



Department
for Education

Mental health and behaviour in schools

Departmental advice for school staff

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Summary

About this departmental advice

This is advice from the Department for Education. All pupils will benefit from learning and developing in a well ordered school environment that fosters and rewards good behaviour and sanctions poor and disruptive behaviour. Our [behaviour and discipline in schools advice](#) sets out the powers and duties for school staff and approaches they can adopt to manage behaviour in their schools. It also says that schools should consider whether continuing disruptive behaviour might be a result of unmet educational or other needs.

This non-statutory advice clarifies the responsibility of the school, outlines what they can do and how to support a child or young person whose behaviour - whether it is disruptive, withdrawn, anxious, depressed or otherwise - may be related to an unmet mental health need.

Schools say that this is a difficult area. They want to know what the evidence says, share approaches to supporting children at risk of developing mental health problems and be clearer on their own and others' responsibilities

One in ten children and young people aged 5 to 16 have a clinically diagnosed mental health disorder and around one in seven has less severe problems.¹ We have developed this advice and practical tools to help schools promote positive mental health in their pupils and identify and address those with less severe problems at an early stage and build their resilience. This advice will also help schools identify and support pupils with more severe needs and help them make appropriate referrals to specialist agencies such as Child and Adolescent Mental Health Services (CAHMS) where necessary.

Review date

This advice will next be reviewed in October 2014.

Who is this advice for?

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

¹ [Mental Health Problems in Children and Young People](#)

Acknowledgments

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

Key points

- **In order to help their pupils succeed, schools have a role to play in supporting them to be resilient and mentally healthy.** There are a variety of things that schools can do, for all their pupils and for those with particular problems, to offer that support in an effective way.
- **Where severe problems occur schools should expect the child to get support elsewhere as well,** including from medical professionals working in specialist Child and Adolescent Mental Health Services (CAMHS), voluntary organisations and local GPs.
- **Schools should ensure that pupils and their families participate as fully as possible in decisions** and are provided with information and support. The views, wishes and feelings of the pupil and their parents should always be considered.
- **Schools can use the Strengths and Difficulties Questionnaire (SDQ) to help them judge whether individual pupils might be suffering from a diagnosable mental health problem** and involve their parents and the pupil in considering why they behave in certain ways.
- **MindEd, a free online training tool,** is now available to enable school staff to learn more about specific mental health problems. This can help to sign post staff working with children to additional resources where mental health problems have been identified. Counselling MindEd, which is part of MindEd, is also available to support the training and supervision of counselling work with children and young people.
- **There are things that schools can do – including for all their pupils, for those showing early signs of problems and for families exposed to several risk factors – to intervene early and strengthen resilience,** before serious mental health problems occur.
- **Schools can influence the health services that are commissioned locally through their local Health and Wellbeing Board** – Directors of Children’s Services and local Healthwatch are statutory members.
- **There are national organisations offering materials, help and advice. Schools should look at what provision is available locally** to help them promote mental health and intervene early to support pupils experiencing difficulties. Help and information about evidence-based approaches is available from a range of sources (see Annex B).

1. Promoting positive mental health

Factors that put children at risk

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

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

Factors that make children more resilient

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

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

1.4. Research suggests that there is a complex interplay between risk factors in children's lives and promoting their resilience. As social disadvantage and the number of stressful life events accumulate for children or young people, more factors that are protective are needed to act as a counterbalance. The key protective factors, which build resilience to mental health problems, are shown alongside the risk factors in table 1, below.

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

² Brown, E., Khan, L. and Parsonage, M. (2012) [A Chance to Change: Delivering effective parenting programmes to transform lives](#). Centre for Mental Health.

³ Murray, J. J. (2010). Very early predictors of conduct problems and crime: results from a national cohort study. *Journal Of Child Psychology & Psychiatry*, 51(11), 1198-1207.

⁴ Rutter, M. (1985) Resilience in the face of adversity. Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry*. Vol. 147, pp. 598-611

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

	Risk factors	Protective factors
In the child ^{5,6}	<ul style="list-style-type: none"> • Genetic influences • Low IQ and learning disabilities • Specific development delay or neuro-diversity • Communication difficulties • Difficult temperament • Physical illness • Academic failure • Low self-esteem 	<ul style="list-style-type: none"> • Being female (in younger children) • Secure attachment experience • Outgoing temperament as an infant • Good communication skills, sociability • Being a planner and having a belief in control • Humour • Problem solving skills and a positive attitude • Experiences of success and achievement • Faith or spirituality • Capacity to reflect
In the family ^{4,5}	<ul style="list-style-type: none"> • Overt parental conflict including Domestic Violence • Family breakdown (including where children are taken into care or adopted) • Inconsistent or unclear discipline • Hostile or rejecting relationships • Failure to adapt to a child's changing needs • Physical, sexual or emotional abuse • Parental psychiatric illness • Parental criminality, alcoholism or personality disorder • Death and loss – including loss of friendship 	<ul style="list-style-type: none"> • At least one good parent-child relationship (or one supportive adult) • Affection • Clear, consistent discipline • Support for education • Supportive long term relationship or the absence of severe discord

⁵ [Young Minds risk handout](#)

⁶ [Young Minds resilience handout](#)

	Risk factors	Protective factors
In the school	<ul style="list-style-type: none"> • Bullying • Discrimination • Breakdown in or lack of positive friendships • Deviant peer influences • Peer pressure • Poor pupil to teacher relationships 	<ul style="list-style-type: none"> • Clear policies on behaviour and bullying • ‘Open-door’ policy for children to raise problems • A whole-school approach to promoting good mental health • Positive classroom management • A sense of belonging • Positive peer influences
In the community 4,5	<ul style="list-style-type: none"> • Socio-economic disadvantage • Homelessness • Disaster, accidents, war or other overwhelming events • Discrimination • Other significant life events 	<ul style="list-style-type: none"> • Wider supportive network • Good housing • High standard of living • High morale school with positive policies for behaviour, attitudes and anti-bullying • Opportunities for valued social roles • Range of sport/leisure activities

Difficult events that may have an effect on pupils

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

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

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

How schools can promote their pupils' mental health

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

- **a committed senior management team** that sets a culture within the school that values all pupils; allows them to feel a sense of belonging; and makes it possible to talk about problems in a non-stigmatising way;
- **an ethos of setting high expectations of attainment for all pupils with consistently applied support.** This includes clear policies on behaviour and bullying that set out the responsibilities of everyone in the school and the range of acceptable and unacceptable behaviour for children. These should be available and understood clearly by all, and consistently applied by staff ⁷;
- **an effective strategic role for the qualified teacher who acts as the special educational needs co-ordinator (SENCO),** ensuring all adults working in the school understand their responsibilities to children with special educational needs and disabilities (SEND), including pupils whose persistent mental health difficulties mean they need special educational provision. Specifically, the SENCO will ensure colleagues understand how the school identifies and meets pupils' needs, provide advice and support to colleagues as needed and liaise with external SEND professionals as necessary;
- **working with parents and carers as well as with the pupils themselves,** ensuring their opinions and wishes are taken into account and that they are kept fully informed so they can participate in decisions taken about them;
- **continuous professional development for staff** that makes it clear that promoting good mental health is the responsibility of all members of school staff and community, informs them about the early signs of mental health problems, what is and isn't a cause for concern, and what to do if they think they have spotted a developing problem;
- **clear systems and processes to help staff who identify children and young people with possible mental health problems;** providing routes to escalate issues with clear referral and accountability systems. Schools should work closely with other professionals to have a range of support services that can be put in place depending on the identified needs (both within and beyond the school). These should be set out clearly in the school's published SEND policy;

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

- **working with others to provide interventions for pupils with mental health problems that use a graduated approach to inform a clear cycle of support:** an assessment to establish a clear analysis of the pupil's needs; a plan to set out how the pupil will be supported; action to provide that support; and regular reviews to assess the effectiveness of the provision and lead to changes where necessary; and
- **a healthy school approach to promoting the health and wellbeing of all pupils in the school**, with priorities identified and a clear process of 'planning, doing and reviewing' to achieve the desired outcomes.⁸

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

⁸ For more information on a healthy school approach see Healthy Schools content in [The National Archives](#): DfE (2011)

⁹ [Working together to safeguard children](#) safeguarding guidance (DfE, 2013)

Case study 1: Promoting positive mental health

Oakington Manor Primary School uses feedback boxes which allow pupils to share a problem anonymously in the 'bullying box' or something good that another pupil did in the 'praise box'. These are managed by the PSCHE (Personal, Social, Citizenship and Health Education) co-ordinator, who may choose to file some comments and will pass safeguarding concerns on to the relevant staff member to follow-up. This anonymous sharing allows teachers to pick up on common worries and problems which can then be discussed in weekly circle time sessions before they grow into more serious wellbeing or mental health risks. The teacher leads the discussion in a calm and respectful environment which allows the whole class to think together about what is happening without being judgemental or singling out the individuals involved. Reports from the boxes may also lead to referrals to Place2Be or CAMHS as well as other school based interventions such as lunchtime nurture clubs.

The St Marylebone CE School in Westminster makes use of the curriculum throughout the whole school to promote mental health and well-being. Students explore the idea of 'being healthy' and are taught that mental health is as important as physical health. The PSHE curriculum includes the promotion of self-esteem, independence and personal responsibility and looks at topics such as work-life balance, stress management and healthy relationships. The PSHE curriculum is also delivered through off timetable 'well-being days' and a cross curricular week with specific sessions to raise awareness of mental health. Teachers are supported to deliver practical sessions about mental health issues, the importance of sleep and practical relaxation techniques such as Yoga and Boxercise. The school also has a 'thought for the day' in which students are read anecdotes, news items and parables to encourage contemplation on issues of morality and their own personal growth.

2. Identification

Identifying children with possible mental health problems

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

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

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

- **effective use of data** so that changes in pupils' patterns of attainment, attendance or behaviour are noticed and can be acted upon; and
- **an effective pastoral system** so that at least one member of staff (eg. a form tutor or class teacher) knows every pupil well and can spot where bad or unusual behaviour may have a root cause that needs addressing. Where this is the case, the pastoral system or school policies should provide the structure through which staff can escalate the issue and take decisions about what to do next.

Case study 2: monitoring and early identification of problems

Oakington Manor Primary School uses a concern sheet which moves through the school with each year group to identify pupils who are experiencing problems. There are spaces for school staff to comment on literacy, numeracy, social and emotional development, behaviour, and medical concerns about individual children. This ensures that a rounded picture of children at risk of mental health problems is available to staff, which includes all the relevant information to give a complete picture. In addition the Inclusion Manager, Place2Be manager, PSCHE coordinator and medical welfare staff meet as a group every six weeks to discuss and identify individuals/groups of pupils who may be at risk.

St Peter's High School has a Student Support Service (SSS). Any parent or head of year can request a referral to the SSS, and pupils can ask to talk to the SSS staff through their head of year. Students can also be referred to the SSS for mental health support by one of the school's mental health nurses or counsellors. Staff make safeguarding referrals to the SSS who then liaise with outside agencies such as the police and social care. The SSS can take a range of actions to help the young person. It has helped pupils in local authority care, those with social difficulties and some with family difficulties. It has developed varied interventions such as specialised programmes of activities, support for parents, reward schemes and an amended curriculum. In a specific example, a pupil was referred to the SSS for poor behaviour. This improved considerably when they participated in workshops and were better supported by a 'pastoral support plan'.

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

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

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

¹⁰ Full figures and data can be found in the 2004 Office National Statistics report '[Mental Health of Children and young people in Great Britain](#)'

Strengths and Difficulties Questionnaire (SDQ)

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

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

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

2.10. The SDQ is not always the right assessment tool for every pupil in each particular set of circumstances. Some schools prefer the Common Assessment Framework (CAF) for assessing needs and involving other professionals where there is a concern over the pupil's health, development, welfare, behaviour, progress in learning or any other aspect of their wellbeing¹³.

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

¹¹ To find the computerised SDQ within the Youth in Mind website select "UK English" then "Teachers and other education professionals" and then "What, if anything, should I be concerned about?"

¹² For scores relating to the impact of difficulties, the versions of the questionnaire that include an "impact supplement" should be used.

¹³ More information on the CAF form is available in the [Working Together to Safeguard Children guidance](#).

¹⁴ NICE guidance - [Anti-social behaviour and conduct disorders in children and young people: recognition, intervention and management](#)

Special educational needs (SEN)

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

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

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

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

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

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

2.15. Where a school has identified that a pupil needs special educational provision due to their mental health problems, this will comprise of educational or training provision that is additional to or different from that made generally for others of the same age. This means provision that goes beyond the differentiated approaches and learning arrangements normally provided as part of high quality, personalised teaching. It may take the form of additional support from within the setting or require the involvement of specialist staff or support services.

2.16. Schools should identify clear means to support such children. Many schools offer pastoral support, which may include access to counselling sessions to help their pupils

with social, mental or emotional health difficulties. Where more specialist provision is required, schools should have support from local health partners and other organisations. Additionally they will need to be clear when referrals to Child and Adolescent Mental Health Services (CAMHS) are appropriate.

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

Working with local GPs

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

¹⁵ The current [SEN Code of Practice](#) DfE (2001)

[The latest draft of the new SEND Code of Practice, currently under review. DfE \(2014\)](#)

3. Interventions

Strategies to promote positive mental health

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

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

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

¹⁶ Green H., McGinnity A., Meltzer H., Ford and Goodman R. (2005) *Mental Health of Children and Young People in Great Britain*. Basingstoke: Palgrave.

¹⁷ Catalano, R. F., Mazza, J. J., Harachi, T. W., Abbott, R. D., Haggerty, K. P., & Fleming, C. B. (2003). Raising healthy children through enhancing social development in elementary school: Results after 1.5 years. *Journal Of School Psychology*, 41(2), 143-164 in Weare, K. (2011) *Op. cit.*

¹⁸ Weare, K. (2011) [Thinking ahead](#): Why we need to improve children's mental health and wellbeing. Chapter 4: Improving mental health and wellbeing through schools. Pp33.

Personal, social, health and economic (PSHE) education

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

Case study 3: PSHE

Hardenhuish School uses the PSHE curriculum to address many of the issues related to mental health. The school gives a particular focus to issues impacting upon teenage boys which, experience suggests, they are sometimes unwilling to speak up about. The PSHE lessons are also used to explore sensitive topics without making the discussion personal to particular pupils. The topics include rape, self-harm, bereavement, anxiety and the expectations placed upon pupils. PSHE lessons are mixed and seating is organised boy/girl to encourage conversation and the sharing of different perspectives. From these discussions school staff are often able to identify at risk pupils and those identifications are then fed back to the pastoral team for follow-up. The PSHE curriculum is highly regarded by pupils throughout the school as shown through externally verified questionnaires. Ofsted also noted that pupils 'feel safe and can explain in detail issues around their own safety'.

Positive classroom management and small group work

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

Case study 4: Approaches beyond the classroom

Widden Primary School has a 'rainbow room', a small, quiet and calm room where staff can take individual children and small groups to get ready for the school day, talk about concerns and worries or to calm down if something has upset or angered them. All the children are supportive and keen to use it and the school works hard to make sure it is not seen as a time out or naughty room. There is no stigma and all of the children like being made to feel unique. The schools has seen benefits in terms of attendance, well-being and achievement. The new behaviour policy which teaches the values of Friendship, Respect, Excellence and Equality (FREE) has also introduced a FREE room where children can explore issues related to behaviour with the learning mentor or welfare officer. Plans are in place to develop student leadership with house captains leading behaviour based activities in the FREE room.

Ocklynge Junior school runs an 'oasis' facility for children who have additional emotional needs. The Oasis staff run a range of sessions for individuals or groups dealing with a wide range of issues including friendships, conflict resolution, social skills, anger management and family break-up. The team also designs specific sessions for individual needs as and when they arise. As children in this school are often working in groups, or individually away from class on a range of learning activities there is no stigma attached to the children who attend these groups. The Oasis is staffed every afternoon by two specially trained teaching assistants. Children are referred by teachers or support staff to the Oasis and the work is managed by the SENCO. Most of the work the Oasis team do is proactive and planned, and it is not a place where children can choose to go at any time. Occasionally children need time away from class and this is managed by individual needs assistants who may remove them from class to a quiet area where any issues can be resolved.

Counselling

3.6. School-based counselling is one of the most prevalent forms of psychological therapy for young people in the UK. Most secondary schools offer some form of counselling service. These services generally provide one-to-one supportive therapy, with pupils referred through their pastoral care teachers, and attending for three to six sessions. Non-directive supportive therapy¹⁹ is recommended by NICE for mild depression²⁰ and there is emerging evidence to suggest that school-based humanistic counselling²¹ is effective at reducing psychological distress and helping pupils achieve their goals. Both the pupils who use it and school staff believe school-based counselling to be an effective means of improving students' mental health and emotional wellbeing. They also believe it enhances pupils' capacity to study and learn.²² A variety of resources and services are available to assist schools in establishing or developing counselling services, including from the British Association of Counselling and Psychotherapists (BACP) and various national and local voluntary organisations. [BACP](#) also have a Register of Counsellors and Psychotherapists which is accredited by the Department of Health. In addition, in March 2014 the Department of Health and BACP launched [Counselling MindEd](#), a free programme of e-learning modules, to support the training and supervision of counselling work with children and young people.

Child and adolescent psychologist

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

¹⁹ Therapy involving the planned delivery of direct individual contact time with an empathic, concerned and skilled non-specialist...to offer emotional support and problem solving help (without specifically telling the pupil what to do) and to review the child or young person's state (for example, depressive symptoms, school attendance, suicidality, recent social activities) in order to assess whether specialist help is needed.

²⁰ NICE (2005) [Depression in Children and Young People: Identification and Management in Primary, Community and Secondary Care](#), in Clinical Guideline 282005, National Institute for Health and Clinical Excellence: London.

²¹ A family of psychological therapies that place particular emphasis on establishing a warm, understanding relationship with clients such that clients can come to uncover, and express, their true thoughts and feelings.

²² Cooper, M. (2013) School-based counselling in UK Secondary Schools: A review and critical evaluation, Lutterworth: BACP/[Counselling MindEd](#).

Developing social skills

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

Working with parents

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

3.10. Whilst it is good practice to involve parents and families wherever possible, in some circumstances the child or young person may wish not to have their parents involved with any interventions or therapies they are receiving. In these cases schools should be aware that those aged 16 or over are entitled to consent to their own treatment, and their parents cannot overrule this. Children under the age of 16 can consent to their own treatment if it is thought that they have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment. Otherwise, someone with parental responsibility can consent for them²⁴.

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

²⁴ [Consent to treatment – children and teens](#)

Case study 5: Working with parents

Ocklynge Junior School works to engage parents to help support their pupils outside of school so that they are mentally healthy and able to engage with their learning in school. Like many schools they have a parent open evening, but they also have an open door policy making themselves available to parents whenever needed. The school also has a Parent Support Advisor who provides out of school support to pupils and their families with emotional wellbeing issues. The Parent Support Advisor will visit the family in their home, set goals to work towards and plan a programme of intervention. These interventions are not time limited. The school has several experienced staff who are available to meet parents and offer advice on a whole range of issues relating to family life and managing the home. The parent support advisor also runs parenting courses on behaviour management. The courses run once a year and cover the causes of challenging behaviour and strategies for managing and reducing it.

St Gregory's Catholic Science College believes that parental engagement is key to keeping children on track and tackling any behaviour or mental health problems early and effectively. Parents are asked to attend a parental induction meeting in July and the October after their child has joined the school. In July the school helps to ensure parents are able to support their child's transition to secondary school. The meeting in October provides parents with the opportunity to meet their child's form tutor informally. These measures ensure new pupils can 'hit the ground running' when they start in September.

The White Horse Federation and Multi Academy Trust is committed to engaging the 'silent majority' of parents and involving as many as possible in school life. To do this parents are invited to join a parent advisory board who are the "experts" in the school and provide unique insight into the wider community perspective. They are also great informal "playground promoters" of the inclusive ethos that the schools promote in terms of educational and behavioural difficulties. The White Horse Federation also supports parents through a Family Skill Force programme which targets families where there may be behaviour or mental health issues. The programme is non-academic, with activities including sailing and orienteering, and runs for six weeks. It brings families together in a safe and relaxed environment and aims to encourage parents to interact positively with their children to support their needs and ultimately make a sustainable change to their behaviour in and out of school. A real advantage of the programme is that the children are frequently praised by their parents, which is often lacking at home.

Peer mentoring

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

Case study 6: Peer mentoring

Hardenhuish School has a peer mentoring system that involves Year 10 working with Year 12. Pupils are paired according to their subject interest and tend to be of the same sex. The Year 12 mentors are trained by the Intervention Manager. Mentors are expected to meet their Year 10 mentee at least every half term for a face-to-face discussion which may lead to further informal meetings. The aim of the peer mentors is to raise the aspirations of Year 10 pupils and to give them an insight into life in the 6th form. Pupils report social benefits of the mentoring and since introducing the scheme 6th form numbers have increased significantly.

Sir Jonathan North Community College runs a peer mentor programme to support year 7 students in the transition from primary school. During the summer term year 9 students volunteer to become a peer mentor and receive a full day of training. The mentors welcome the year 6 students on transition day and also meet them on their first day at school. This helps the year 7 students to feel at ease and more relaxed about starting secondary school. The mentors run activities in form time one morning each week and conduct one to one meetings under the supervision of an adult learning mentor. Students are supportive of the mentoring scheme and one student commented that “the peer mentors are amazing because they are funny and kind and make me happy to be here”.

Children with more complex problems

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

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

- **family support and/or therapy could also be considered by mental health professionals** – to help the child and their family better understand and manage behaviour.

Case study 7: Supporting children with more complex problems

Hardenhuish School has recruited non-teaching staff, known as pastoral managers, to support pupils with mental health needs prior to, during and after CAMHS's involvement. They are a central contact point for parents, pupils and teachers. The pastoral managers support pupils in a number of ways depending upon the individual. These can include providing daily support, liaising between the pupil and teachers and offering a morning check-in to discuss possible trigger points during the day. Pastoral managers are specifically trained to deal with mental health issues and have the opportunity to attend Mental Health Cluster Group networking meetings. The school also provides a fully qualified counsellor for two days each week to speak with pupils with identified needs and difficulties.

Sir Jonathan North Community College has a pastoral support programme for students who have been supported by pastoral teams but have failed to make sufficient progress. Students are offered a more intensive support programme with a range of interventions that are tailored to meet individual needs and support student achievement. Students may have a learning mentor, counselling or be offered in-class support. Students have a meeting every 6 weeks with their parent/carer to review progress. For example one student was supported through her time at the school with a learning mentor, a personalised learning programme and external support from CAMHS which enabled her to complete her qualifications and progress to a placement at college.

The White Horse Federation and Multi Academy Trust, run by 2 executive heads, comprises seven primary schools and two children centres. The trust has created posts to support vulnerable families, funded therapeutic provision for very needy pupils and created bespoke provision for families and bespoke timetables for children with challenging behaviours

Approaches used by professionals to tackle mental health problems

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

4. Referral and commissioning

Involvement of schools in defining local services

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

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

4.3. Local authority directors of children's services and local Healthwatch²⁵ are statutory members on health and wellbeing boards. They will be critical in promoting the interests of all children and young people, including those with disabilities and SEN. Schools are not statutory members of health and wellbeing boards. It will be for local authorities and health and wellbeing boards themselves to use their discretion in shaping the wider membership in a way that reflects local priorities and encourages meaningful dialogue.

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

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

²⁵ [Local Healthwatch: a strong voice for people – the policy explained](#)

may also reduce inaccurate referrals to CAMHS; provide quick response services and long term planning for the school population.

4.5. More information on the health and wellbeing boards can be found on the Department of Health website²⁶.

Referring serious cases to CAMHS

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

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

- **using a clear process for identifying children in need of further support** (such as the Strengths and Difficulties Questionnaire detailed at section 3);
- **documenting evidence of the symptoms** or behaviour that are causing concern (and including this with the referral);
- **encouraging the pupil and their parents to speak to their GP**, where appropriate;
- **working with local specialist CAMHS to make the referral process as quick and efficient as possible** – for example by being clear who can refer, by ensuring schools have access to the relevant forms and by sharing information about when decisions will be taken and fed back;
- **understanding the criteria that will be used by specialist CAMHS** in determining whether a particular pupil needs their services;
- **having a close working relationship with local specialist CAMHS**, including knowing who to call to discuss a possible referral and allowing pupils to access CAMHS professionals at school – see, for example, Case Study 8); and
- **consulting CAMHS about the most effective things the school can do to support children** whose needs aren't so severe that they require specialist CAMHS.

²⁶ [A short guide to Health and Wellbeing Boards](#)

Schools commissioning services directly

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

4.9. Many individual schools are able to commission individual support and health services for pupils, which gives increased flexibility and provides an early intervention response. Schools therefore need to have a robust commissioning process that ensures that the services they choose are suitably accredited and can demonstrate that they will improve outcomes for their children and young people. Guidance on good commissioning, based on evidence from the DfE funded BOND programme is available online²⁷.

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

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

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

4.13. A selection of contacts available nationally is available at [Annex B](#).

²⁷ BOND consortium '[Learning from best practice review](#)'

Case study 8: Working with partners

Compton School is very successful at engaging organisations beyond the school to support any students who might have emotional and mental health needs. The school has strong links with its local CAMHS and two support programmes (Health and Emotional Wellbeing Service and Barnet Secondary Schools CAMHS Project) are provided in school on alternate weeks for up to six students. The student will be seen every fortnight for a number of sessions depending on the level of need. Depending on the nature of the case alternative routes may be offered; usually the case will be closed or a student can be referred on to specialist CAMHS or other agencies for more intensive work. The school also buys in a counselling service called Catch 22, in which a counsellor sees up to six children a week, providing support for students who have emotional issues which they need to talk through but which may not be at the stage of requiring CAMHS involvement. The Targeted Youth Service is also used by the school, mainly offering support to KS4 students some of whom are at risk of becoming NEET. The school has positive relationships with other local schools and can work collaboratively to share good practice in the management of behaviour and emotional health issues. As a result of their work with the range of external agencies Compton School is able to provide swift and easy access for students and their families enabling them to be happy and successful.

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

Good mental health

5.1. Children who are mentally healthy have the ability to:

- develop psychologically, emotionally, intellectually and spiritually;
- initiate, develop and sustain mutually satisfying personal relationships;
- use and enjoy solitude;
- become aware of others and empathise with them;
- play and learn;
- develop a sense of right and wrong; and
- resolve (face) problems and setbacks and learn from them.²⁸

Mental health problems in children and young people

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

5.3. Mental health professionals have defined these as:

- emotional disorders, e.g. phobias, anxiety states and depression;
- conduct disorders, e.g. stealing, defiance, fire-setting, aggression and anti-social behaviour;
- hyperkinetic disorders e.g. disturbance of activity and attention;
- developmental disorders e.g. delay in acquiring certain skills such as speech, social ability or bladder control, primarily affecting children with autism and those with pervasive developmental 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; and

²⁸ Mental Health Foundation (2002) A bright future for all: promoting mental health in education, London: MHF.

- other mental health problems include eating disorders, habit disorders, post-traumatic stress syndromes; somatic disorders; and psychotic disorders e.g. schizophrenia and manic depressive disorder.²⁹

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

Numbers of children and young people with a mental health problem

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

5.6. Beyond the 10% discussed above, approximately a further 15% have less severe problems that put them at increased risk of developing mental health problems in the future³¹.

²⁹ DfEE (2001) *Promoting Children's Mental Health within Early Years and School Settings*, DfEE.

³⁰ Green et al. (2004) *Mental health of children and young people in Great Britain*, Office of National Statistics

³¹ Brown et al. (2012) *Delivering effective parenting programmes to transform lives* Elena Rosa Brown, Lorraine Khan & Michael Parsonage Centre for mental Health

Annex B – Sources of support and information

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

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

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

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

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

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

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

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

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

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

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

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

Annex C – Main types of mental health needs

6.1. This annex provides a brief description of the main types of mental health needs and summarises which approaches other professionals might use if a mental health problem is diagnosed. The information draws on the evidence collected from the Targeted Mental Health in Schools (TaMHS) project and gives information about the kinds of treatments and approaches that are supported by the evidence reviewed in the new edition of *What Works For Whom? A Critical Review of Treatments for Children and Adolescents*.³²³³

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

³² DCSF (2008) [Targeted Mental Health in Schools Project: Using the evidence to inform your approach, a practical guide for headteachers and commissioners.](#)

³³ Fonagy, P, Cottrell, D, Philips, J., Bevington, D., Glaser, D. E., & Allison, E. (in press). *What Works For Whom? A Critical Review of Treatments for Children and Adolescents* (2nd ed.). New York: Guilford.

Conduct disorders

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

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

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

Intervention for primary school pupils

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

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

³⁴ Brosnan and Carr, 'Adolescent Conduct Problems', in Carr (2000) *What Works with Children and Adolescents*. London: Routledge.

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

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

There is also evidence to support:

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

Intervention for secondary school pupils

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

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

Where particular problems have been identified the strongest evidence supports:

- Working with the family is preferable as therapeutic approaches are most effective when they look at the young person in the context of their family structure and work with all family members, even while intervening in the school. Where this is impossible, individual work focusing on thoughts and behaviour can also be helpful. The more social systems engaged in a

coordinated fashion by the intervention, the more effective the intervention is likely to be;

- For more severe and entrenched problems, a range of tailored, multi component interventions. In multi-systemic therapy, therapists have multiple contacts each week and deliver a range of different evidence-based services according to each family's individual needs. While effective, this approach involves high levels of professional resources; and
- For chronic and enduring problems, specialist foster placement with professional support, within the context of an integrated multi-agency intervention. Multicomponent interventions without integration by an overarching organisational focus and shared set of principles are ineffective.

Anxiety

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

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

Clinical professionals make reference to a number of diagnostic categories:

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

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

³⁵ [Anxiety](#)

³⁶ [Panic disorder](#)

³⁷ [Obsessive compulsive disorder](#)

³⁸ [Anxiety disorders](#)

³⁹ [Separation anxiety](#)

⁴⁰ [Anxiety disorders](#)

⁴¹ [Agoraphobia](#)

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

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

Where particular problems have been identified the strongest evidence supports:

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

There is also evidence to support:

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

Depression

Feeling low or sad is a common feeling for children and adults, and a normal reaction to experiences that are stressful or upsetting. When these feelings dominate and interfere with a person's life, it can become an illness. According to the Royal College of Psychiatrists, depression affects 2% of children under 12 years old, and 5% of teenagers.

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

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

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

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

Where particular problems have been identified the strongest evidence supports:

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

Hyperkinetic disorders

(e.g. disturbance of activity and attention)

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

Attention Deficit Hyperactivity Disorder (ADHD) is a diagnosis used by clinicians. It involves three characteristic types of behaviour – inattention, hyperactivity and impulsivity. Whereas some children show signs of all three types of behaviour (this is called 'combined type' ADHD), other children diagnosed show signs only of inattention or hyperactivity/ impulsiveness.

Hyperkinetic disorder is another diagnosis used by clinicians. It is a more restrictive diagnosis but is broadly similar to severe combined type ADHD, in that signs of inattention, hyperactivity and impulsiveness must all be present. These core symptoms must also have been present before the age of seven, and must be evident in two or more settings.

The strongest evidence supports:

- Use of medication, where ADHD is diagnosed and other reasons for the behaviour have been excluded. These treatments have few side-effects and are effective in 75% of cases when there is no depression or anxiety accompanying ADHD. High doses can be avoided if behavioral treatments accompany medication;
- Introduction of parent education programme and individual behavioural therapy where there is insufficient response to medication. These need to be provided in the school as well as home, as they do not appear to generalise across settings;
- For children also experiencing anxiety, behavioural interventions may be considered alongside medication; and
- For children also presenting with behavioural problems (conduct disorder, Tourette's Syndrome, social communication disorders), appropriate psychosocial treatments may also be considered by medical professionals.

Evidence also supports:

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

Attachment disorders

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

The strongest evidence supports:

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

Evidence also supports:

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

Eating disorders

The most common eating disorders are anorexia nervosa and bulimia nervosa. Eating disorders can emerge when worries about weight begin to dominate a person's life. Someone with anorexia nervosa worries persistently about being fat and eats very little. They lose a lot of weight and if female, their periods may stop. Someone with bulimia nervosa also worries persistently about weight. They alternate between eating very little, and then bingeing. They vomit or take laxatives to control their weight. Both of these eating disorders affect girls and boys but are more common in girls.

The strongest evidence supports:

- The primary aim of intervention is restoration of weight and in many cases inpatient treatment might be necessary;
- For young people with anorexia nervosa, therapeutic work with the family, taking either a structural systemic or behavioural approach may be helpful even when there is family conflict; and
- For young people with bulimia nervosa, individual therapeutic work focusing on cognition and behaviour, for example to change thinking patterns and responses.

Evidence also supports:

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

Substance misuse

Substance misuse can result in physical or emotional harm. It can lead to problems in relationships, at home and at work. In the clinical field, a distinction is made between substance abuse (where use leads to personal harm) and substance dependence (where there is a compulsive pattern of use that takes precedence over other activities). It is important to distinguish between young people who are experimenting with substance and fall into problems, and young people who are at high risk of long-term dependency. This first group will benefit from a brief, recovery oriented programme focusing in cognitions and behaviour to prevent them to move into more serious use. The second group will require ongoing support and assessment, with careful consideration of other concurrent mental health issues.

The strongest evidence supports:

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

Evidence also supports:

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

Deliberate self-harm

Common examples of deliberate self-harm include 'overdosing' (self-poisoning), hitting, cutting or burning oneself, pulling hair or picking skin, or self-strangulation. The clinical definition includes attempted suicide, though some argue that self-harm only includes actions, which are not intended to be fatal. It can also include taking illegal drugs and excessive amounts of alcohol. It can be a coping mechanism, a way of inflicting punishment on oneself and a way of validating the self or influencing others.

The strongest evidence supports:

- Brief interventions engaging the child and involving the family, following a suicide attempt by a child or young person;
- Assessment of the child for psychological disturbance or mental health problems which, if present, should be treated as appropriate. At times, brief hospitalisation may be necessary; and
- Some individual psychodynamic therapies (*Mentalisation Based Treatment*) and behavioral treatments (*Dialectic Behavior Therapy*).

Post-traumatic stress

If a child experiences or witnesses something deeply shocking or disturbing they may have a traumatic stress reaction. This is a normal way of dealing with shocking events and it may affect the way the child thinks, feels and behaves. If these symptoms and behaviours persist, and the child is unable to come to terms with what has happened, then clinicians may make a diagnosis of posttraumatic stress disorder (PTSD).

The strongest evidence supports:

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

The evidence specifically does not support:

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



Department
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