nurturing and caring behaviour; encouraging the emergence of skills of empathy, negotiation, mediation and relationship building; encouraging children to respect, accept and celebrate diversity.

Although the team's focus is on preventive work with children, for those children who have already defined and complex needs, it ensures that there is a co-ordinated response to their needs via the various parent organisations. It can actively dissipate confusion over lines of responsibility between agencies due its multi-agency nature.

Previous to the project, many of the schools in the three areas had been extremely frustrated about the level of need that many of their children were presenting with and their inability to gain appropriate help and support for them. One of the positive impacts that the project has already had is that the teams can offer ‘hands on’ input and support for individual children and their parents, often co-ordinated with interventions developed by the schools. Finally, schools and pre-schools have benefited from training, information and advice on children’s mental health and emotional well-being.

Case Study 12 Excluded Children’s Project – Rochdale

The aim of the project in Rochdale was to develop a multi-agency team to intervene with children under 12 at risk of and experiencing school exclusion. The team is based within the Child and Adolescent Mental Health Services in Rochdale – and comprises a team leader, community psychiatric nurse, two social workers and an educational psychologist.

The ethos of the team is to ensure that those children who have experienced an exclusion from school gain access to a multi-agency assessment of their needs so that an appropriate package of support can be offered to them and their family. The project had initially aimed to work in a preventive way with children at risk of developing mental health problems – however, their experience to date has been that those children who are particularly at risk of exclusion are children with multiple needs, who have often previously been in contact with a range of agencies.

On being alerted to the child’s needs, the project initially contacts the parent/s – in order to ascertain whether they would be willing for their child and themselves to be referred to the project for support. After this, the team assesses the child’s needs. This work is often led within the school by the educational psychologist – who had already established links with schools in the area prior to the project.

The team completes a full social, personal, educational and family history for each referred child. In addition, there are discussions with the school about the child’s reason for exclusion and the behaviour problems. The child is given a simple educational screening to determine whether there is a need for a further more detailed educational assessment.

A meeting is then held with the school, family and other professionals to decide the most appropriate intervention. The options are:

- cognitive behavioural therapy;
- behaviour modification;
- brief family intervention;
- education inputs in targeted areas;
- nurture approaches;
- play therapy;
- counselling;
- social skills training/group;

- experience therapies;
- parent management training.

The project's main focus is to work with the child and family, outside the school environment – offering a range of behavioural and therapeutic interventions in order to help the child and family address their behaviour and underlying causes of this. In addition to this, the team works with the school, helping them further develop their skills and practices in relation to working with the excluded child i.e. – what sorts of supports are available within the school? how is the child's behaviour being managed? This two-pronged approach appears to be being extremely well received by the schools – and by the children and families.

The team has been providing a detailed multi-disciplinary assessment of the children's needs and has been quite successful in reintegrating children in school, enabling behaviour to settle and be managed. The presence of an educational psychologist on the team has meant that statementing issues can be addressed. Social workers have also been able to address wider home issues affecting the children. Health professionals have been helpful in identifying undiagnosed mental health problems like ADHD, which has been assessed in a number of the children enabling them and their parents to receive appropriate support from the CAMHS (Child and Adolescent Mental Health Services) team.

It has been stated that those schools that have worked with the project can see a real gain – they are gaining definite help with managing and supporting pupils with complex needs – and they can see a positive impact through the project on the behaviour of the children. As the project said: 'This multi-disciplinary approach has provided a more holistic assessment of the child's needs, which in the vast majority of cases appears to be successful and the children are functioning better with no further exclusions. We await with interest whether we have made any difference to their mental health.'

Case Study 13

Dudley Local Education Authority

Dudley Local Education Authority runs a counselling service in primary and secondary schools in the Dudley area. A team of professional counsellors, all with teaching qualifications, provides the Counselling service. It consists of eight counsellors who work with around 160 secondary aged pupils and 30 primary pupils at any given time. Counsellors operate within schools, and prioritise referrals for the service in liaison with head teachers, pastoral care staff and special needs co-ordinators. Children and young people enter the counselling relationship voluntarily, after the school has obtained parental permission. Some of the most recurring reasons for referral for counselling include family/separation issues, anxiety/stress, bereavement/loss, peer relationship difficulties and bullying.

In addition to the individual support offered to young people, the counselling service supports staff in the schools by offering annual two day training courses on 'listening skills' and 'listening to children who have been bereaved. The service also provides information and supports to staff around the development of peer support projects, relationship issues within the curriculum and the management of conflict and bullying incidents within the school.

Case Study 14 **Nurse-led Project in Huddersfield**

In Huddersfield NHS Trust, school nurses have developed, with the help of the CAMHS team, an effective method of screening Year 9 pupils’ health needs, which whilst looking at general health needs pays specific attention to emotional and psychological well being.

Year 9 pupils are requested to fill in a health questionnaire, which covers such issues as general health information, alcohol and drug use, emotional and psychological well being, in a quasi exam type setting. The filling in of the questionnaire is a voluntary activity by pupils.

The questionnaire is filled in confidentially, with only the school nurse having access to the names of young people. In addition to filling in the questionnaire, each young person is offered an individual health interview with the school nurse, the basis of which is provided by the information contained within the questionnaire.

Where young people have indicated that they are experiencing difficulties, or where in discussion with the nurse it becomes clear that the young person is experiencing problems, the nurse will provide initial support for the young person, through basic counselling or where appropriate refer them on to the more specialist CAMHS team. Nurses gain access to specialist supervision on a monthly basis with psychologists and Community Psychiatric Nurses.

In addition to the individual work with young people, the questionnaires are analysed on a school basis, to enable each school to have the health needs of the young people profiled. The school can use this profile to inform its PSHE curriculum and other support work that it undertakes.

Case Study 15 **Peer Coping Skills Training**

In such projects, groups of young people who are coping well and young people experiencing behaviour problems are set up. Within the group, young people are taught pro-social coping skills in 22 weekly 50-minute sessions. The teams progress through different skills and levels of difficulty, with new skills being introduced when the group has demonstrated mastery over the previous skill. This format encourages and reinforces peer support. An evaluation of the scheme showed that young people who took part in these schemes were rated by teachers as being less aggressive, and significant improvements were also noted in the young person’s pro-social coping and teacher-rated social skills.

Case Study 16 **Canon Lee Secondary School – York**

A multi-agency initiative to support vulnerable pupils within a secondary school has been developed in the City of York. The project is still at an early stage in its development; however, a range of ways of engaging with young people who might be experiencing mental health problems have been developed. Whole school approaches to promoting the young people’s mental health are being developed through the PSHE curriculum and a peer support programme. Eighteen young people have received training in developing peer support skills from two Educational Psychologists, which has enabled a service for younger

pupils to be launched within the school. A relate-teen counsellor is in school one morning a week to support pupils with concerns surrounding family break-ups.

Through utilising SRB funding, a youth worker has been appointed who works within the school. Two dinner times a week, he and a female colleague make informal contact with the students, which enables him to identify those who might be at risk of experiencing problems. Alongside offering anger-management classes for aggressive students – which have been very well received, he is also able to refer those pupils he thinks are at particular risk to the project co-ordinator for further input.

The project co-ordinator in turn is able to work directly with children experiencing problems at school. This work involves carrying out initial assessments of pupils who have been referred to her by year staff and the youth worker, and after initial liaison work with the child's parents, working with the young person in a 'counselling type approach'. Such an informal approach enables the co-ordinator to build up trust with the young person, and where appropriate to be able to refer them onto more specialist help. Where specialist help is needed, the co-ordinator is able to set up a meeting at the school to bring together the various agencies who might be involved in working with the young person, to ensure that their services are co-ordinated and the school is fully involved in the process.

Case Study 17 **Middlesbrough Hospital Teaching Service**

Middlesbrough LEA's Hospital Teaching Service is an established service, which offers support to children and young people experiencing the full range of clinically defined mental health problems. Within the service the LEA works collaboratively with the local CAMHS to provide education support for both in-patients and community day-patients (out-patients) of the Tees and North-East Yorkshire NHS Trust.

The model of education delivery described below is interwoven with the four-tier structure recommended by the HAS report 'Together We Stand'^{xi}.

The collaboration works in two main ways.

- Medical staff are able to advise the educational specialists on medical matters which impinge on the young person's ability to engage with education. This results in the development of suitable educational support.
- Education team members act in both a consultative and practical capacity, providing information to the health specialists, implementing education programmes and acting as essential liaison between CAMHS and the schools. This link to schools is provided either directly to the pupil, or indirectly through the teacher and parents.

The education provision is as follows:

Tier 1:

At this level, education and training are provided to community professionals, particularly mainstream teachers either through informal contact in relation to individual pupils or through more formal training and support within the school. The range of work that the team are involved in within schools includes:

- observations of children within the school setting – in order to assess children’s needs;
- work with children experiencing difficulties on an individual basis in order to address such issues as behaviour, self-esteem, friendships etc.;
- work with schools on a whole school level around such issues as:
 - children’s development when it differs from that normally expected;
 - ADHD (the team is involved in developing a specific project around the needs of children with ADHD within the school setting);
 - behaviour management; and
 - suicide/self-harm.

Tier 2

At this level, the hospital teaching staff provides individual or group tuition for pupils away from the hospital environment. The emphasis of the work is education, underpinned by a clear understanding of the health needs of the pupils. The education programmes are developed and supervised by specialist teachers, referred to as education case managers, who in turn liaise with the CAMHS referrers.

Tier 3

Within this tier education offers a complex multi-disciplinary approach to a group of patients referred to as Community Day Patients. The education programme has two main purposes:

- to maintain the young person in mainstream school or in appropriate complementary education; and
- to assist in the prevention of admission to Tier 4 provision (in patients).

The specialist teachers in this team are represented on the hospital Multidisciplinary Team and in addition have a specialist teacher permanently attached to the Options Team, which manages the cases of young people who deliberately self-harm.

This specialist team of teachers takes referrals from psychiatrists and other clinicians where there is a strong education element in the young person’s difficulties. The teachers, following consultation with the referrers, develop an appropriate educational intervention for the young person and act as education case managers. They work jointly with health and other professionals such as social workers and LEA personnel to address the special educational needs that may arise from the young person’s mental health problems.

Tier 4

At the tier 4 level, a part of the specialist education team work on the in-patient ward providing ongoing education with a therapeutic approach. The aim is to facilitate the return of the young people to mainstream education when they are ready and to make reintegration as seamless as possible. Follow up support to young people is provided through the community day patient service described in Tier 3.

In discussion with the team, it was felt that the particular strengths of this model include:

- an ability to respond quickly to the young person’s needs within the school setting;

- an understanding of how education works and an increased acceptance by schools as a result of this;
- effective liaison with parents – making parents feel part of the process. This was felt to be particularly important for those parents whose relationship with school had broken down;
- supporting schools to speed up the assessment/early intervention criteria for young people experiencing mental health difficulties;
- being able to support young people through transitional periods, from in-patient settings back into mainstream school;
- being able to remain in contact with young people who are unable to return to mainstream school, in order to provide continuing support and education for this group.

The development of this service has been enhanced recently by focused funding from three main sources additional to normal LEA funding.

- A successful joint bid in 1998 to fund the appointment of a specialist teacher to research the interface between CAMHS and the education services. This post carried a remit to develop information and strategy packs for schools, particularly in relation to the management of children with ADHD. The cost of this post is now shared between Education and CAMHS.
- LEA funding to train a member of the team as a psychotherapist.
- EAS funding for the training of education team members in Drama Therapy.

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Useful further reading

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Young Minds (1996)

Intervening Early. How primary schools can help children get the best from school.
DfEE (in press)

Bright Futures. Promoting children and young people's mental health. Mental Health Foundation (1999)

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