



A REPORT BY THE ALL-PARTY PARLIAMENTARY GROUP
ON A FIT AND HEALTHY CHILDHOOD

CHILDREN'S MENTAL HEALTH BEYOND THE GREEN PAPER: THE ROLE OF PRACTICE BASED EVIDENCE

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This Report was prepared by a Working Group of the All-Party Parliamentary Group on a Fit and Healthy Childhood and we are grateful for the contributions of:

HELEN CLARK	Chair of the Working Group
PHIL ROYAL	APPG Secretariat
HELEN WEST	APPG Secretariat
JEFF THOMAS	Play Therapy UK
MONIKA JEPHCOTT	Play Therapy UK
PROF. JONATHAN GLAZZARD	Leeds Beckett University
SHARON SMITH	The University of Northampton
DR. AMANDA NORMAN	The University of Winchester
DR. DEBORAH ALBON	The University of Roehampton
AGNES JAVOR	Independent Counsellor
DR. STUART W. FLINT	Leeds Beckett University
CATHERINE HUTCHINSON	London Borough of Waltham Forest
PROF. FRANCIS MCGLONE	Liverpool John Moore's University
KATE DAY	Senior Lecturer Child Counselling
PROF. FRASER BROWN	Leeds Beckett University
LORNA LEWIS	British Council for Therapeutic Interventions with Children
KATHRYN SALT MBE	Emotional Education Academic

THE ALL-PARTY PARLIAMENTARY GROUP AND THE WORKING GROUP

The Working Group that produced this Report is a sub-group of the All-Party Parliamentary Group on a Fit and Healthy Childhood.

The purpose of the APPG is to promote evidence-based discussion and produce reports on all aspects of childhood health and wellbeing including obesity; to inform policy decisions and public debate relating to childhood; and to enable communications between interested parties and relevant parliamentarians. Group details are recorded in the Parliamentary website at:

<https://publications.parliament.uk/pa/cm/cmallparty/150929/fit-and-healthy-childhood.htm>

The Working Group is chaired by Helen Clark, a member of the APPG secretariat. Working Group members are volunteers from the APPG membership with an interest in this subject area. Those that have contributed to the work of the Working Group are listed on the previous page.

The report is divided into themed subject chapters with recommendations that we hope will influence active Government policy.

The Officers of the APPG are:

CHAIR

Jim Fitzpatrick MP

CO CHAIR

Baroness (Floella) Benjamin OBE

VICE CHAIRS

Ian Austin MP, Nic Dakin MP, Diana Johnson MP, Lord McColl of Dulwich, Julie Elliott MP Nigel Dodds MP, Dr. Philippa Whitford MP.

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CHILDREN'S MENTAL HEALTH BEYOND THE GREEN PAPER: THE ROLE OF PRACTICE BASED EVIDENCE

INTRODUCTION

In June 2018, the All Party Parliamentary Group on A Fit and Healthy Childhood published *'Mental Health in Childhood'*. This Report included a detailed response to the Green Paper, *'Transforming Children and Young People's Mental Health Provision'* (4th December 2017) and stated that:

'It can, and must be, a foundation for child mental health services that work in the interests of the individual and the wider society of which they are a part.'

The Government's proposals are now it seems, in implementation stage and Chancellor Philip Hammond's Budget Statement of 29th October 2018 contained his announcement that NHS mental health services will receive a £2 billion a year real terms funding boost by 2023. He said:

'There are many pressing demands on additional NHS funding but few more pressing than the needs of those who suffer mental illness and today I can announce that the NHS 10-year plan will include a new mental health crisis service with comprehensive mental health support available in every major A&E, a children and young people's crisis team in every part of the country, more mental health ambulances, more safe havens in the community and a 24-hour mental health crisis hotline':

<https://www.nursingtimes.net/news/politics/budget-hammond-reveals-measures-to-support-mental-health/7026537>

As a component of the Government's avowed aim to achieve parity of esteem between mental and physical health, the cash injection will finance dedicated in-school teams supporting children and young people with mild and moderate mental health problems.

The proposal received a careful welcome with the following caveats:

- The £2bn extra money *'was only half what was needed to put spending more on a par with that of physical health'* (Institute of Public Policy Research):
<https://www.theguardian.com/uk-news/2018/oct/28/mental-health-services-to-get-2bn-funding-boost-in-budget>
- The drivers of poor mental health (have been) left unaddressed *'Poverty, abuse, neglect, unmet needs and exclusion'*, (National Children's Bureau):

<https://www.ncb.org.uk/news-opinion/news-highlights/budget-piecemeal-approach-crisis-will-not-deliver-change>

- There are no plans to make early intervention methods integral to the policy. The Early Intervention Foundation:
<https://www.theguardian.com/society/2018/oct/29/britain-childhood-crisis-politicians-early-intervention-westminster>
- *'While it makes sense to set up closer links between schools, social services and the NHS, around 5,000 mental health nurses have left the health service since 2010, so it's difficult to see how this vision will be realised without a sufficient, well-trained nursing workforce. A&E departments already have significant staffing gaps', (Dame Donna Kinnair, acting Chief Executive and General Secretary of the Royal College of Nursing)*

Prior to the Budget Statement, a National Audit Office Report entitled *'Improving children and young people's mental health services'* October 2018:

<https://www.nao.org.uk/search/sector/children-and-families/type/report/>

had emphasised that there is still much ground to be covered before parity of esteem between physical and mental health services for children and young people will be achieved; there is more to be done around cross sector coherence and coordination and significant data weaknesses are slowing progress.

Meanwhile, those working to support children and young people with mental health challenges might concur with this admission from Dr Marc Bush, Head of Policy with Young Minds:

'Every day we get calls to our helpline from a parent whose children have been waiting months for an appointment with CAMHS or who have been turned down because the thresholds for treatment are so high', 26th June 2018:

<http://www.dailymail.co.uk/health/article-5883515/Children-turned-away-mental-health-care-unless-suicidal-experts-warn.html>

The APPG on A Fit and Healthy Childhood's new Report presents 'practice based evidence' as a child-centred strategy concerning the use of therapies and interventions designed to promote and maintain good mental health. This approach measures what progress is being achieved (not what might be possible) against objectives such as those supplied by the National Audit Office in assessing the delivery of improved mental health services to children and young people as set out in the Green Paper.

It does not entail additional funding streams and includes a method by which to test the accountability and outcomes of spending.

The recommendations as listed below have already been shown to work in practice across a range of real life conditions. Implementation time scales will vary between one and four years and the proposals include:

- A complete revision of what is considered to be 'evidence based practice' taking account of the different 'hierarchies' of evidence required for children's mental health with an emphasis upon practice based evidence and to support the recommendations of the National Audit Office
- More effective coordination of government departments' and agencies' responsibilities by means of a permanent inter-departmental body which will create parity between the Department of Health and Social Care (DHSC) and the Department for Education (DfE). The new body will have a power of co-option
- Recognition of the need to safeguard children by restricting employment to practitioners who are registered through the Professional Standards Authority (PSA) or Health and Social Professions Council (HCPC). Registrant training must include the collection and use of practice based evidence
- An extension of the definition of the Children and Young People's Health Service Data Set (CYPHS) to include all locations that deliver children's mental health services through the Data Co-ordination Board
- The extension of responsibility for the children's mental health workforce development beyond the Department of Health and Social Care (DHSC) to encompass the Department for Education (DfE) and other departments with a demonstrable interest
- A substantial extension of the range of interventions beyond the current limited compass of behavioural family therapy and cognitive behavioural therapy (CBT)
- The alignment of learning objectives with practice based evidence as well as to other forms of evidence based practice and a revision and streamlining of training content and evaluation
- A commissioned authority to ensure the establishment of unified policies and standards for the inspection of children's mental health
- A requirement for the Charity Commission to review its rules for Public Service Delivery to ensure that the delivery of services for children's mental health regular report on the application of funds, the activities and the resulting outcomes are provided
- The weaknesses displayed in consultations upon children's mental health and evidence gathering by government departments must be rectified by a more proactive consultation process with the professional organisations involved in working therapeutically with children. The registrants of these organisations should be co-opted into the communication of policy changes and methods of implementation at local level.

The Green Paper, *'Transforming Children and Young People's Mental Health Provision'* alludes to 'evidence based practice' but the references are neither explained nor developed; therefore having the potential to mislead and confuse the non-expert reader. In this Report, the APPG on A Fit and Healthy Childhood will explain and discuss the essential aspects of implementing practice based evidence interventions; demonstrating that they are both effective and representative of good value for money.

As the draft of this Report was being finalised, it was announced that the percentage of children with diagnosable mental health problems has risen from 9.7% in 1999 and 10.1% in 2004 to 11.2% in 2017. (*Survey commissioned by NHS Digital and undertaken by the National Centre for Social Research, the Office for National Statistics and YouthinMind; published 22nd November 2018.*)

Resultant calls for immediate action have been widely publicised.

'Seven Opportunities, Seven Ways Forward for Government Action' is a strategic approach that has been distilled from this, and previous work from the APPG on A Fit and Healthy Childhood. It is included as a separate briefing document, appended to this Report.

SUMMARY OF RECOMMENDATIONS

1. PRACTICE BASED EVIDENCE: A DEFINITION AND HISTORY:

- 1.1 A parallel hierarch of practice based evidence (PBM) to be established alongside the existing EBM hierarch.

2. THE PRESENT SITUATION IN THE DEVOLVED UK WITH ILLUSTRATIVE EXAMPLES OF GOOD PRACTICE AND SHORTCOMINGS:

- 2.1 The creation of a Non-Cabinet Committee reporting to the Cabinet Office with responsibility for monitoring and advising the inspection and regulatory organisations about the implementation of evidence based children's mental health. A priority is to educate officials responsible for setting policies and standards and ensuring that these are based on the importance of practice based evidence
- 2.2 Full implementation of the recommendations as set out in the National Audit Office Report '*Improving Children and Young People's Mental Health Services*'; provided that clear, quantifiable objectives are then established and progress measured through practice based evidence
- 2.3 The NAO to co-opt individuals with demonstrable expertise and practice in children's and young people's mental health to assist in the implementation of their recommendations
- 2.4 The active involvement of the PSA and HCPC to be sought in setting and applying standards of practice based evidence to those registrants who work therapeutically with children.

3. 'CONTENTIOUS INTERVENTIONS' INCLUDING TOUCH METHODS AND TECHNIQUES, ON-LINE THERAPIES AND SCREEN TIME:

- 3.1 Government to commission and fund research into new therapies (in particular touch therapies) and extensions of play and creative arts. Pilot projects designed to test the outcomes of such research must use practice based evidence and be at all times, sensitive to safeguarding needs
- 3.2 Systems designed to record practice based evidence for consistency must be flexible and accommodating. They will need to consider the qualities that cannot be measured and power of the therapeutic process and relationship and it should be understood that outcome cannot always be quantified in the present yet may have life enhancing and lifelong benefits to the needs

and wellbeing of the child

- 3.3 Practice based evidence must be child-centred and accessible for both the child and practitioner to measure the child's progress throughout counselling. The collection of such data would aim to be flexible and accommodating to the ever-changing needs and desires of the child.

4. PRACTICE BASED EVIDENCE VIEWED IN RELATION TO, AND IN THE CONTEXT OF, OTHER RESEARCH METHODS

- 4.1 Data relating to the adverse effects of medicines to be included in therapists' record management systems
- 4.2 The National Audit Office (NAO) to become the central repository of data related to the costs and outcomes of all research projects funded directly or indirectly by national government
- 4.3 The proposed parallel practice evidence based hierarchies (as above) to be added to the existing evidence based classifications for use by all bodies concerned with the evaluation of the quality of research or children's mental health and commissioning policies
- 4.4 A working party to be convened to agree a set of standards for the development of practice based evidence systems for the interventions for children with mental health and emotional welfare problems. The envisaged time span for this is one year
- 4.5 1% of the national budget for children's mental health care to be devoted to measuring the effectiveness of the funded programmes followed by NAO evaluation.

5. EVIDENCE DISSEMINATION AND AUDIENCE

- 5.1 In evidence dissemination, an integrated 'joined-up' approach is essential, including voices of parents, children and professionals such as mental health practitioners and teachers who work regularly with children themselves
- 5.2 Children's mental health professional organisations are required and supported to provide systems for registrants to gather data for, and use, practice based evidence guidelines
- 5.3 Expansion of The Health and Social Care Regulators' remit to include the dissemination of practice based evidence for children's mental health

- 5.4 The NHS Commissioning Board and Monitor to be expanded to embrace the full spectrum of provision for children's mental health, especially within the education service.

6. CONTRIBUTION TO 'JOINED UP CARE' AND IN RELATION TO CHILDREN WITH ACES, DISABILITY, FROM MIGRANT, REFUGEE, CULTURALLY AND ETHNICALLY DIVERSE AND SOCIOECONOMICALLY DEPRIVED COMMUNITIES

- 6.1 Practice based evidence to be integral to the design of strategies to engage joined-up services in the delivery of mental health and wellbeing support to children and their families belonging to 'difficult to reach' groups (in particular child refugees and migrants)
- 6.2 Training modules for therapists and practitioners in the community and within school to reflect ways in which practice based evidence may be best used and disseminated in the interests of children from difficult to reach groups
- 6.3 The Government to allocate sufficient resources to cover additional training and staffing arrangements and inter agency coordination arrangements as required.

7. INTERNATIONAL PRACTICES AND EXAMPLES

- 7.1 Some of the 2018 Budget Statement money allocated to children's mental health to be used to prepare a Directory of practice based evidence examples from national and international sources to inform ongoing therapy and treatments
- 7.2 Professional training modules and CPD for therapeutic practitioners to include national and international examples of practice based evidence that have been recommended as examples and for use and modelling by Accredited Professional Registers.

8. APPLICATION TO CLINICAL PRACTICE INCLUDING CASE STUDIES

- 8.1 We need to establish clearer terminology, reliable measures and be able to more effectively develop, collect, record, share and use the evidence of what works to improve wellness and wellbeing in promoting and safeguarding the mental health of all children and young people
- 8.2 It is important that examples of practice based evidence that work and are

capable of successful replication are harvested and made use of so that their benefit is not circumscribed by one setting, one group, or one geographical location. The best of practice based evidence excellence must be allowed and enabled to 'travel'.

9. PRACTICE BASED EVIDENCE WITHIN THE CONTEXT OF THE GOVERNMENT'S GREEN PAPER ON MENTAL HEALTH

The Green Paper: Transforming Children and Young People's Mental Health:

- 9.1 The processes of conducting Consultations upon Green Papers is reviewed to provide more effective input from the people involved in implementing the proposals in practice; also taking into account the extent to which opinions are supported by evidence.

The Children and Young People's Improving Access to Psychological Therapies programme (CYP-IAPT) is a 'change' programme for existing services delivering CYP mental health care:

- 9.2 The CYP-IAPT programme to be revisited and aligned with Green Paper aspirations and NICE guidelines to be revised and extended in accordance.

The Children and Young People's Health Services Data Set (CYPHS) provides information about children and young people who are in contact with health services:

- 9.3 Either the CYPHS Data Set definition is extended (in scope of coverage) to include all locations that deliver children's mental health services through the Data Coordination Board, or a group of professional organisations managing Accredited Registers and the HCPC assume this responsibility. The Green Paper is insufficiently specific; failing to acknowledge that this is not a health service responsibility alone
- 9.4 More data items must be included so that the data to manage the *effectiveness* and *efficiency* of these services is improved and guidelines provided for the development of the practitioner's practice.

The workforce for children's mental health falls within the remit of the NHS:

- 9.5 Responsibility for developing the children's mental health workforce must be extended beyond DHSC to include the DfE and other departments with a demonstrable interest. The range of interventions should also be grown substantially beyond the existing limited ones of behavioural family therapy and cognitive behavioural therapy (CBT)

9.6 Learning objectives must be relevant to practice based evidence as well as to other forms of evidence based practice

9.7 Training must include placements providing at least 100 hours of clinical practice and have outcomes measured by an appropriate psychometric questionnaire.

The current inspection regime for mental health services contains significant gaps in the way in which the services are regulated:

9.8 An authority is commissioned to ensure the establishment of unified policies and standards for the inspection of children's mental health

9.9 The Charity Commission should review its rules for Public Service Delivery to ensure that in delivering services for children's mental health, regular reports on the application for funds, the activities and resulting outcomes are provided

9.10 The Gambling Commissions in its regulation of the National Lottery in reviewing applications for funding services related to children's emotional wellbeing as well as mental health should place an emphasis on the application of funds, the activities and the resulting outcomes.

A high quality workforce for children's mental health by means of:

9.11 A training loan scheme; eligibility to include postgraduate level 7 training provided by a university for Play and Creative Arts Therapists

9.12 Therapists to qualify for a PSA Accredited Register or the HCPC posts with a minimum of 100 clinical placement hours, including the collection of practice based evidence

9.13 Trainees to be part time with a course intensity of 50%

9.14 Placement organisations to warrant employment following successful completion of training

9.15 Loan to be repaid on a similar basis to the existing undergraduate scheme (ie a repayment threshold of £25,000).

1. PRACTICE BASED EVIDENCE: A DEFINITION AND HISTORY

It is essential to define three key terms which are frequently used interchangeably (but incorrectly) to distinguish the role of practice based evidence (PBE) from evidence based practice (EBP):

- Efficacy is the potential to achieve a beneficial change, normally identified through original research conducted under 'laboratory' conditions. Efficacy trials determine whether an intervention produces the expected result under ideal circumstances and has been the main direction to date of evidence based practice (EBP)
- Effectiveness is the achievement of satisfactory outcomes within real life conditions and is generally measured via pragmatic observations of the degree of beneficial change under 'real world' clinical settings. This evidence is best achieved through the continuous observations (over a long period of time) characteristic of PBE
- Efficiency is functioning in the best possible manner with the least expenditure of time and effort. It involves comparison of 'inputs' and 'outputs' and includes cost effectiveness. This evidence is best achieved through PBE.

The defining distinction is that being effective is about doing the right things, while being efficient is about doing things in the right way.

Evidence based practice

The history of EBP is distorted by concentrating upon medical rather than social care research and by an emphasis on 'one off' trials as opposed to the continuous recording of results obtained from practitioners. The concept of EBP requires major revision to include practice based evidence (PBE) in order to demonstrate the effectiveness and efficiency of children's mental health practice.

'Evidence based medicine' (EBM) described an approach to medical practice designed to improve decision-making by emphasizing the use of evidence from well structured and conducted research. The assumption underpinning EBM was that only the strongest types of empirical support (from meta-analyses, systematic reviews and randomised controlled trials) yielded strong recommendations, while the recommendations from types perceived to be weaker (case-control studies) were themselves weak.

'EBM' was originally used to describe an approach to teaching the practice of medicine and improving an individual physician's ability to make informed decisions about individual patients/clients. It widened into a method that

emphasised the use of evidence to design guidelines and policies applying to groups of patients/clients and populations. Subsequently called 'evidence based practice' (EBP) it spread (sometimes indiscriminately) to encompass a decision-making approach used today at virtually all levels of health care as well as in other fields.

The multiple tributaries of EBM share an emphasis on the importance of incorporating evidence from formal research in medical policies and decisions, but differ over the extent to which they insist upon good evidence of effectiveness before promulgating guidelines or funding policies; also the feasibility of incorporating individual-level information in decisions. The most effective managers and clinical leaders make choices based upon a broad spectrum of management knowledge instead of a simple reliance upon formal experimental evidence.

Evidence hierarchies

Evidence hierarchies are integral to evidence based medicine (EBM). They reflect the relative authority of various types of biomedical research which create levels of evidence (or methodologies that produce evidence) and have been widely adopted by the National Institute for Health and Care Excellence (NICE). Over 80 separate hierarchies have been proposed for assessing medical evidence and their significant weakness is the omission of any reference to practice based evidence (PBE) which provides data on outcomes achieved in real life practice. The following are highly placed in the table:

- **Randomised control trials:** originally designed for pharmaceutical interventions and currently difficult to reproduce because they seek to exclude all variables other than the intervention and condition they wish to treat
Systematic reviews: designed to provide an exhaustive summary of current evidence relevant to a research question. Systematic reviews of randomised controlled trials are deemed key to the practice of EBM and a review of existing studies is often quicker and cheaper than undertaking new work
- **Meta-analysis:** a statistical analysis combining the results of multiple scientific studies; mainly RCTs. A good meta-analysis cannot correct poor design and/or bias in the original studies and the most severe inherent fault often occurs when the individuals responsible for delivery have an ulterior economic, social or political agenda determining the selection or rejection of particular bodies of research. The authors of research selected for meta-analysis may be personally biased or financially contracted to produce findings supportive of their overall political/socioeconomic goals; choosing

for example, small, favourable data sets and ignoring larger, unprepossessing samples.

Practice based evidence (PBE) includes all outcomes received from a broad range of practitioners thus surmounting the perceived weaknesses of RCTs and meta-analyses.

Efficacy studies

Efficacy studies are tightly controlled and methodological: the psychotherapy scrutinised is used with one patient/client group while other *control* groups are either not treated or receive credible placebos. Selected participants must demonstrate a particular disorder and those with multiple disorders are usually excluded.

Participant therapists act strictly in accordance with predetermined, continuing guidance and patients/clients are seen for a relatively few number of sessions. The evaluating diagnosticians are *blind* as to which group a participating patient/client belongs. The evaluation of an efficacy study continues for some time after the conclusion of the therapy; thus increasing financial and time costs.

Effectiveness studies

By contrast, effectiveness studies consider the benefit that 'actual' patients/clients derive from 'real-life' therapy. Those who have begun (or possibly completed) therapy are surveyed by researchers and questioned intensively about their treatment and its effectiveness. The researchers can neither dictate the ways in which the therapy is performed nor select which patients/clients undergo particular therapy types or which therapist a patient/client sees. There are no baseline control groups and no placebo therapies. Multiple-disorder patients/clients cannot be excluded and the therapy occurs with neither therapist nor patient/client knowing that they will be part of a study.

A substantial revision of the specification and application of EBP and the evidence hierarchies is now imperative. Children's mental health lies within the remit of Social Care and Education as well as Health and methods of producing evidence must therefore be extended and adjusted in accordance.

Recommendations:

- 1.1 A parallel hierarch of practice based evidence (PBM) to be established alongside the existing EBM hierarch.

2. THE PRESENT SITUATION IN THE DEVOLVED UK WITH ILLUSTRATIVE EXAMPLES OF GOOD PRACTICE AND SHORTCOMINGS

Twinned shortcomings in the delivery of therapeutic support to children are characterised by a lack of clarity about a definition of 'evidence based' and the composition of the current workforce. Professional organisations that are specifically concerned with children's mental health have Professional Standards Authority (PSA) accredited registers and require their members to have undergone training at postgraduate level validated by a UK university. The Green Paper provides no specification about the nature of an evidence base for children's mental health, leaving the term open to interpretation by practitioners who may themselves be insufficiently trained and regulated. At worst, 'evidence' can be a handful of case studies that might show some degree of efficacy (defined above) but no proof that the outcomes are capable of large-scale reproduction in real life practice.

At present, the greatest credence in evidence based guidelines is given to findings arising from highly controlled trials; ideally by random assignment (but in fact made more artificial or unrepresentative by whatever control methods are used). Such processes are ineffective in respect of the large number of variables, the great variability within them, and the diverse circumstances of public health practice.

Lorna Lewis, Chair of the British Council for Therapeutic Interventions with Children (BCTIWC) warns of:

'The dangers posed by people claiming that they are Play Therapists after taking on-line courses or other CPD (Continual Professional Development) courses that do not meet the standards of an Accredited Register. The people writing and directing them have no way of establishing if the person is fit for practice both before the course and after completion.....Often there is no monitoring of work done post qualification. There is not only the risk of unsafe practice but also the waste of public funds through ineffective work and also the learning objectives are not derived from practice based evidence.'

It is essential that services designed to address children's mental health and wellbeing are regulated scrupulously. The relevant regulatory organisations are:

- Department for Education: the main service delivery channel for children's and young people's mental health; providing an accessible, non-stigmatising environment for therapy and point of contact with family members. About 3000 primary schools (out of a total of 20,925) currently supply therapeutic support for their pupils to the standards necessary

- Department of Health and Social Care: DHSC provides strategic leadership for public health, the NHS and social care in England. Locally organised Child and Adolescent Mental Health Services (CAMHS) are NHS-provided services for children (generally until school leaving age) who are experiencing emotional or behavioural wellbeing difficulties
- NICE: the National Institute for Health and Care Excellence (an executive non-departmental public body of the UK Department of Health and Social Care) publishes clinical practice guidelines mainly based on random controlled trials and meta-analyses with little use of practice based evidence.

Agencies with responsibility for inspection and enforcement of standards and policies are:

- Ofsted: the Office for Standards in Education, Children's Services and Skills is a non-ministerial UK government department reporting to Parliament. It is responsible for inspecting a range of educational institutions; also childcare, adoption and fostering agencies and initial teacher training. Ofsted regulates a range of early years' and children's social care services. The DfE normally sets inspection standards
- Professional Standards Authority: the PSA bears responsibility for public protection via working with the organisations that register and regulate health and social care workers. It focuses on individual practitioner performance and activity as managed by statutory regulators the HCPC (Health and Care Professions Council) and Accredited Registers
- Care Quality Commission: the CQC monitors, inspects and regulates services ensuring that they meet fundamental quality and safety standards including both community and inpatient mental health services. CQC focuses upon the performance of organisations
- National Audit Office: the NAO (an independent UK parliamentary body) audits central government departments, government agencies and non-departmental public bodies, conducting Value for Money (VFM) audit into the administration of public policy
- The National Lottery Organisation: the NLO was assimilated by the Gambling Commission (an executive non-departmental government public body) in 2013. It influences a significant proportion of children's mental health services that are delivered by charitable voluntary organisations and dependent upon lottery funding and donations.

The National Audit Office Report '*Improving children and young people's mental health services*', (9th October 2018) contains explicit and implicit criticism of the lack of evidence available to identify whether the Government is on track to meet its ambition for improving mental health services for children and young people.

Present day issues influencing the mental health of children and young people
Children and young people's mental health and wellbeing are influenced continuously in today's society. From an early age, they encounter idealised images of body shape and size, attractiveness and perceived 'success' that are assiduously promoted via traditional and social media. Appearance-related concerns are reinforced by the current climate and in many instances, children encounter instances of stigma and discrimination which could affect their later life chances. Developing resilience in children was deemed a key priority by the Department for Education (DfE) in 2014, but successful resilience interventions must be context specific and there remains a tangible lack of research-informed and conclusively evaluated resilience programmes for UK children.

Examples of poor practice

The foremost cause of poor practice (apart from over-reliance on RCTs) is the failure to distinguish between knowledge and evidence bases.

'Knowledge base' as a term (originally described as representing facts about the world) has developed with the rise of internet documents, hypertext and multimedia. It has been used to distinguish from the more widely used and known term, 'database'. Knowledge management systems serve as a repository of manuals, procedures, policies, best practice etc contained in books, journals, dissertations and academic papers; describing a small number of cases and using a variety of interventions and different measuring tools. Knowledge bases are sometimes coupled with an inference engine to deduce new facts or highlight inconsistencies.

The PSA requires a knowledge base for a profession seeking to manage an Accredited Register. However, the problem is that a knowledge base is not linked to full scale real life practice and therefore does not demonstrate what works consistently for children's and young people's mental health and wellbeing.

Alternatively, practice based evidence based design and development decisions are made after reviewing information from repeated rigorous data gathering exercises instead of relying on rules, single observations or custom. Using an evidence based approach to social as well as health policy has the potential to decrease the tendency to run programmes which are socially acceptable (eg drug education in schools) but which are often proved to be ineffective when evaluated.

For example, a Play Therapy Outcome Research Database published online by a US organisation:

<http://evidencebasedchildtherapy.com/news/welcome-to-the-home-of-the-play-therapy-outcome-research-database/>

is entitled Evidence Based Child Therapy. The stated objective is to provide *'an interactive, sortable database of treatment outcome research which can serve as a useful source of information regarding the evidence base for play therapy's effectiveness.'*

The content is preponderantly RCT, meta-analyses or case studies which demonstrate efficacy but not effectiveness. It is therefore a good knowledge base but not an evidence base.

Examples of good practice

Some schools in the London Borough of Waltham Forest have in place proactive strategies designed to *'ensure that students had access to the support they needed early on'*, (Catherine Hutchinson, Public Health Strategist and Public Health Nutritionist).

The Early Help Hub at Chingford Foundation School is a Safeguarding First Line Assessment Service where cases with life-threatening risk are identified, treated and referred on. The school also has a Mental Health & Wellbeing First Aid Triage Service providing assessment and first stage treatment plans for a broad spectrum of psychiatric problems. Many are life-threatening major traumatic cases; others (whilst not immediately life-threatening) require intensive daily care in the Hub.

It provides:

A Safeguarding First Line Assessment Service

- To identify risk
- To recognise warning signs of risk
- To assess, manage, raise awareness of safety and under Section 47 of The Children's Act 1989
- Report cases in circumstances of risk, abuse and neglect; of which some may be at life-threatening risk; eg family physical or sexual abuse and require immediate action and referral
- Prioritisation of cases based on risk.

A Mental Health & Wellbeing First Aid Triage Service

- To assess need
- To provide initial treatment for a broad spectrum of psychiatric problems; some major trauma cases may be life-threatening eg with suicidal ideation and suicidal plans or harm to others and require immediate action
- Prioritisation of cases based on level of need

- Some minor cases complete treatment in the School Early Help Hub
- Others with serious conditions referred to Borough Tier 3 or Tier 4 Provisions
- Cases which exhibit signs of being seriously mentally ill, but not in immediate danger of life, triaged to 'acute/intensive care' and treated daily during registration time in school
- Combining Individual Therapy, Cognitive Behavioural Therapy, Family Therapy/Mediation, Solution Focused Brief Therapy, Mindfulness through Art Therapy, Restorative & Mental Health First Aid.

The Peer Listening Club

To support the work of the Early Help Hub and counteract rising levels of vulnerability and poor mental health among young people, Chingford Foundation School developed a Peer Listening Service in order to afford early access support to all students. 12 students and 6 support staff completed an intensive training programme. The Service went live on 16th April 2018 with 3 student/staff teams currently offering a drop-in service on Monday, Tuesday and Wednesday lunch times, having relinquished their own free time to help others. Some team members patrol playing areas wearing high visibility vests; others work from the Wellbeing room so that students can pop in for a chat. The Marketing Team has designed posters and brochures containing self-referral forms for students who may also wish to make advance appointments.

Outcomes include:

- Raised awareness of the proposed project in school assemblies, known as The Listening Club; gauging interest in the types of problems that students might be willing/likely to bring to the Service
- Developed Training Programme for staff and students
- 25 students and 8 Support Staff recruited and trained to form a Wellbeing Team

(Acknowledgements: Kay Hall, Safeguarding Lead, Early Help Child Protection Officer, Sharon Goldstone, Deputy Safeguarding Leader, Early Help Mental Health & Wellbeing Officer, Chingford Foundation School, Waltham Forest).

Youth Health Champions

For the past three years, The Youth Health Champion (YHC) programme for secondary schools has been commissioned by Waltham Forest Public Health. The programme recognises the power of peer influences in shaping health behaviour

and arose in response to a school health survey that found 90% of Waltham Forest Secondary pupils surveyed replied 'yes' to the question:

'Do you think it's a good idea to train students in your year groups to become young health advisers so that they can give other students advice about staying healthy?'

The Youth Health Champion model is designed to give young people the skills, knowledge and confidence to act as peer mentors, increasing awareness of healthy lifestyles and encouraging involvement in activities to promote good health.

Young people from age 14 undertake either a Royal Society of Public Health Level 1 or Level 2 Certificate for Youth Health Champions (the equivalent of a GCSE). It consists of four modules:

- Basic understanding of the key determinants of health
- Research task about the health facilities available in their own community
- Practice at delivering health messages to peers
- One specialist module to deepen understanding of a specific aspect of health.

The young people then offer peer support to others by providing:

- Confidential signposting to specialist health professionals
- Raising awareness of health issues
- Delivery of health promotion campaigns
- Acting as healthy role models in their communities.

School support for the team necessitates a YHC School coordinator who (after initial training) is required for approximately one hour per week to support the programme internally. The Royal Society for Public Health Young Health Movement provides a national hub for Youth Health Champion programmes.

Youth Health Champions are not expected to supply direct health advice or offer one on one support counselling. They are required to act as sign-posters or links between students and other health professionals and services. The programme has to date trained 215 young people to become YHCs and in 2017 their reach was estimated at 10,000 individuals, achieved via campaigning, peer support activities and social media. Waltham Forest Public Health is also leading a project in schools tackling Violence against Women and Girls. The focus by young people (facilitated by the YHC programme) showed the growing awareness of mental ill health and the need for support. Programme evaluation has found that students in the schools are more aware of the YHCs and realise that they are knowledgeable and

can be approached confidentially. Knowledge about mental health has increased and feedback has been overwhelmingly positive for staff and students involved in YHC events. Health has become a higher profile priority in the schools and has contributed to a Whole School Approach. Some schools have linked with health services and with their local communities which has strengthened these and the support available.

(Acknowledgements: Waltham Forest Youth Health Champion schools; Alix Sheppard Health Talks Ltd).

The Waltham Forest model is a comprehensive current example of good practice that could be used to inform strategy in the area of children's and young people's mental health and wellbeing but may be circumscribed by borough boundaries while the prevailing ethos is that:

'If it isn't proven via an RCT (randomised controlled trial) it should never be done', (Anne K Swisher, PT, PhD, CCS, Professor and Director of Scholarship Development; Chief Division of Physical; Therapy West Virginia University).

Observing that most of the 'evidence' in evidence based practice is 'not very practice-based', Professor Swisher then advises that:

'Rather than more EBP, what we really need is what has been called PBE – practice based evidence. High quality scientific evidence that is developed, refined and implemented first in a variety of real-world settings.' (Anne Swisher, as above).

Recommendations

- 2.1 The creation of a Non-Cabinet Committee reporting to the Cabinet Office with responsibility for monitoring and advising the inspection and regulatory organisations about the implementation of evidence based children's mental health. A priority is to educate officials responsible for setting policies and standards and ensuring that these are based on the importance of practice based evidence
- 2.2 Full implementation of the recommendations as set out in the National Audit Office Report '*Improving Children and Young People's Mental Health Services*'; provided that clear, quantifiable objectives are then established and progress measured through practice based evidence
- 2.3 The NAO to co-opt individuals with demonstrable expertise and practice in children's and young people's mental health to assist in the implementation of their recommendations

- 2.4 The active involvement of the PSA and HCPC to be sought in setting and applying standards of practice based evidence to those registrants who work therapeutically with children.

3. 'CONTENTIOUS INTERVENTIONS' INCLUDING TOUCH METHODS AND TECHNIQUES, ON-LINE THERAPIES AND SCREEN TIME

It is widely recognised that children and young people face an unprecedented mental health crisis and need urgent help that (for a variety of reasons) many do not receive. There is therefore considerable and ongoing debate about the nature of appropriate sources of help and provision.

'Mental Health in Childhood':

https://royalpa.files.wordpress.com/2018/06/mh_report_june2018.pdf

published by the APPG on A Fit and Healthy Childhood, noted that the credentials of counsellors and therapists employed or contracted by schools can be checked against the professional registers: Professional Standards Authority Accredited Register:

<https://www.professionalstandards.org.uk/what-we-do/accredited-registers>

and Health Care Professions Council:

<http://www.hcpc-uk.co.uk/>

However, large-scale cuts to school budgets (documented by amongst others, the Save Our Schools campaign):

<https://saveourschools.uk>

mean that in practice, the first savings that many schools are forced to make have required the reduction or closure of counselling and therapy services. The Green Paper specified that Designated Senior Leads for children's and young people's mental health be identified within schools and trained to direct new Mental Health Support Teams. The October 2018 Budget Statement allocated an additional £2bn to mental health services but the following issues remain outstanding:

- The type, content and affordability of training for the new Leads
- Whether the new responsibilities will be 'stand alone' or appended to the specifications of other posts
- Whether schools' requirement to appoint a Lead will be statutory.

The content of therapeutic/counselling sessions is itself contentious.

Senior Lecturer Kate R Day (*The National Counselling Society Ambassador, November 2018*) cites feedback from young people that she has worked with (and

counsellors that she has trained) recording increased disillusionment with the amount of time devoted to form-filling procedures in the CAMHS data-led services. Common examples of dissatisfaction include 'not being listened to' and being unable to make an attachment with the practitioner which is often in polarity to their experience of counselling. The CAMHS practitioners are required to focus on questionnaires, or 'tick box' forms which often define the organisational outcomes and expectations of the sessions. A crucial component of bonding and attachment is the maintenance of eye contact; considered essential to the reparative nature of the counselling and the therapeutic relationship. The National Counselling Society Codes of Practice endorse that initial reviewing and concluding evaluating paper work in terms of contracting and assessment demonstrate both ethical and good practice and should be undertaken by all counsellors practising with children and young people. However, the essence of 'assessment' and the measurement of outcomes should neither dominate the session nor interfere with the child's freedom to express themselves without evaluation.

Children and young people who have experienced Adverse Childhood Experiences (ACEs) and those struggling to maintain stability, need a consistent model. It can be supplied through counselling and play therapy as the child and practitioner form a 'Reparative/Developmentally Needed' therapeutic relationship:

'The reparative/developmentally needed relationship is an intentional provision by the therapist of a corrective, reparative, or replenishing relationship or action where the original attachment was deficient, abusive or over-protective.' Petruska Clarkson, 1994, 'The Therapeutic Relationship'.

The significance of the relationship in therapy to a child's progress and mental wellbeing is paramount. The benefits and maintenance of a consistent, committed and healing 'significant other' in therapy can enable the child (especially where positive attachments have been deficient) to navigate not only relational complexities but life long attachments.

It is arguable that the significance of the relationship can be maintained by means of online forums and counselling forums. Such sites are very accessible and can provide support to many children and young people who are experiencing emotional and mental health issues. They can also function as sources of early help; supplying some of the gaps in youth and community services. However, online services should not be seen as a replacement (or cheaper alternative) to 'one-on-one' therapy.

'Whilst the benefits of online services should be welcomed, they should not supersede the work that lies in the healing space between a therapist and child in the presence of the counselling room.' Kate R Day, 2018.

A crucial component of progress in the therapeutic counselling of a child is the expertise of the counsellor/play therapist and their modelling of an attachment that is 'consistent' and 'physically present'. By providing this attachment model in school, the child or young person must physically attend their own session and can then begin to recognise and learn the commitment and energy required to build healthy attachments and develop resilience. Online services are very accessible, but in comparison to the physical presence of a counsellor or play therapist, forming an attachment to a single, consistent figure can be harder. The young person's commitment to the process may waver and they can choose to disengage more easily due to the very nature of social media.

Within the wider context of educational services, teachers who have been trained to teach by screen will be reluctant to reduce their reliance upon them. If however, they are encouraged to sign up to a relational pedagogy model they will need to invest time and energy into developing and nurturing positive and interactive human relationships with their pupils across the educational spectrum.

There is a distinct difference between online and in person interaction. School-placed mental health services allow children the opportunity to access counselling/therapy for themselves (*Gillick Principles, 1994*). In-house counselling/play therapy can help them to develop a relationship with the counsellor that is independent of family, school and peers and explore and express the differing relationship dynamics that impact their emotional worlds. A face-to-face counselling/play therapy base in school (or similar organisation) offers a safe 'holding space' apart from everyday life so that feelings may be shared more freely. Children who access online counselling services from their bedrooms will encounter a 'virtual' screen human rather than derive benefit from a real life therapeutic relationship characterised by a crucial attachment and bonding process that cannot be compromised by a 'virtual' equivalent.

Interventions involving appropriate play therapies for children are important and a set of competencies and learning objectives has been developed by Play Therapy UK (PTUK). Ongoing research both in Sweden and the UK (*Professor Francis McGlone*):

<https://somaffect.org>

shows that many of the mental health problems experienced by children and young people have their genesis in the early days and months of a new life. The use of appropriate touch for infants (through, for example, baby massage) is now considered to be an essential component of the development of secure

attachment. Researchers have identified a touch system of nerves; called c-tactile afferents (CT) which are to be found in the skin of all social mammals and when stimulated, these encourage social bonding.

Anthropological studies have provided suggestive evidence of the calming effect of extensive close contact (inspiring the so-called 'baby wearing' movement and 'kangaroo mother care') and skin to skin contact for premature babies has been shown to have very beneficial effects in respect of infant health and development. Further circumstantial evidence for the potential importance of CTs comes from neonatal intensive care units where early mother/infant touch is, perforce, limited.

The more that is discovered about CTs, the clearer their importance in neuro developmental processes becomes – and hence the value of regular physical contact between infant and parents and carers. However, advocating strategy, practice and pilot projects consequent upon this understanding must be balanced with the equal importance of child safeguarding.

In respect of all interventions, care must be taken in application. The use of some objects (for example, in sand tray/sand worlds and art constructions) which have been traditionally considered to be intrinsic to a Play Therapist's 'toolkit' can be contentious. The most common objection is to the use of toy guns; in other cases, replicas of particular animals and religious symbols can cause offence to families. Therapists must be trained to be sensitive to these issues; weighing genuine concerns with the children's need to express their emotions with the minimum of necessary constraints.

Recommendations

- 3.1 Government to commission and fund research into new therapies (in particular touch therapies) and extensions of play and creative arts. Pilot projects designed to test the outcomes of such research must use practice based evidence and be at all times, sensitive to safeguarding needs
- 3.2 Systems designed to record practice based evidence for consistency must be flexible and accommodating. They will need to consider the qualities that cannot be measured and power of the therapeutic process and relationship and it should be understood that outcome cannot always be quantified in the present yet may have life enhancing and lifelong benefits to the needs and wellbeing of the child
- 3.3 Practice based evidence must be child-centred and accessible for both the child and practitioner to measure the child's progress throughout counselling. The collection of such data would aim to be flexible and

accommodating to the ever-changing needs and desires of the child.

4. PRACTICE BASED EVIDENCE VIEWED IN RELATION TO, AND IN THE CONTEXT OF, OTHER RESEARCH METHODS

The development of evidence based practice for the provision of children's mental health services has stalled because it has largely ignored practice based evidence.

When following evidence based working approach, practitioners operate according to commonly held basic principles, but 'systems strategies' are insufficiently flexible when used in planning individual sessions and reacting to children's behaviour during the course of them. Also, most of the readily available evidence is not very practice based.

Effectiveness assessment must include patients/clients who reflect external population diversity; the full spectrum of the human population, the presence in the patient/client of one or more additional diseases, variable rates of compliance and the use of other medications and therapies. External validity will be limited unless study protocols reflect clinical practice. Pharmaceutical efficacy trials are required for the purpose of obtaining approval and investigators' design study durations and treatment modalities to prove an effect and ensure safety. The trial time span may not equate to that of therapy in daily practice. In addition, trials may be reliant upon strict diagnostic criteria that are not usually employed in primary care settings. (In effectiveness research, modalities are reflective of clinical relevance; i.e. number of sessions as opposed to dose designs.)

The evaluation of treatment risk/benefit entails undertaking objective assessments of adverse effects caused by medicines over an appropriate timescale. Random Control Trial (RCT) reporting procedures are often limited and adverse assessment methods poor. Investigators rarely employ objective adverse event scales and to date, this area has also been neglected by practice based evidence. A vigilant approach should therefore be intrinsic to assessment. More data are needed in general so that the relative advantages and disadvantages of psychological therapies and pharmaceuticals may be compared.

A study's capacity to identify a statistically significant difference is primarily dependent upon sample size. Large, simple data sets with few levels of analysis provide an ideal study design to detect small but clinically significant treatment effects. Samples should be of sufficient size to detect a difference that is at least minimally important on a health-related quality of life scale.

Two situations are relevant to the analysis of children's mental health:

1. The overall effectiveness of the intervention for the total child population. This is rarely problematic when practice based evidence derives from all practitioners nationwide. The case number quickly rises to over 1000; more than adequate for statistical strength
2. Sub-sets of data. The more selection criteria used, the smaller the resultant sample size will be. For example:
 - *All girls = 6209 measures – highly reliable*
 - *Girls aged 9 referred for ADHD – 132 records – not so reliable.*

Paradoxically, conclusions deriving from sub-sets of data are often more 'useful' because of their specificity, but less 'reliable' - particularly in the early stages of a data collection programme.

The primary goal of an efficacy trial is the determination of whether or not a treatment works under ideal circumstances. These require the minimization of factors capable of altering the effect of a treatment and therefore, patients/clients with protocol deviations are frequently excluded during statistical analyses in efficacy. Yet factors in clinical practice such as compliance, adverse effects, drug regimens, co-morbidities, concomitant treatment or costs can all alter efficacy. A 'completers only' analysis would not take these factors sufficiently into account.

Practice based evidence is drawn from the practitioner's records of:

- Patients/clients that they are seeing
- Patient/client attributes and environmental factors
- Therapy objectives
- Session content
- Results produced at milestones in the therapy process.

Data concerning the therapist's attributes, costs and service delivery channel are also available. Unlike the trial process, data is collected continuously over the course of the therapist's career and is capable of analysis by any time period: a year, month, school term, funding period or management regime.

Efficacy and effectiveness are points on a spectrum and whilst advocating practice based evidence as the main way forward in demonstrating the effectiveness of treating children's mental health issues, trials should retain an important role in identifying new methods and interventions. Proposed solutions to the reproducibility crisis (at present impacting the credibility of trials) are also important in the collection and use of practice based data in order to avoid the mistakes of the current evidence based model and include:

Remove/reduce questionable research practices (QRPS):-

1. These typically involve the exclusion of data that do not comply with a theoretical hypothesis. For example: selective reporting of (dependent) variables; selective removal of outliers to produce a significant outcome; immediately concluding data collection after the demonstration of a significant result; too many conditions included in a research design.

Practice based evidence must include data from all patients/clients where the specified model is being used:-

2. Report studies that did not work. Studies that do not demonstrate a planned effect must be reported; otherwise the published evidence will give an overly positive picture of the robustness of a phenomenon and inflate the size of effects. This is a familiar problem with reviews based on meta-analysis.

Published practice based evidence can include all cases with good or bad results that are relevant to a report or analysis:-

3. Conduct studies with high statistical power (the likelihood that a test will be able to detect an effect) because the main reason for failed trial studies is 'low power'. The sample size determines the amount of sampling error inherent in a test result and effects are harder to detect in smaller samples. Increasing sample size is often the easiest method of boosting the statistical power of a test.

Practice based evidence provides large data sets (such as the 49,000 outcome measures gathered by Play Therapy UK).

Review the use of statistical methods

Larger sample sizes than those used in the original study are often needed to improve the quality of replications and practice based evidence should be based on a sufficient number of cases to meet this criterion. Additionally, using the *R Index* (to interpret ranking data) and *Bayesian statistical methods* (to compute and update probabilities after obtaining new data) are recommended. Also, to be explored in the analysis of practice based evidence data which has the advantage of considerable prior (eg annual) data.

Key Considerations:

Caseness: whether or not a referred child has a condition that requires the therapy that has been prescribed. This is an important component of efficiency that can only be measured through an analysis of patient/client data. The therapist explores this data further through reference to the parents' referrers' and child's own wishes and objectives which may not have been disclosed by the psychometric test. On a practical level, therapists who are thus equipped can avoid waste of their resources.

Data collection methods: A Practice Research Network (PRN) consists of a group of community based clinicians who collaborate on data collection for research purposes. The main disadvantage is that it is dependent upon participants volunteering to devote their time to data collection and recording. A bias may be introduced; simply through the volunteers' motivation to join a network. An alternative approach (currently being used in the UK and other countries) is to add the collection of practice based evidence to the daily routine of all practitioners. This is best set up and managed by a professional organisation thereby creating its own PRN. A professional organisation whose register is accredited by the Professional Standards Authority (PSA) has governance of all therapists fit for practice (unlike a service provider who only has a sub-set).

Criteria for an improved approach: These are based on ways in which to resolve the above issues and others that may impede the implementation of an improved evidence base. They largely derive from the past 12 years' development work by Play Therapy UK (PTUK). Each Accredited Register (AR) will have different requirements to match their therapy models and starting points, but an overall framework is needed to guarantee sufficient comparability.

Relevant data: The data must supply a reliable basis for policy changes and enable guidelines to be produced so that individual practitioners can improve their practice. The therapeutic activities within a particular intervention model must be understood (and if necessary, changed) to effect an improvement in outcomes. It is also necessary to know the potential for change as indicated in the patient's/client's attributes. Data should be aggregated at therapist level for their own reflection and comparison with guidelines and national/international level to set guidelines.

This approach alters the emphasis of data collection from 'scientific' controlled trials based on one variable, to a continuous multi-variate approach, using registrants' real life practice data. Employers must be willing/required to release the specified data in a pseudonymized form that protects patient/client privacy in a way that is complicit with the Data Protection Act 2018, embodying the European Union's General Data Protection Regulation (GDPR) and the Freedom of Information Act 2000.

Resolve much of the reproducibility crisis: This will mainly be achieved by the continuous collection and processing of data. *Patient/Client values* must be built into the therapeutic process and evidence base, by using appropriate questionnaires covering parents’ and referrers’ objectives, expectations and quality of service.

Transparency: Regular analyses of each accredited data base should be made available to a central agency for publication at least annually.

Improving the hierarchy of evidence: The use of hierarchies of evidence and the omission of practice based evidence has been discussed. The development of practice based evidence in children’s mental health is at different levels of sophistication. The levels must be recognised and taken into account when making clinical and commissioning decisions. They should be comparable with the structure of the existing hierarchy of evidence. Major factors taken into account are:

- The statistical strength through number of measurements, observations or cases
- The number of variables included to ensure the completeness and relevance of guidelines
- The number of years to provide sufficient evidence of reproducibility.

<u>Existing Levels:</u>	<u>Proposed parallel levels:</u>
1a: Systematic reviews (with homogeneity) of randomised controlled trials	1a: Practice based evidence programme with over 250 therapists/10,000 cases, conducted over more than 5 years including many variable as well as clinical outcomes
1b: Individual randomised controlled trials (with a narrow confidence interval)	1b: Practice based evidence programme with over 100 therapists/4000 cases conducted over at least two years including many variables as well as clinical outcomes
1c: All or none randomised controlled trials	1c: Practice based evidence programme conducted with over 100 therapists / 4000 cases conducted for at least two years including several variables as well as clinical outcomes

2a: Systematic reviews (with homogeneity) of cohort studies	2a: Practice based evidence programme conducted with over 100 therapists/1000 cases for at least two years including only clinical outcomes
2b: Individual cohort study or low quality randomised controlled trials (eg <80% follow-up)	2b: Practice based evidence programmes conducted over one year by less than 100 therapists/1000 cases and including only clinical outcomes
2c: 'Outcomes' research; ecological studies	2c: Practice based evidence programme conducted over one year including only clinical outcomes
3a: Systematic review (with homogeneity) of case control studies	3a: Systematic review (with homogeneity) of single case studies with continuous clinical outcome measures also covering several weeks of pre and post therapy
4: Case series (and poor quality cohort and case-control series)	4: Case series with clinical outcome measures
5: Expert opinion without explicit critical appraisals, or based on physiology, bench research or 'first principles'.	5: Expert opinion without outcome measures based on personal clinical practice.

Proposed content of a practice evidence base:

This section combines a description of the content required to meet the above criteria with experience of what is feasible and practical. A practice evidence base has a much richer set of data than an efficacy trial.

Sufficient relevant data:-

Effectiveness: Data from appropriate general purpose psychometric measures and those related to specific conditions such as autism e.g. Autism Diagnostic Observation Schedule (ADOS) that show change pre and post therapy. This group of data must be capable of analysis by client and therapist attributes

Efficiency: Data that indicate the resources used to achieve the outcomes

(typically session data)

Activities: Data on the activities that have taken place to achieve the change. (Type of therapy and the use of different therapeutic media)

QA: Data concerned with quality assurance eg through clinical supervision

Improvement of practice: Methods used: CPD plans, learning objectives, activities and results. Guidelines derived from the practice evidence base for practitioners.

Resolving much of the reproducibility crisis:-

Data set sizes: To improve the probability of reproducibility

Statistical analysis methods: Built into the CEB – methods to be determined.

Effective dissemination:-

The public: Direct and indirect contact data needed for dissemination

The practitioners: Policy making.

Patient/Client values and expectations:-

Clients: Sufficient data to set therapeutic objectives and measure the degree to which they have been achieved

Those responsible for clients: Other measures of patient/client satisfaction.

Transparency:-

Regular publication of results: Automated report production for different audiences.

Stakeholders' responsibilities:-

Practitioners: Monitoring on how well the responsibilities are being met

Employers: Organisations' objectives and how well they have been met.

Epidemiology

The study and analysis of the distribution and determinants of health and disease conditions in defined populations is an important part of evidence based medicine and must be included:-

Potential for improvement: Data showing the outcomes for each presenting condition and the incidence

Demographic: Persons/population attributes. Data showing the potential for improvement geographically and for demographic groupings.

Systems thinking and modelling seem to offer an alternative to the controlled trial with actual practice results rather than control as the major source of evidence. It treats the multiplicity of variables as a resource to be used for deeper analysis rather than as a nemesis to be controlled. The evidence from practice can reflect the complex reality rather than mask it.

Recommendations

- 4.1 Data relating to the adverse effects of medicines to be included in therapists' record management systems
- 4.2 The National Audit Office (NAO) to become the central repository of data related to the costs and outcomes of all research projects funded directly or indirectly by national government
- 4.3 The proposed parallel practice evidence based hierarchies (as above) to be added to the existing evidence based classifications for use by all bodies concerned with the evaluation of the quality of research or children's mental health and commissioning policies
- 4.4 A working party to be convened to agree a set of standards for the development of practice based evidence systems for the interventions for children with mental health and emotional welfare problems. The envisaged time span for this is one year
- 4.5 1% of the national budget for children's mental health care to be devoted to measuring the effectiveness of the funded programmes followed by NAO evaluation.

5. EVIDENCE DISSEMINATION AND AUDIENCE

In promoting child health and wellbeing and reducing the prevalence of mental health problems there should be a focus on development from conception; supporting parents in building attachment with the professionals working alongside families who recognise (and understand) mental health issues and behaviours:

<https://www.mentalhealth.org.uk/blog/reflections-children-and-young-people%E2%80%99s-mental-health-green-paper>.

Early intervention offers greater opportunity for the reduction of mental illness and mitigating its effects when it does occur.

Croydon Health Service NHS Trust is a 'practice' example of trying to provide mothers with greater support in the first two years of a child's life through measures such as identifying and addressing attachment issues generally, tackling postnatal depression and confronting problems with drink, drugs and domestic violence:

<https://www.theguardian.com/society/2018/oct/19/welcome-uk-2018-babies-dying-nhs-council-cuts>

According to the Children's Society, priorities for children's wellbeing should include:

- Having a positive view of themselves
- Having an identity that is respected
- Engagement in positive activities
- Having positive relationships with family and friends
- Having a safe and suitable home environment and local area:

https://www.childrenssociety.org.uk/sites/default/files/tcs/promoting_positive_well-being_for_children_policy.pdf

Those who have lived the experience can play a pivotal role when it comes to shaping the services for others and influencing how care is planned and delivered as effectively as possible.

The Health Improvement Analytical Team Department of Health (2014) collated 'A Compendium of Factsheets: Wellbeing across the Life Course' and in 2018, the inclusion of Parenting programmes continues to be evaluated and supported. Main points arising include:

- Mothers with infant children programmes which are led by peers, have been found to be effective in improving maternal mental health, reducing stress and increasing confidence
- Home visitations should occur over a longer term. For example; nurse-led parental support provided to vulnerable families has been found to be the most effective intervention to prevent the mistreatment of children
- Parental programmes and other programmes which are aimed at children with a greater likelihood of social, emotional or behavioural disorders may be an effective preventative method to increase the future wellbeing of participants:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277593/What_works_to_improve_wellbeing.pdf

Teachers, as frontline professionals, are also calling for guidance and action in developing greater understanding and support in their dealings with children who have mental health problems. A 2016 Department for Education (DfE) survey found that nearly a quarter of teachers (23%) did not feel equipped to identify behaviour linked to mental health issues and more than a third (34%) felt ill-prepared to teach children in their class who have mental health issues. Young Minds has said that more proactive accessible support is needed in schools so that children's wellbeing is prioritised within the education system:

<https://www.theguardian.com/education/2018/jan/23/children-young-three-self-harm-mental-health>

The Anna Freud National Centre for Children, and Public Health England, have produced a joint Toolkit to measure and monitor children and young people's mental wellbeing that is designed to be used practically by a wide range of professionals including teachers. The focus is to educate, rather than determine, children's emotional states and how they could be enhanced:

<https://www.annafreud.org/media/4612/mwb-toolkit-final-draft-4.pdf>

From the therapist's standpoint, 'what works' is a prerequisite and practitioners in clinical, community and policy-making roles all concur in wanting their work to benefit from more evidence from practices or populations like their own; more evidence based in real time, typical patients/clients without all the cumbersome screening and control and with staff like their own. The ideal setting in which to conduct such studies would therefore be their own.

To date, progress in developing these solutions has been limited. Comprehensive therapy record managements systems provide a potential platform for expansion into practitioners' own evidence bases. For example, in designing a session with a new patient/client and recording the presenting condition, information from guidelines drawn from practice based evidence provided by their peers could be

readily at hand. Similarly, when asked to estimate the number of sessions needed, practice based guidelines could be made available. In rare cases, data provided in real time might be useful. (However, this would be more complicated and expensive to provide.)

Professional organisations are ideally placed to provide practice based research networks. They can provide incentives through supporting their registrants in good record keeping, quality assurance and development of their clinical skills. They can also apply penalties if necessary such as suspension of registration in cases of non-compliance.

Integrated Care

Integrated care is essential to meet the needs of children, transform provision for the carers of those with long term conditions and enable children with complex needs to live healthy, fulfilling lives and achieve their potential. There is no single 'best practice' model of integrated care, but approaches are likely to succeed when they cover large populations (a city or county) and a range of groups.

For example, the evidence for case management and care coordination shows that it is less likely to work well unless it forms part of a 'programme approach' to a specific population group that includes good access to extended primary care services, supporting health promotion and primary prevention and coordinating community based packages. Evidence shows that the cumulative impact of multiple strategies for care integration is more likely to be successful in meeting demands and improving the experience of patients/clients, service users and carers. Practice based evidence is thus far, disseminated to practitioners and their individual employers. A greater concentration is needed on the distribution of suitably aggregated data and reports to local and national authorities.

In conclusion, the two main purposes of disseminating practice based evidence of children's mental health practice are:

- To ensure good quality commissioning and practice
- To benefit individual patients/clients through integrated care.

Children's mental health services and support programmes (whether located in school or the community) have been jeopardised by chronic under-funding; creating a siege mentality and increasing the risks facing the most vulnerable. A child may be at crisis point before interventions are made. This in turn, drives up long term costs to public services as children grow and struggle to cope in later life with the aftermath of trauma. Financial cuts and reductions in services designed to address domestic violence and addiction have put more children in harm's way.

Liz Wilson, a teacher based in Birmingham has detailed a constant battle to access help for children who need it; one which has almost always ended in defeat due to a lack of money:

<http://www.itv.com/news/2018-02-09/teachers-demand-support-amid-dramatic-rise-in-children-as-young-as-three-who-are-self-harming/>

The October 2018 Budget Statement specified an additional £2bn for children's mental health services; money that is certainly welcome, but hardly lavish in addressing present provision and future needs. In such a climate, justifying specific spend becomes imperative.

It is therefore essential that the audience for the dissemination of practice based evidence encompasses those in position to act upon what an analysis of its data suggests in terms of clinical need – and results in a commensurate and sufficient allocation of resources.

Recommendations

- 5.1 In evidence dissemination, an integrated 'joined-up' approach is essential, including voices of parents, children and professionals such as mental health practitioners and teachers who work regularly with children themselves
- 5.2 Children's mental health professional organisations are required and supported to provide systems for registrants to gather data for, and use, practice based evidence guidelines
- 5.3 Expansion of The Health and Social Care Regulators' remit to include the dissemination of practice based evidence for children's mental health
- 5.4 The NHS Commissioning Board and Monitor to be expanded to embrace the full spectrum of provision for children's mental health, especially within the education service.

6. CONTRIBUTION TO 'JOINED UP CARE' AND IN RELATION TO CHILDREN WITH ACEs, DISABILITY, FROM MIGRANT, REFUGEE, CULTURALLY AND ETHNICALLY DIVERSE AND SOCIOECONOMICALLY DEPRIVED COMMUNITIES

A 'people-oriented' practice based evidence approach is ideally suited to working with children. Assessment and outcome processes can be designed around the individual child (who is at the centre of all activities) and this is especially useful in supporting children from 'difficult to reach' groups. Children with adverse

childhood experiences (ACEs), disabled children, migrants and refugees have very distinct needs. 'Joined up care' is endemic to each and every strategy designed to advance child health and wellbeing, but a proactive approach to individual and specific need should be integral.

There is a strong correlation between ACEs and later manifestation of poor physical and mental health and engagement with education. 'ACE' is customarily used to describe growing up in a violent household as well as experiencing deprivation or the trauma and stress of neglect, physical, emotional and sexual abuse (Bethell CD, Newacheck P, Hawes E and Halfon N, 2015 'Changing Epidemiology of Children's Health. Adverse Childhood Experiences: Assessing the Impact on Health and School Engagement and the Mitigating Role of Resilience', *Health Affairs*, 33(12):2016-2115).

Children and young people in care will often have had ACEs (and will usually demonstrate greater mental health needs than their peers). The transition process from care to independence and adulthood has been the focus of critical scrutiny following research findings suggesting that those in receipt of care from child and adolescent mental health services (CAMHS) encounter a service gap as they shift towards adult equivalents (Butterworth S, Singh SP, Birchwood M, Islam Z, Munro ER, Vostanis P, Paul M, Khan A and Simkiss D, 2017 'Transitioning Care Leavers with Mental Health Needs: 'They Set you Up to Fail!', *Child and Adolescent Mental Health*, 22(3):138-147). According to care leavers in the Butterworth study, service coordination (and a continuity of mental health support during transition) is vital to avert powerful feelings of isolation and abandonment.

The experience of a disabled child and their family also requires particular attention. Chantrell ('Growth in Emotional Intelligence. Psychotherapy with a Learning Disabled Girl', Chantrell S, *Journal of Psychotherapy*, 35(2): 157-174) found that children with learning disabilities were more likely than their peers to develop mental health problems and that the pattern outlasted adolescence. Disabled children and their families are known to encounter many barriers impeding access to essential services and are further disadvantaged by experiences of marginalisation which inhibit their full participation in society. A study consisting of interviews with families who use over 6 multi-agency services (Abbott D, Watson D and Townsley R, 2005 'The proof of the pudding. What difference does multi-agency working make to families with disabled children with complex health care needs?' *Child and Family Social Work*, 10:229-238) found that a key component of disadvantage for families with a disabled child was the enforced social isolation. Many wanted greater opportunities for the family unit to enjoy a holiday or break and to participate in leisure services. These families however, experienced a distinct lack of emotional support, typified by the instance of a family where the father had died and the grieving disabled child was not offered

the bereavement counselling made available to her two siblings. Disability also intersects with other social categories such as race, increasing disadvantage and marginalisation - and knowledge and participation in different support groups is shown to be lower in Black families with a disabled child (*Chambra et al, 'On the Edge' 1999, Minority Ethnic Families Caring for a Severely Disabled Child, Bristol: The Policy Press*).

Migrant children and refugees have highly distinctive needs and a world-wide increase in child migration shows no sign of abating. The ISSOP Migration Working Group (*International Society of Social Pediatrics and Child Health Migration Working Group 2017, 'ISSOP position statement on migrant child health', Child: Care, Health and Development:*

<https://doi.org/10.1111/cch.12485>

<https://onlinelibrary.wiley.com/doi/full/10.1111/cch.12485>

contends that:

'The health of migrant children is related to their health status before their journey, the conditions during their journey and at their destination, and the physical and mental health of their caregivers.'

Alongside vulnerability and susceptibility to conditions which may have been prevented by vaccination, children who have faced situations of war, exploitation or separation from some, or all, of their family members and friends, may have experienced a high level of trauma. The resultant physical and psychological effects (such as PTSD and depression) can be enduring. ISSOP has singled out the particularly sensitive circumstances of unaccompanied minors, pregnant women and newborn babies.

Newly arrived migrant children will often have to endure potential threats to their mental health occasioned by one or more of the following factors:

- Social marginalisation
- Poor living conditions
- Adverse mental health of caregivers
- Services which are not informed by expertise in working with children and families who have experienced trauma.

ISSOP's position statement (2017) emphasises the value of joined-up care (involving education, social care and health in working *with* child migrants) alongside a parallel determination to valuing and respecting the voices of migrant children and their families. Building on commitments enshrined in the UNCR, ISSOP maintains that the care for such children should at least equal that afforded to children in the local population. The need for culturally sensitive provision

('cultural competency') is recognised, which in part would include access to people who can communicate with migrant children and their families in a language that they readily understand and feel comfortable in using.

It is important to acknowledge the resilience of many migrant children and research has shown that a number of factors are supportive to this:

- Social inclusion (not exclusion)
- Positive school experience
- Support for the mental health of caregivers
- A stable family environment.

ISSOP therefore recommends that policy makers consider smoothing the immigration transition process so that children and families' asylum claims are processed swiftly and appropriate services made readily available. This would further the social integration of child migrants whilst promoting their health and wellbeing.

'Difficult to reach' children as described above, may also experience an intersection of different kinds of discrimination. A Black family with a disabled child may feel especially isolated (*Chambra et al, as above*). In a 2017 study of data for US National Survey of Children's Health (*Kerns C, Newschaffer C, Berkowitz S and Lee B, 2017, 'Brief Report: Examining the Association of Autism and Adverse Childhood Experiences in the National Survey of Children's Health: The Important Role of Income and Co-occurring Mental Health Conditions', Journal of Autism & Developmental Disorders, 47(7):2275-2281*) a link was made between ACEs and autistic spectrum disorder (ASD) impacted further by low income and concurrent mental health conditions; combining to produce a complex and highly toxic amalgam of disadvantage.

It has been argued that joined-up services are essential, particularly in response to intricate family situations (*Hutchings J and Williams ME, 2014, 'Joined-up-thinking, joined-up services, exploring coalface challenges for making services work for families with complex needs', Journal of Children's Services 9(1): 31-41*). A strong case is made for the use of evidence based programmes, but the difficulty in selecting from the plethora of options on offer is stressed, as is the need to ensure that the pathway eventually chosen is implemented in full.

In respect of service delivery, Glennie argues that the many professionals coming into contact with children and their families require greater and more intensive inter agency training in order to promote effective working relationships (*Glennie S, 2007, 'Developing Inter-Professional Relationships: Tapping the Potential of Inter-Agency Training', Child Abuse Review, 16(3):171-183*). Although this study

focuses on child protection, the need for improved training is an outcome of many research programmes and reports; within and outside the child protection remit.

It is therefore, essential that services used in work with children from difficult to reach groups (in particular, migrant and refugee children) should be 'trauma-informed' and 'culturally competent.' Research consistently advocates that it is imperative that services for children and families are joined-up and a need for greater service coordination becomes of especial import where a child's circumstances are especially complex.

Listening and being alert to the real life needs of children and families themselves should be the bedrock of service provision. Practice based evidence should therefore be a logical and key component of the closer inter agency and professional working that will deliver optimum outcomes for children whose particular circumstances place them in the greatest need.

Recommendations

- 6.1 Practice based evidence to be integral to the design of strategies to engage joined-up services in the delivery of mental health and wellbeing support to children and their families belonging to 'difficult to reach' groups (in particular child refugees and migrants)
- 6.2 Training modules for therapists and practitioners in the community and within school to reflect ways in which practice based evidence may be best used and disseminated in the interests of children from difficult to reach groups
- 6.3 The Government to allocate sufficient resources to cover additional training and staffing arrangements and inter agency coordination arrangements as required.

7. INTERNATIONAL PRACTICES AND EXAMPLES

Practice based evidence is central to the work of play and creative arts therapists in the UK and internationally.

Play therapy originated in the US and the greatest number of Play Therapists work there (partly due to the total population size). It has evolved from the 1960 era US and UK psychological theories to an 'Integrative Holistic' 21st century template that affords Play Therapists a framework from which to conceptualize the play therapy process and evaluate their therapeutic interventions when working with children.

The Integrative Holistic model developed by PTUK includes a decision making guide; based on the premise that because each child seen in therapy is unique, all interventions must be tailored to the child. Originally developed in the UK, the Integrative Holistic model is now delivered in 55 countries. By studying real life practice examples of relevant work taking place overseas, Play Therapists in the UK can enrich their understanding of how the model can be adapted to suit children from different ethnicities, cultures and religious backgrounds, speaking different languages.

Practice based evidence: an international example

The specific example below examines the impact of a therapeutic playwork project on a group of abandoned children living in a paediatric hospital in Transylvania.

Background

The project (started in 1999 and continuing) stemmed from concerns voiced by the newly appointed Director of the Sighisoara Paediatric Hospital, Dr Cornel Puscas about the plight of a group of abandoned children who were living in the hospital. The children (aged between one and ten) had been chronically neglected and abused and had spent most of their short lives tied to the same cot in the same hospital ward. Dr Puscas obtained funding from a Yorkshire charity called The White Rose Initiative and the first Romanian play worker was trained on a specially designed programme at Leeds Beckett University. Following her return to Romania she was joined for differing periods of time by Leeds Beckett researchers, Sophie Webb and Fraser Brown the original (and ongoing) WRI Therapeutic Playwork Project was followed in the first year by a small scale research study by Webb and Brown (*'Children without play', Journal of Education, No 35, March 2005 special issue: Early Childhood Research in Developing Countries'*).

Methods

During a period in their lives when nothing changed (apart from a therapeutic playwork project) the children themselves changed dramatically. It was therefore decided to conduct a research study of project outcomes with the aim of evaluating developmental changes during the first year. The children were observed daily and details of their social interaction and play behaviours were documented. The observations were conducted unobtrusively in order to avoid disrupting what they were achieving in their play and to enable the researcher to take notes at close quarters. Assessments were made using 154 questions (largely derived from play and playwork theory) grouped under eleven general headings in order to encompass the full range of children's play behaviours and/or characteristics of play:

- Freedom
- Flexibility
- Socialisation
- Physical activity
- Intellectual stimulation
- Creativity & problem solving
- Emotional equilibrium
- Self discovery
- Ethical stance
- Adult child relationships
- General appeal.

All the children exhibited evidence of change; albeit to differing degrees and the findings afford encouraging proof of the recovery potential of abused and neglected children. A follow up study six years later confirmed the conclusions of the original study; namely that the children's developmental progress was clearly identifiable and apparently achieved through the experience of the therapeutic playwork project.

Their remarkable progress meant that fourteen out of the original sixteen children were eventually either adopted or fostered.

The therapeutic form of playwork observes certain guiding principles and the researchers' diary extracts selected to accompany them below, illustrate some of the ways in which the principles were put into practice to benefit the Romanian children.

1. Children learn and develop while they play

Children will learn and develop during play. It is the role of a playworker to create conditions for the play process to be effective:

'Virgil is becoming more and more sociable and really enjoys drawing. He's started to develop his own ways. Two crayons at once for example.....We put the soft toys on the floor again and they just lay on them chilling-out. It was lovely to watch.'
(Reflective Diary, 23rd February 2003)

2. Many modern environments contain elements that act against the play process.

The play worker's initial role is to analyse the children's environment in order to identify and remove any barriers to the play process. Given the extreme levels of

neglect and deprivation occasioned by the Romanian setting, the issue of 'barriers to play' was far more significant than might be encountered in most UK settings.

3. An enriched play environment holds greater potential for children's development.

The playworker is concerned with enriching the child's play environment in order to stimulate the play process. The following diary extract illustrates the way in which the playworker's gentle interaction helped to motivate the children and enable them to take control of their own environment:

'Today I sat Elena on the car and she stayed there, so I showed Carol how to push her and then they were able to do it on their own! I think it was a real step for Elena, as she never 'plays' with the others, she just touches them every so often. Until today, this WAS her play....a beginning that needed nurturing?' (Reflective Diary, 24th March, 2000)

4. Compound flexibility.

For many playworkers, the most important element in their work is compound flexibility, ie *'the interrelationship between a flexible/adaptable environment and the gradual development of flexibility/adaptability in the child'* (Brown F, 2014 *'Play and playwork: 101 stories of children playing: Maidenhead: Open University Press*). Portchmouth (Portchmouth J, 1969, *'Creative crafts for today'*) says that *'it helps if someone, no matter how lightly, puts in our way, the means of making use of what we are doing.'* He cites the example of providing buckets and spades for children to play with on the beach. The following diary extract shows how the Romanian children made use of the inherent flexibility of a box (rather than for example, a fixed and static climbing frame) to create their own games:

'While Ion was sitting in a big yellow box, Virgil started to play a game with him, involving an imaginary object....the spontaneous interaction between them both was fascinating to watch. Afterwards, Virgil continues playing with the yellow plastic box by putting it on his head and walking around the room....He created a sort of obstacle course out of the cots and tables.' (Reflective Diary, 25th February, 2000)

This is known as 'loose parts' play.

5. Negative capability, the suspension of judgement and prejudice.

When coming into contact with children, the playworker tries to suspend their personal agenda including any preconceptions and prejudices and go along with

the flow of the child's needs and tastes. The playworker therefore must be prepared to stand back when others might be inclined to rush in:

'The children do fight a lot and I only intervene if it gets too violent or if I can see they won't work it out for themselves. I think that they learn more from their own reactions than from adults at times and it's good for them to work out their own disagreements.' (Reflective Diary, 22nd March 2000)

6. The child's agenda has to be taken as the starting point.

For the playworker in a therapeutic setting, it is especially important to take the child's agenda as the starting point for interactions. Hughes suggests that both the content and intent of play should be determined by the child and that playwork should be '*child empowering*' (Hughes B, '*Evolutionary Playwork*', Abingdon: Routledge). In the child's daily life, play is their only experience of being in control of events. The Romanian children required a stronger presence over a more extended period, but it remained the case that most of the researcher's interventions were a response to the specific play behaviour of the child. The example below concerns a ten year old child who was too frightened to walk independently. He was obsessed with shoes and the playworker was able to work with that with dramatic results:

'I have played 'shoes' with Nicolae for the past two weeks and that appears to have led him to trust me. Today, after playing 'shoes' yet again, I stood him in the middle of the room, about four steps away from me....Usually, he just sits down, but this time he walked towards me with his arms stretched out for a hug. I think that these may have been his first independent steps (after 10 years!). (Reflective Diary, 24th February, 2000)

7. Making appropriate responses to children's play cues.

Babies immediately show an interest in their environment (especially other human beings) and those participating in play activities learn how to interpret the 'cues' given by other people during the process. This skill is fundamental to effective playwork practice (Sturrock G, and Else O, 1998, '*The playground as therapeutic space: playwork as healing*', *Proceedings of the IPA/USA Triennial National Conference, Play in a Changing Society: Research, Design, Application. June 1998, Colorado, USA*).

There is evidence from the Romanian research of Brown and Webb (Brown F and Webb S, 2005, '*Children without play*', *Journal of Education, No. 35, March, 2005, special issue; Early Childhood Research in Developing Concepts*) that 'affective

attunement' ('I am in tune with you') can easily be achieved by an empathetic adult working with a severely disturbed child:

'Today I was sitting on the floor tossing a ball gently into the air. Carol was watching me intently. First, he came close. Then he backed away, all the time, keeping eye contact. This was a clear play cue ('throw it to me'). I flicked the ball to him. The thrill of having someone respond to his play cue was immense. He became so excited he crammed the ball into his mouth, before returning it to me for another go.' (Reflective Diary, 4th August 2000)

8. Creating relationships and building the child's self-esteem.

One of the most significant elements of the playwork role is the way in which relationships are made with children. If the child–adult relationship is effective, there is a good chance of not only helping the children with their problems, but also of raising their self esteem generally. Respecting the things that matter to a child is a powerful message and by so doing, a playworker can help to build a child's self esteem:

'Virgil was happy about playing with the crayons, he was laughing about taking them out of the box and putting them in again. He likes doing this more than using them to colour in! He does it with other toys he plays with, always has to tidy!' (Reflective Diary, 22nd February 2000)

9. Cultural Awareness.

Among other things, Brown (Brown F, 2018, 'Therapeutic Playwork: Theory and Practice', In: Brown, F & Hughes B, (eds) *Aspects of Playwork: Play and Culture Studies. Vol.14. Lanham, MD; University Press of America*) suggests that therapeutic playworkers should have 'cultural competency' i.e. some understanding of their own and others' culture. In the Romanian example, it was important not only to develop an understanding of national characteristics, but also the culture of the local town and the paediatric hospital. Here is an extreme example of the lengths to which Brown and Webb had to go in order to be allowed to stay and work with these children:

'I think that the hardest part of the day for me is having to put them back in their cots again, but it will create even more aggravation if I don't, and that could ruin everything. People would probably think I'm awful for doing it, but I've had to accept that this is part of their system whether I like it or not. I know the nurse will tie them back in after we leave.' (Reflective Diary 25th February, 2000)

On a positive note, it appears that the longer term impact of the project has been considerable. The nurses stopped tying children to their cots during the second year of the project. The children are now well fed and their nappies changed regularly. The hospital subsequently adopted a policy of finding abandoned children foster placements within six months and the playworkers are still employed to this day.

In less than a year, these chronically abused and neglected children made the sort of progress than many experts assumed would be impossible. During the period of research study, the only change in the children's life experience was the therapeutic playwork project. Therefore, it is logical to ask what it is about playwork that has contributed to these changes.

- The children's learning and development resulted substantially from the playworkers' ability to create an enriched play environment that was substantially supportive of the play process
- The playworkers' suspension of judgement and prejudice combined with a determination to take each child's agenda as his/her starting point helped to create a good quality playwork environment
- Through their empathy and ability to interpret the children's play cues, the playworkers were able to create strong, trusting relationships which in turn helped to enhance the children's self esteem.

This practice based example of work in Romania has been described in some detail because each of the approaches listed could indeed be used and adapted by practitioners in the UK in a typical playwork setting and focusing on the children with whom they are currently working. This straightforward playwork approach appeared to resonate with some of the most deprived children in the world and shows that practice based evidence can be used to inform therapeutic work above and beyond the primary subjects of the initial work.

Practitioners can thus learn from each other, surmounting barriers presented by socioeconomic circumstances, culture and geography in the interests of children's mental and emotional health, welfare and wellbeing.

Recommendation

7.1 Some of the 2018 Budget Statement money allocated to children's mental health to be used to prepare a Directory of practice based evidence examples from national and international sources to inform ongoing therapy and treatments

7.2 Professional training modules and CPD for therapeutic practitioners to

include national and international examples of practice based evidence that have been recommended as examples and for use and modelling by Accredited Professional Registers.

8. APPLICATION TO CLINICAL PRACTICE INCLUDING CASE STUDIES

Practice based evidence has an important, widely recognised role in promoting children's health and wellbeing. Applying this knowledge to practice is essential if health outcomes are to be sustainable and relevant. The National Institute for Health and Clinical Excellence (NICE) supports the best possible delivery of care based on the best available evidence and supports the delivery of practice that assures good quality and value for money:

www.nice.org.uk

Good practice examples will provide ideas and opportunities for improving care and clinical practice. They enable practitioners to take account of where practice improvements have resulted in real change for people. There is further work to be done. However, early progress has been made in some areas of public health, nursing and midwifery practice. Some best practice examples can be seen in Health Visiting, School Nursing and PHE for wider public health interventions.

A practice based evidence case study

In schools too, practice based evidence contributes to a wider understanding of the effectiveness of school-based interventions, as illustrated by findings from the following case study (stemming from work that was conducted in schools in Cambridge).

A mental health curriculum (*Mind Your Head*) was delivered by sports coaches who work for Cambridge United Community Trust and footballers from Cambridge United. The programme was delivered to 557 students in secondary schools over six sessions during 2017-18 and its impact on students' wellbeing and mental health was then evaluated.

The results of the programme demonstrated the beneficial impact that sports coaches and athletes can have on students' mental health literacy by delivering a short, focused mental health curriculum. The fact that students could articulate how to seek help and how to manage their own mental health at the end of the intervention was encouraging and likely to lead to improved mental health in the long term:

'There are things that you can do to manage stress. Stress can be a good thing. It can help you to improve your performance. If you think of stress in a negative way, then it can start to affect your sleep.' (Student, Y9)

'It's important to talk to someone about your worries. If not, this will make your thoughts and feelings worse and can lead to serious situations for some people.' (Student, Y9)

'To me, mental health is understanding my own feelings, being healthy in my mind and physically healthy.' (Student, Y8)

'You can talk to your family and friends on social media. The disadvantages are that you can get stalked. People can create fake accounts. You can get cyber-bullied. People can hack into other people's accounts and you might not know who is communicating with you. People can become jealous of other people's lives and this can make you sad and depressed.' (Student, Y9)

'I know how important it is to listen to others. If I don't know how to help them, I can take them to someone else in the school who might be able to help them.' (Student, Y9)

Quantitative analysis of the practice based evidence demonstrated statistically significant improvements to students' mental health literacy across all gender and ethnicities (although there are slight variations in the degree of improvements between different ethnic groups). Females demonstrated marginally greater increases in mental health literacy than males. Changes in wellbeing were not statically significant.

The qualitative data revealed a range of findings. The adolescents broadly understood mental health to exist along a continuum from being mentally healthy to mentally ill. Students who had participated perceived a range of mental health benefits from engagement in physical activity and recognised other ways of improving their own mental health. Their mental health literacy improved as a result of their participation in the programme. They were able to identify the signs of mental illness and could describe ways of supporting others who were experiencing mental ill health. In addition, the students were able to identify population groups at risk of developing mental ill health:

'There are some groups that are more prone to developing poor mental health such as LGBT, males and athletes.' (Student, Y8)

The students could talk about the importance of being resilient in the face of adversity:

'Resilience is when you don't give up and you keep going. You can bounce back from things like failing a test. Resilience helps you to achieve things. It changes your mindset into a positive mindset.' (Student, Y8)

They were able to identify the negative effects of social media and ways of keeping themselves safe online. They valued the opportunity to develop their awareness of mental health through listening to athletes speaking about their own issues. Sports participation was reported to have both positive (therapeutic) and negative (stressful) effects on mental health; the latter including the perceived pressure to perform, slumps in performance levels and having less time to socialise with friends.

The participating schools were unanimously positive about the programme and its benefits on pupils' mental health literacy. *'Mind Your Head'* is clearly valued by pupils and schools and delivers measurable statistically significant improvements in mental health literacy across all genders and ethnicities. It is included here as an example of a successful practice based evidence programme that is certainly capable of successful adoption and replication in other school settings.

Who is likely to have poor mental health?

Several overlapping populations of children could be conceptualised as having poor mental health:

- Those in difficult circumstances or that place them at risk of developing diagnosable psychiatric disorders including special education needs
- Those with diagnosable psychiatric disorder
- Those whose poor mental health and/or difficult psychosocial circumstances impairs their ability to function.

For each child who meets the diagnostic criteria, there are three or four others with poor mental health and based on Census of Population data and an incidence of 20%, Play Therapy UK (PTUK) has estimated the number of children in the UK requiring help as follows:

England	1,121,186.20
Scotland	198,794.40
Northern Ireland	36,198.80
Wales	61,144.00
Total:	<u>1,417,323.40</u>

Patient-focused research

A patient/client focused project (*Harmon, Lambert, Slade, Hawkins & Whipple, 2005*) showed the value of aggregating data across many clinicians and then supplying individual clinicians with feedback about their patients'/clients' progress. In the project, patients/clients regularly provide ratings of their progress in therapy; these are compared to normative ratings and the therapist is advised if ratings dip below a prescribed cut-off score. In some variations, the therapist can be advised about possible helpful alterations in treatment. The difference in outcome for patients/clients whose therapists were given feedback and those who were not, clearly supported the value of the feedback.

Outcome measures

Two types of outcome measures should be used in children's mental health:

1. Nomothetic measures (use with all patients/clients regardless of presenting conditions or therapy objectives)
2. Idiographic measures (applying to particular presenting conditions and/or particular patients/clients eg identifying therapy objectives for individual patients/clients).

Children's mental health requires more emphasis on idiographic measures to guide the therapist and demonstrate benefits for individual patients/clients.

Play Therapy UK (PTUK) registrants have found that measurements taken before and after a therapy session (typically 12 sessions in total) are sufficient to demonstrate effectiveness and patient/client progress. In this case, independent observations from the parents and referrers are used rather than those of the therapist.

Priorities and levels of systems

It has been established that a PSA Accredited Register (AR) is able to build a practice evidence base for children's mental health; neither an easy nor a 'short term' process and one requiring a continuous commitment of resources.

Two levels of systems are necessary.

Levels:

Practitioners:

Roles:

Manage consent to use data processes and other GDPR/FOI requirements

Gather and record data using quality controls

Produce analyses and reports to reflect on their own practice

Communicate outcomes to parents, referrers and commissioners

Send relevant data to PBEH annually

Apply guidelines published by PBEH to practice

Manage the consent to use data processes and other CDPR/FOI requirements.

Practice evidence base holder (PEBH): Import data and check quality

Aggregate data

Produce analyses, reports and guidelines

Disseminate information.

Stakeholder's responsibilities:

Professional organisations' (normally those organisations identified earlier):

1. Develop and manage the practice evidence base in accordance with agreed standards, observing data protection, freedom of information and other legislative requirements
2. Supply the necessary data collection software to registrants
3. Disseminate information to assist the improvement of practice and to encourage the commissioning of therapy for children's mental health.

Practitioners':

1. Use practice based evidence guidelines in clinical practice
2. Help develop and update evidence in their area of expertise
3. Engage patients in the process (in the case of children's mental health, this will necessarily include parents and referrers as well as the children themselves)
4. Comply with data protection requirements and freedom of information legislation.

Employer organisations':

1. Define organisational objectives that are dependent upon clinical work and measure progress against them

2. Ensure that practice evidence based guidelines are used in clinical practice
3. Help practitioners develop and update evidence in their area of expertise
4. Allow practitioners to supply necessary data to PEBH
5. Manage patient work in studies of treatment, diagnosis and prognosis on which their service is based
6. Comply with data protection requirements and freedom of information legislation.

Education and training providers':

Ensure that training courses for trainees working with children who have mental health problems include:

1. A clear description of the differences between evidence based practice and practice based evidence as related to the principles of efficacy, effectiveness and efficiency
2. An understanding of the hierarchy of practice based evidence
3. The provision of software for the collection of practice evidence data where placement or intern schemes are used.

Lessons learnt from practice

Many CAMHS in the UK routinely evaluate change in a service user's presenting difficulties, functioning and progress towards their goals over the course of treatment by means of filling in questionnaires by young people and/or their parents and/or the therapist. The disadvantages of this Routine Outcome Monitoring (ROM) according to some young people have been described earlier and have at worst, actively impeded the development of a safe and trusting relationship between the patient and therapist.

Therapists have found the process to have its uses but some negatives encountered (and largely overcome) by Play Therapy UK (PTUK) include:

- Does not suit more complex cases
- Time-consuming; a digital record is more efficient than a manual one
- Concerns about potential misuse; should be a useful way in which to identify a therapist who may need extra support, but not used as a stand alone punitive measure
- Careful selection of variables and the statistical methods used is required
- Lack of technological support for sharing and inputting the data
- Additional workload burden
- The measures taken alone are insufficient in crisis work. A range of measures is needed to cover all circumstances.

Development of a practice evidence base for children's mental health: a case study from Play Therapy UK (PTUK)

Play Therapy UK's development of a practice evidence base for children's mental health began with the collection of data from registrants for quality assurance. In 2013 it was decided that extra data items such as patient/client attributes, session, and supervision and CPD data should be added and that digital methods of data collection should now replace the manual one. The Professional Standards Authority gave support in helping to overcome a fear of change as expressed by some of the registrants.

By 2016 it had become apparent that the focus of the system should change from being a revalidation and data collection tool to one providing a complete play and creative arts therapists' record management system, that would improve the quality of data, meet the new GDPR requirements, increase security, produce better reports and communication with stakeholders and save time. The approach was more aligned to therapists' needs. The new system (Caerus) was considered to be an improvement but there were important lessons to be learned and obstacles to be surmounted with regard to the registrants' experience:

- Fear of using IT
- Lack of basic IT skills
- Diversity of machines
- Unwillingness to follow guidance.

The time it takes to overcome these issues rather than the system development itself, is the main determinant of progress. In parallel, the features of the central database were expanded to provide more automation of checking registrants' revalidation applications and more analyses of practice based evidence.

The case has shown that a moderately sized (2200 registrant) professional organisation can achieve success in developing a large and extensive practice evidence base progressively meeting the evidence hierarchy proposed earlier.

Recommendation

- 8.1 We need to establish clearer terminology, reliable measures and be able to more effectively develop, collect, record, share and use the evidence of what works to improve wellness and wellbeing in promoting and safeguarding the mental health of all children and young people
- 8.2 It is important that examples of practice based evidence that work and are

capable of successful replication are harvested and made use of so that their benefit is not circumscribed by one setting, one group, or one geographical location. The best of practice based evidence excellence must be allowed and enabled to 'travel'.

9. PRACTICE BASED EVIDENCE WITHIN THE CONTEXT OF THE GOVERNMENT'S GREEN PAPER ON MENTAL HEALTH

As earlier stated, this work began following receipt of feedback in response to the publication of our earlier report, *'Mental Health in Childhood'* (June, 2018).

The APPG on A Fit and Healthy Childhood considered that there was 'more to say', firstly concerning practice based evidence (the central theme here) and secondly in relation to the Government Green Paper *'Transforming Children and Young People's Mental Health'*, (4th December 2017) which we viewed as the starting point of a cumulative strategy; widely predicted to follow the traditional Westminster pattern of progressive unveiling via a White Paper and ultimately, a Bill.

Following the unanticipated announcement of a 'policy proposal prelude' to the Chancellor's pledge of an additional £2bn for child mental health in his Budget Statement (29th October, 2018) it would seem that the customary legislative process of Green Paper being succeeded by White Paper prior to the introduction of a Bill has been in effect sidestepped. The Government now appears to be in 'implementation mode' and there is no indication that a White Paper is in the offing; much less a Mental Health Bill. The body of this concluding chapter will therefore treat some main issues deriving from the Green Paper and recent policy statements; offering recommendations as they arise and as appropriate.

The chapter will then be followed by an additional and separate recommendation.

The most recent policy announcements (10th October 2018) made whilst this report was in the process of being written, the above continue a theme of governmental 'good intentions' but lack the practical and effective means of implementation.

1. Appointment of a Government Minister for Suicide Prevention.

Suicide is a terrible tragedy in each and every instance, but there are many issues involving the mental health of children that are extremely serious and a Ministerial role and title should be widely reflective. The current uncoordinated approach is ineffective.

Already, the 'post' (which really amounts to a highlighting of one of the existing responsibilities of a Health Minister) has suffered a credibility crisis, due to its misnomer: the 'Minister for Suicide'.

2. The instigation of a 'child mental health assessment' for every pupil upon entry to school.

The measure used should be specified as the Goodman SDQ in order to align data with the periodic reviews of British Children's Mental Health. The same assessment process should also be conducted at transition from primary to secondary education and thence to higher education. The data would form the basis of a longitudinal study.

3. The designation of a lay staff member as 'Head of Mental Health'.

Some primary schools already have multi-role teaching staff trained at postgraduate level to provide therapy who could undertake this role. This would also be more cost effective than having to train other staff. The Green Paper's suggestion of 'Mental Health Lead' seems more appropriate.

The Green Paper: Transforming Children and Young People's Mental Health

The Consultation upon the Green Paper did not demonstrate a readiness to pursue discussions with the respondents and also showed a lack of discrimination by not taking into account the relative experience of the respondents and the quality and relevance of their evidence. Therefore a person offering 'opinions' divorced from evidence, has been afforded the same weight as a professional organisation representing the views of thousands of registrants providing hundreds of thousands of outcomes in a practice evidence base.

A Consultation of this importance should not be open to the charge that it simply a public invitation to complete a questionnaire; another mechanical exercise in 'form filling'.

Recommendation

- 9.1 The processes of conducting Consultations upon Green Papers is reviewed to provide more effective input from the people involved in implementing the proposals in practice; also taking into account the extent to which opinions are supported by evidence.

The Children and Young People's Improving Access to Psychological Therapies programme (CYP-IAPT) is a 'change' programme for existing services delivering CYP mental health care.

The original programme was designed for adults; taking little or no account of practice based evidence and with the main objective being the improvement of access to therapy via the reduction of therapy waiting times. The current NICE guidelines for the treatment of presenting conditions fail to cover the 51% of conditions that are not reported by CYP-IAPT (deriving largely from medical referrals unlike, for example Play Therapy UK's school based referrals). Such a substantial gap suggests that there should be no requirement to use the NICE guidelines in their current form in the treatment of children's mental health problems.

Recommendation

9.2 The CYP-IAPT programme to be revisited and aligned with Green Paper aspirations and NICE guidelines to be revised and extended in accordance.

The importance of establishing effective therapy record management systems to provide the required data has been discussed earlier. The Children and Young People's Health Services Data Set (CYPHS) provides information about children and young people who are in contact with health services. It is potentially a useful standard and source of data to be built upon for evaluating the effectiveness and value for money of health services. Although it describes national definitions for data in relation to:

- Personal and demographic
- Social personal circumstances
- Long term conditions and childhood disabilities
- Scored assessments.

It does not include sufficient data that are specifically relevant to children's mental health (as earlier outlined) and is thus currently unfit for purpose.

Recommendations

9.3 Either the CYPHS Data Set definition is extended (in scope of coverage) to include all locations that deliver children's mental health services through the Data Coordination Board, or a group of professional organisations managing Accredited Registers and the HCPC assume this responsibility. The Green Paper is insufficiently specific; failing to acknowledge that this is not a health service responsibility alone

- 9.4 More data items must be included so that the data to manage the *effectiveness* and *efficiency* of these services is improved and guidelines provided for the development of the practitioner's practice.

The workforce for children's mental health falls within the remit of the NHS whose current plans place responsibility upon providers to ensure that they have sufficient suitably qualified, competent and experienced staff (including psychiatrists, clinical psychologists and mental health nurses) to offer safe, high quality care. Providers are responsible for staff employment and supplying in-post training. The workforce in education and social services is therefore overlooked.

Recommendations

- 9.5
- Responsibility for developing the children's mental health workforce must be extended beyond DHSC to include the DfE and other departments with a demonstrable interest. The range of interventions should also be grown substantially beyond the existing limited ones of behavioural family therapy and cognitive behavioural therapy (CBT)
- 9.6
- Learning objectives must be relevant to practice based evidence as well as to other forms of evidence based practice
- 9.7
- Training must include placements providing at least 100 hours of clinical practice and have outcomes measured by an appropriate psychometric questionnaire.

The current inspection regime for mental health services contains significant gaps in the way in which the services are regulated.

The Care Quality Commission's Review of Children and Young People's Mental Health Services (October 2017) found gaps in the recording and reporting of important information; necessary to ensure that care is safe, effective and compassionate. The report concluded that a lack of accurate and comprehensive data undermines attempts to provide care that meets the mental health needs of children and young people and pointed out that there may be significant omissions in the understanding of the mental health needs of children and young people in certain circumstances.

For example, some routinely collected data fails to identify some groups of children and young people (such as those who are homeless or those who are lesbian, gay, bisexual or trans). In turn, this risks exacerbating inequalities in

their access to, and experience of, care, because services cannot draw upon accurate information to design and deliver provision that meets their specific needs.

Gaps in data also make it difficult to ascertain service availability in different parts of the country and therefore whether the demand for mental health care is met adequately.

Recommendations

- 9.8 An authority is commissioned to ensure the establishment of unified policies and standards for the inspection of children's mental health
- 9.9 The Charity Commission should review its rules for Public Service Delivery to ensure that in delivering services for children's mental health, regular reports on the application for funds, the activities and resulting outcomes are provided
- 9.10 The Gambling Commissions in its regulation of the National Lottery in reviewing applications for funding services related to children's emotional wellbeing as well as mental health should place an emphasis on the application of funds, the activities and the resulting outcomes.

The above suggestions are designed to amplify and build upon the content of the Green Paper and the subsequent proposals for children and young people's mental health, but despite a welcome £2bn for services as announced in the Budget Statement, ingrained patterns of service neglect mean that a good case for additional funding can always be made!

The concluding recommendation is therefore, in the light of 'blue sky thinking' and designed to expand and improve an essential workforce so that mental health outcomes for children and young people are the best that they can be. The scheme described below would not only improve access to therapy, but provide proof of effectiveness. It would also enable primary schools and other organisations to initiate a support service for the children, using their existing staff in many cases.

We therefore offer the proposal as our conclusion to this report and trust that it will serve as a prompt to discussion, debate and ultimately action in the interests of children and young people who deserve services that work for them; at a time and place that is also, and most importantly, commensurate with that need.

Recommendation - A high quality workforce for children's mental health by means of:

- 9.11 A training loan scheme; eligibility to include postgraduate level 7 training provided by a university for Play and Creative Arts Therapists**
- 9.12 Therapists to qualify for a PSA Accredited Register or the HCPC posts with a minimum of 100 clinical placement hours, including the collection of practice based evidence**
- 9.13 Trainees to be part time with a course intensity of 50%**
- 9.14 Placement organisations to warrant employment following successful completion of training**
- 9.15 Loan to be repaid on a similar basis to the existing undergraduate scheme (ie a repayment threshold of £25,000).**

APPENDIX 1: SEVEN OPPORTUNITIES – SEVEN WAYS FORWARD

The proposals below are immediately required to address the current children's mental health crisis and already proven in practice as discussed here and elsewhere. The measures are used successfully in 55 other countries; therefore their adoption in the UK would not be contingent upon the outcome of lengthy and expensive trials.

The seven steps advocated are:

1. Focus more on the needs of children

Poor mental health in children is usually occasioned by 'life' events including trauma, loss, and insecure attachment, being bullied and needing respect. They start as 'mind' issues which have a neurobiological impact. Play and creative arts therapies are psycho-social rather than medical interventions and generate healing neurotransmitters.

Policy strategies work best when they act in parallel to good practice by integrating mind and body approaches.

It is necessary to distinguish between 'children' who are largely reluctant (or lack the capacity) to discuss their problems, and 'young people'. Talking therapies are less effective for children. 'Infants' differ from children because they respond best to touch-based interventions. Children attending school require:

- a) The curriculum to have embedded within it an understanding of emotional wellbeing and the principles of good mental health
- b) The certainty of therapeutic support for those children who have a diagnosable mental health condition (and those with an incipient condition that will deteriorate if not treated quickly).

These needs require clear definition and separate funding streams.

2. Children are insufficiently protected; too many unqualified and unsupervised persons are practising

Any individual who works therapeutically with children must be registered through an independent government-approved agency such as the Professional Standards Authority's Accredited Register programme or the HCPC. No additional finance will be needed.

3. Ensuring value for money

It is essential to define what constitutes an 'Evidence Base' for working therapeutically with children. The way forward is the measurement of what actually does happen; 'effectiveness.' Practice based evidence uses continuous

measurements obtained from real life practice and must have at least an equal place and hierarchy of evidence alongside the existing hierarchy for policy making (based upon assessing 'efficacy' via the use and meta-analysis of Random Control Trials).

4. Also focus on the needs of parents; main agents of change

Primary schools are viewed by parents as effective, familiar, accessible and empathetic service delivery channels. School Mental Health Leads as proposed in the Green Paper should be supported by the wider school staff; appropriately trained to deliver therapeutic play on site. This will require a re-balancing of funding streams between Health and Education.

5. Growing a qualified workforce

Level 7 postgraduate training is essential. There is existing annual training capacity for 4,000 new therapists at the required standard, but the main obstacle is a lack of financial support; the majority of trainees currently invest £8000 of personal funds on the training required for the registration process. A solution would be to open up the apprenticeship scheme (revised in 2017 and currently failing to meet its target numbers) for children's mental health therapy training. There are well defined competencies for Play & Creative Arts Therapists that meet the criterion that the skills, knowledge and behaviours needed to be fully competent in the relevant occupation are set out.

6. Improvement of practice

A commitment to 'joined up' working would see potential benefit for individual children through sharing appropriate data to all agencies concerned with the child's welfare (such as schools, social services and health). All children would derive benefit from the dissemination and application of practice based evidence through the development of collective intelligence. The standards and advanced data collection systems already in use should be more widely spread and coordinated with government support.

7. Making policies work

As usual, managing change is the main hurdle, rather than technical or financial obstacles.

Direction and control as well as coordination between all departments and agencies at national and local level are therefore required.