



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

MENTAL HEALTH IN CHILDHOOD

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We thank the National Counselling Society for the financial support that made this Report possible and wish to make it clear that the National Counselling Society neither requested nor received approval of its contents.

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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 on 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 on the Parliamentary website at: <https://publications.parliament.uk/pa/cm/cmhallparty/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.

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MENTAL HEALTH IN CHILDHOOD - EXECUTIVE SUMMARY

The 2017 Government green paper entitled *'Transforming children and young people's mental health provision'* was seen by many as a welcome recognition that, in reference to child mental health facilities in England, the euphemism *'could do better'* should be replaced by *'now fit for purpose'*.

By adopting a time-dishonoured approach to the mental health of children and young people that can best be described as *'muddling along'*, the UK had certainly not been alone. Neither is it true to say that we had been the foremost international offender.

'Across the pond' in the USA, whilst 1 in 5 children present with a diagnosable mental health condition, only 21% actually receive treatment. No UK Minister has ever been required to defend the Government in face of such atrocious statistics. Indeed, by comparison, a pan-European survey conducted by The Economist Intelligence Unit places the UK second only to Germany in a league table of countries that have been ranked on their stance toward child mental health. However, this is no reason for Ministers to rest on their laurels. A superficially advantageous placing appears to rely on the UK's ability to 'talk a good game,' mouthing modish words about 'early intervention' and 'integration into society', for example, but failing to back these with statute – and above all, financial resources.

Germany, with its strongly-funded Health and Welfare systems and demonstrable commitment to early intervention and community integration in practice, deservedly leads the field. The green paper however, offers a once-in-a-generation opportunity for England to reverse the long, slow decades of decay in the field of child mental health by prioritising:

- Early intervention in fact as well as theory
- A properly-funded CAMHS service with statutory referral times
- A Government commitment to child mental health as a priority service
- UK-wide collaboration between the education, health and voluntary sectors in the interest of child mental health and emotional wellbeing services
- A national in-school counselling service staffed only by professionally accredited counsellors on an Accredited Register
- Compulsory initial training and ongoing CPD for all teachers and other professionals dealing with the mental health of children and young people
- Re-balancing the National Curriculum to include statutory child mental health and wellbeing content and the re-positioning of play and physical activity within a 'whole child' context

- The Government to provide more accessible and timely support for children, young people and families who have experienced adversity and trauma with a specific focus on Adverse Childhood Experiences (ACEs)
- New plans to fill the gap between school-based counselling and CAMHS for the school-aged child and speedy, responsive services for students/apprentices embarking upon an FE place, degree or mix of work and training who currently 'fall between services' and are unable to access sources of help
- Government to initiate dialogue with media outlets about the screening of potentially contentious material at times of stress (examination cycles etc)
- Government to initiate an 'awareness' campaign in order to lessen the chance of children with a mental health disability or illness suffering discrimination in society outside the immediate environs of school
- Government commitment to ring-fenced funding for antenatal, postnatal and early years mental health provision for children and parents
- Government regulation of social media where appropriate for child safeguarding purposes
- Government funding for child mental health to reflect the needs of culturally-diverse and socio-economically disadvantaged communities
- Inter-departmental collaboration on policy to promote child mental health and wellbeing; ideally co-ordinated and audited by a Secretary of State for Children.

These and other measures are discussed in the body of this report. We hope that they will assist the Government in making its eagerly awaited child mental health legislation 'as good as it can be' rather settling for, in time-honoured fashion, a strategy that is 'just about good enough'. The green paper as it stands is not perfect, but neither should it be denounced as emblematic of yet another policy failure. 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.

Within this context, a Department for Children and a Secretary of State with responsibility for cross-departmental audit scrutinised by a new Select Committee are integral.

HELEN CLARK: MAY 2018

SUMMARY OF RECOMMENDATIONS

1. WHERE ARE WE NOW? AN OVERVIEW OF CHILD MENTAL HEALTH SERVICES AS HISTORICALLY AND PRESENTLY AVAILABLE:

- 1.1 UK Government to require all local authorities to make counselling services available to children in both primary and secondary schools
- 1.2 All professionals offering therapies to children to be required to register either through the AR programme or with the HCPC to ensure appropriate training, safety of practice and quality of work
- 1.3 All mental health services available to children in school settings to be subject to Ofsted inspection
- 1.4 Children's mental health to be designated a national priority necessitating co-ordinated action across all Government Departments.

2. MATERNAL AND CHILD MENTAL HEALTH; IN PARTICULAR, PREPARATION FOR PREGNANCY, THE ANTE AND POST-NATAL PERIOD

- 2.1 Expand proposals in the 2018 green paper to include strategies for working with parents and infants during the antenatal, postnatal and 0-2 years time spans
- 2.2 Allocate a higher proportion of the CAMHS budget to the under two year old age group
- 2.3 Ensure that all women and parents have regular access to professionals who are specifically trained in specialist perinatal health services both in home, medical and community settings
- 2.4 Government to promote paid maternity and paternity leave as being associated with better maternal and child health, lower maternal depression, lower infant mortality, more breastfeeding and an increase in general wellbeing
- 2.5 Government to study established schemes, targeted intervention and groups that work well and cascade good practice widely rather than devoting time and resources to reinventing the wheel.
- 2.6 To further connect and jointly commission adult perinatal mental health or drug abuse services, with children's services: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/642/64206.htm#jdTexAnchor027>

3. EARLY YEARS SETTINGS: CHILD MENTAL HEALTH AND WELLBEING

- 3.1 Health and education professionals to receive initial training and CPD in attachment and brain development

- 3.2 Accessible and 'reader friendly' guidance in early years mental and emotional wellbeing to be made available for parents
- 3.3 Further professional training and requirements for childminders and those responsible for children under two years of age
- 3.4 Government to commit additional resources to early years support
- 3.5 Place an emphasis on active play in settings and the home that are clearly linked to better social and emotional wellbeing, brain and language development

4. CHILD MENTAL HEALTH AND WELLBEING PROVISION WITHIN THE EDUCATION AND HEALTH SERVICES

- 4.1 Health and education professionals to receive initial training and CPD in attachment and brain development and the impact of Adverse Childhood Experiences (ACEs) and trauma-informed practice
- 4.2 Accessible and 'reader friendly' guidance in early years mental and emotional wellbeing to be made available for parents
- 4.3 The adoption of a 'whole-school' approach to the provision of mental health services for children and young people which also encompasses and addresses the mental health and wellbeing of teachers and adults in the school environment
- 4.4 Government to commission further research into the impact of high-quality physical activity interventions in achieving positive mental health outcomes in children and young people
- 4.5 Specifications, protocols, directives and incentives required for the sharing of children's mental health data to be clarified in order to facilitate collaborative working between health, education and social care concerns
- 4.6 Counselling to be provided as integral to all educational settings. The Department of Health estimate that a targeted therapeutic intervention delivered in school costs around £229 but derives an average lifetime benefit of £7,252, thus producing a cost benefit ratio of 32-1
- 4.7 All counselling to be delivered by suitably trained practitioners who are on a Professional Standards Authority Accredited Register: <http://www.nationalcounsellingsociety.org/accredited-register/> or included in the HCPC register <http://www.playtherapyregister.org.uk>
- 4.8 The training of such practitioners to include specific training in safeguarding, mental health, child attachment and development and awareness of the impact on children and young people of social media and the internet
- 4.9 The Government to recognise the importance of physical education, sport and physical activity in supporting children's mental and physical wellbeing and for this to be reflected in the structure of the school day

- 4.10 There is a need to re-think the content, aims and structure of the curriculum, given that even the advisers who worked on primary curriculum content and testing now have reservations: <https://www.theguardian.com/education/2017/may/09/fronted-adverbials-sats-grammar-test-primary>
- 4.11 The Government to provide policies and systems to help young people in the 'transition' phase between leaving school and obtaining access to full adult mental health services.

5. TRAINING NEEDS OF HEALTH AND EDUCATION PROFESSIONALS

- 5.1 ITT programmes to ensure that mental health forms part of core content curriculum for ITT
- 5.2 A revision of the Teachers' Standards to explicitly highlight that teachers show evidence of knowledge in child mental health before obtaining Qualified Teacher Status
- 5.3 All schools to allocate a designated lead for child mental health to oversee staff training and multi-agency partnership
- 5.4 Schools to access free training and resources to ensure that teachers maintain a current and contemporary knowledge of mental health awareness in young people
- 5.5 ITT mental health training for teachers and CPD to embed strategies to improve the mental wellbeing of teachers
- 5.6 The lunchtime period and its part in the encouragement of child mental health and wellbeing to be included in individual school development plans as an Ofsted requirement
- 5.7 Training grant/funding for employers and/or individuals, possibly on a matched-funding basis, to be made available for therapists, to include children's counsellors
- 5.8 A statutory requirement for all those working as therapists with children to have successfully completed a professional course that meets QAA standards
- 5.9 QAA to be encouraged to develop a Subject Benchmark Statement for Children's Mental Health that subsumes the competencies that have been defined to date by the professional organisations working in this field.

6. IDENTIFYING AND TACKLING SOCIAL AND ECONOMIC INEQUALITIES, CULTURAL AND ETHNIC DIVERSITY AS THEY INFLUENCE CHILD MENTAL HEALTH AND WELLBEING

- 6.1 Mental health budgets to be ring-fenced to ensure that children receive the services and support that they need from a young age
- 6.2 Government to prioritise early intervention in all matters concerning services to support the mental health of children and young people

- 6.3 Government to fund research into the links between physical activity, wellbeing and mental health and use findings to develop mental health services within school and the wider community.

7. SERVICES IN THE COMMUNITY AND LOCAL AUTHORITY PROVISION AND RESOURCING

- 7.1 A national commissioning model for welfare secure placements, with urgent action to increase capacity across the country. It should be designed to fully integrate commissioning for all tier 4 (CAMHS) provision across health, social care and youth justice
- 7.2 Strategic alignment of all programmes and priorities that are relevant to vulnerable groups at national level to contribute to the delivery of an integrated response from Children's Social Care (CSC) youth justice and health
- 7.3 Resources to support children and young people's mental health services to be allocated holistically and with regard to demographic need
- 7.4 Government to make a clear statement of support for play as an essential component in children's physical and mental health, backed by a programme of investment in playgrounds and play spaces. Just £100 million would provide over 1,600 playgrounds and play spaces and reverse the decline typified by playground and play space closure.

8. INTERNATIONAL AND DEVOLVED UK MODELS OF PRACTICE

- 8.1 The adoption of a multi-disciplinary approach to children and young people's mental health, utilising experts from a range of professionals and agencies including health, education, social work and the third sector
- 8.2 A 'no wrong-doer' approach to be embedded into all strategies for mental health and wellbeing with a commitment to ensure that young people receive the appropriate type of help at the appropriate time
- 8.3 School improvement plans to specifically address child mental health and wellbeing and a 'whole school' agenda to be adopted covering all aspects of schooling
- 8.4 All mental health policies should address three central areas of prevention, protection and intervention and be free at the point of need for all young people until the age of 18
- 8.5 Support for children and young people with other health or physical and mental learning indicators to be reinforced by specialist health care providers in all educational settings
- 8.6 Training in mental health and CPD to be made available for all non-specialists in education, health and social services

- 8.7 Targeted mental health support to be provided for all young people who have been through the justice system, or who are identified as being at risk of offending.

9. THE INFLUENCE OF INDUSTRY, ADVERTISING AND THE MEDIA IN PROMOTING CHILD MENTAL HEALTH

- 9.1 The digital industry should build safety features into all products which are designed for children and young people as part of the design process
- 9.2 The digital industry should react more quickly to abuse by removing the accounts of perpetrators and reporting the abuse. It should remove inappropriate content rapidly
- 9.3 The advertising industry should ensure that advertisements do not promote low body-esteem
- 9.4 The media should play an even greater role in developing people's mental health literacy and highlighting issues in relation to the mental health of children and young people.

10. THE IMPACT OF SOCIAL MEDIA AND SCREEN TIME

- 10.1 Policy makers and associated organisations should adopt a clear public health position on children's age of initiation to Discretionary Screen Time (DST), along with the amount and time of day for DST as the prudent approach to good child mental health until more is known
- 10.2 Government must prioritise raising parental awareness of the potential risks of excessive internet use and ensure that all messaging is conveyed by health/education professionals (properly equipped and with CPD opportunities regularly updated) from antenatal care onwards
- 10.3 The National Curriculum to include digital literacy and digital citizenship and schools to provide age-appropriate curriculum content which focuses on developing these skills
- 10.4 Schools to develop peer support and digital ambassador schemes to support digital curriculum content as above
- 10.5 The digital industry should have a statutory requirement to report and remove abuse within strict timescales, suspend the social media accounts of perpetrators and interrupt the user's experience in response to inappropriate searches
- 10.6 App store providers should build in safety features from the outset to prevent children's exposure to harmful content
- 10.7 Government to promote greater opportunities for physical activity both in school and the wider community (thought to lead to a reduction in Discretionary Screen Time (DST) and the risk of Screen Dependency Disorder (SDD) in children and young people)

- 10.8 Policy makers to familiarize themselves with the influence of the technology industry in lobbying, funding research and influencing media depiction of Discretionary Screen Time (DST) and Screen Dependency Disorder (SDD) and be vigilant in detecting and publicising conflicts of interest
- 10.9 Policy and guidance in this area to be overseen and owned, by the Department of Health, *not* the Department for Digital, Culture, Media and Sport or Department for Education.

11. CHILD MENTAL HEALTH: THE WAY FORWARD

- 11.1 Joint action across government to improve co-ordination of the wider system of mental health support for children and young people by establishing a top level Inter-Departmental Group on Children's Mental Health with external representatives as appropriate. The group should ideally be convened by a Cabinet Minister for Children
- 11.2 The provision and universal requirement of qualified counselling services in all schools across the UK; Ofsted and the CQC to have responsibility for ensuring that unregistered, unqualified, unsupervised and unsafe practitioners are not being employed or contracted
- 11.3 School funding for child mental health services to include resources for engaging parents whose children receive therapy via a therapeutic coaching programme
- 11.4 Agree the specifications, protocols, directives and incentives required for the sharing of children's mental health data to make it easier for health, education and social care professionals to work more closely and effectively together (joined up care) and to improve practice through dissemination of practice-based evidence
- 11.5 Ensure that CAMHS have the resources for earlier and long-term intervention
- 11.6 All teachers to receive training in child mental health as part of initial training and CPD with all programmes to include emotional wellbeing, child mental health and child development
- 11.7 Supervision to support the wellbeing of teaching staff and mental health practitioners
- 11.8 PSHE curriculum to proactively support mental health and wellbeing from early years to secondary and further education
- 11.9 A focused and holistic approach in health and education to engender both positive empowering emotions and normalise emotions such as feeling of sadness or loss
- 11.10 Embodying play in a holistic approach to policy around child mental and physical health and this to be free outside and unstructured activity where children are allowed to use not only their physical skills but also their social, emotional and cognitive abilities

- 11.11 Reorienting the subject of physical education as integral to the social and emotional development of every child and not just to their physical capacity.

Note

The Term 'Counselling' has been used generically for reasons of brevity. This term also includes other proven therapeutic interventions for children, such as Play Therapy and Child Psychotherapy which have PSA Accredited Registers and in some cases an extensive evidence base.

1. WHERE ARE WE NOW? AN OVERVIEW OF CHILD MENTAL HEALTH SERVICES AS HISTORICALLY AND PRESENTLY AVAILABLE

The need to reform child mental health in England was recognised by the Government in *'Transforming children and young people's mental health provision: a green paper'* (2017). Launching the initiative, Health Secretary Jeremy Hunt said that the Government's £300 million plan was intended to finance *'hard action to ensure our young people get the support they need to stay well and help them achieve their true potential'* (3rd December 2017). Hunt's pledge was subsequently augmented by the Prevention Concordat for Better Mental Health: <https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-consensus-statement> (13th March 2018) and endorsed by a range of statutory organisations, professional and wider bodies and a first wave of geographical local area signatories.

Underpinning the Concordat statement was the assumption that *'taking a prevention-focused approach to improving the public's mental health is shown to make a valuable contribution to achieving a fairer and more equitable society'*. Signatories agreed preventative and cross-sector action with a strong emphasis on collaboration *'across organisational boundaries and disciplines'* and prioritised local area needs.

Any new health policy will, quite rightly, attract public scrutiny. There are many services administered by dedicated individuals who consistently put children first; but these people often work long hours with limited financial resources and increasing demands on their time. In the long term, a situation whereby some children wait up to eighteen months for treatment which only 25% are even able to access (*'The Guardian'*, 9th March 2018) must be deemed unsustainable.

'Sometimes we never escape our childhood. It doesn't matter how old you are; those toxic memories cling around you like plaiting fog. A fog which is so deeply embedded and entwined in a child's memories like being relentlessly bullied, depression, chronic panic attacks, self-harming, eating disorders and lack of food...hence the Government needs to put more investment in every way into the wellbeing and mental health of our young people, otherwise we will have many adults in future generations who never escape their childhood' (Kathryn Salt MBE: *Emotional Education Academic*, March 2018).

The current system of child mental health is funded, commissioned and supplied by many differing organisations. Lack of collaboration and fragmented care, waiting list pressure and the infrastructure of allocated funding all add up to a child mental health service currently in crisis. The individual child's welfare is frequently obscured by a myriad of complexities from differing providers,

themselves allocated by Clinical Commissioning Groups (CCGs). The overall picture is challenging, as illustrated by statistics supplied by Young Minds (*Young Minds Freedom of Information FOI Report: 2015*):

- Approximately 850,000 children and young people have a clinically significant mental health problem
- 1 in 10 children between the ages of 5-16 years (3 in every classroom) have a diagnosable mental health problem
- 1 in 4 children showed evidence of mental ill health (including depression and anxiety)
- Child and Adolescent Mental Health Services (CAMHS) are on average, turning away nearly 25% of child referrals
- 75% of mental health trusts between 2013/2014 and 2014/2015 have had budgets cut or frozen; CAMHS budgets have been annually depleted in this way since 2010
- Only 0.75% of NHS budget is directed to children's mental health; 6.36% of total NHS mental health-spend.

'In school' services for children and young people experiencing mental health issues are unsatisfactory for a variety of reasons. It is extremely disappointing that the Green Paper does not include a commitment to the universal provision of school-based counselling, despite the fact that when delivered well, it is one of the most effective ways of maintaining and achieving early mental health support for children.

In April 2008, the Welsh Government pledged to provide school access to counselling services for all pupils in Wales, but this is not customary elsewhere in the UK. Despite evidence that school-based counselling complements the approaches already available in schools (supporting the health, emotional and social needs of pupils whilst fostering a positive school culture) many primary and secondary schools have either no access to counselling or a strictly limited service. Established provision within an educational setting is one of the most reliable ways of maintaining and achieving mental health support to children. All professional and experienced counsellors working within a school setting consider counselling to be an essential component of a 'whole school' approach to child mental health.

Where counselling services do exist within school, excessive reliance is frequently placed upon professionals who have no specific training in child mental health. Similarly, a CAMHS service may be used that is over-stretched and underfunded. A Young Minds research survey: <https://youngminds.org.uk/media/2258/youngminds-fightingfor-report.pdf> shows excessive waiting times for much-needed support. Of those parents whose children had received assistance from

CAMHS, 425 encountered difficulties in securing an initial referral, 64% endured a long wait between referral and first assessment and 43% faced an undue delay between assessment and treatment.

Child mental health needs are various. Data gathered by Play Therapy UK over 17 years reveals 1,417,300 UK children in need of therapy requiring 21,500,000 treatment sessions and 23,370 properly qualified therapists. The data represents a 'snapshot' view of 375 local authority areas and 8546 districts and the top nine presenting conditions are listed as:

- Relationship difficulties
- Anger
- Attachment issues
- Lack of self esteem and confidence
- Adjustment issues
- Bereavement
- Domestic violence
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism Spectrum Disorder (ASD)

Yet this list represents only 63% of a total of 14460 clients and in the current workforce, there are insufficient adequately-trained therapists and clinical supervisors to match demand. Primary schools are proven service delivery channels for a number of therapies and the main child interventions that fulfil the requirements of either the Professional Standards Authority's (PSA) Accredited Register programme, or the Health and Social Professions Council (HCPC) are play therapy, child psychotherapy and arts therapies. The number of inadequately-trained and clinically supervised persons who are practising some form of therapy with children is a further problem. Their ultimate effect might consist of merely affording the employer a 'tick box' opportunity, but at worst it could result in damage to a child's mental health.

Overall, the majority of children and young people experiencing mental health problems do not receive the type, availability and quality of services that they deserve. There is a steady rise in the number of young people who present with symptoms of depression, anxiety and psychosis; suicide being the most common cause of death in boys between 5-19 years and the second in girls of this age group. Professionals can feel disheartened and unsupported by the lack of response from CAMHS; themselves also encumbered by intransigent difficulties in the form of extra referrals, staff shortage and inadequate funding.

Jeremy Hunt has said: *'Childhood should be the happiest time in life, but for those experiencing poor mental health, it can be anything but.'* (3rd December 2017)

Policy makers must confront the present crisis without delay, or risk of confirming Polly Toynbee's judgment that *'This is no country for children.'* (*'The Guardian,' 8th March 2018*).

Delay is, of itself, the clog lying in wait to derail the entire green paper strategy:

'The long timeframes involved in the strategy will leave hundreds of thousands of children and young people unable to benefit from the proposals. Rolling out the plans to only 'a fifth to a quarter of the country by 2022/23' is not enough. We advocate more widespread implementation and iterative learning methods to inform best practice across the piece,' (*'The Government's Green Paper on mental health: failing a generation,' First Joint Report of the Education and Health and Social Care Committees, 9th May 2018 www.parliament.uk*)

Recommendations:

- 1.1 UK Government to require all local authorities to make counselling services available to children in both primary and secondary schools
- 1.2 All professionals offering therapies to children to be required to register either through the AR programme or with the HCPC to ensure appropriate training, safety of practice and quality of work
- 1.3 All mental health services available to children in school settings to be subject to Ofsted inspection
- 1.4 Children's mental health to be designated a national priority necessitating co-ordinated action across all Government Departments.

2. MATERNAL AND CHILD MENTAL HEALTH; IN PARTICULAR, PREPARATION FOR PREGNANCY, THE ANTE AND POST-NATAL PERIOD

The perinatal period immediately before and after birth starts at the 20th–28th week of gestation, and ends 1-4 weeks after birth. Early attachments are formed during this time and can influence the lifespan and the individual's subsequent adult contribution to society: <https://www.learning-theories.com/attachment-theory-bowlby.html>

'Teaching parents-to-be about bonding and attachment and the importance of holding, talking and gazing at their infant, cannot be underestimated. It is possibly the single most important role that a parent has in terms of the child's emotional development, yet most parents are completely unaware of how infants' brains develop or what they can do to give their infant the best start in life.'

<https://www.infants.uk.com/about-us-antenatal-classes/dreams/>

By observing the interplay of a baby's facial and body movements, parents learn to recognise and understand their child's cues and direct their own behaviour in response. The infant will potentially develop feelings of self worth and attachment, leading to the establishment of relationships that underpin good mental health. When its cries are disregarded, large amounts of the distress hormone cortisol can impact a baby's developing brain and may also be activated in early pregnancy by a mother's natural anxieties and other causes of distress including domestic abuse. The absence of minimal bonds and attachment experiences by the time a child is aged two can presage later anti-social problems: <http://ecswe.net/qoc-vol2/>

Pregnancy and birth are traditionally associated with sensations of achievement, satisfaction and joy. The all too frequent reality however, is that both parents can feel insecure, anxious and utterly ill-equipped to deal with unfamiliar new demands.

Between 10 and 20% of women develop a mental illness either during pregnancy or within the year after giving birth. Illnesses include antenatal and postnatal depression, obsessive compulsive disorder, post traumatic stress disorder (PTSD) and postpartum psychosis. They all require treatment and often progress and worsen suddenly necessitating a variety of approaches and care plans to minimise damage to mother and child. NICE guidelines on antenatal and postnatal health (2014) identify women experiencing problems during and after birth as follows: <https://www.nice.org.uk/guidance:>

- Severe anxiety and depression – parents referred to a GP with specific actions recommended, including pharmaceutical intervention
- Less severe - counselling, therapy and access to support groups

- Existing mental health difficulties such as eating disorders – continuation and adaptation of ongoing treatment: <https://www.health-ni.gov.uk/publications/endorsed-nice-clinical-guidelines-20162017>

Unresolved childhood issues can adversely impact an individual's experience of parenting and evidence suggests that trauma can be unwittingly transferred across the generations and mimicked by the new parent and child. Parents who were unable to recall their own childhood emotional feelings (in particular, memories of abuse) were likelier to repeat the adverse behaviour patterns with their own children: [http://www.jaacap.com/article/S0002-7138\(09\)61442-4/abstract](http://www.jaacap.com/article/S0002-7138(09)61442-4/abstract)

Maternal mental health problems have been found to have negative physical and emotional impact upon children including:

- Congenital malformation, associated with maternal life event stress in the first trimester: https://journals.lww.com/epidem/Fulltext/2000/01000/Maternal_Life_Event_Stress_and_Congenital.8.aspx
- Lower birth weight and a reduced gestational age associated with lower stress levels: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2830085/>
- Regional reduction in brain grey matter, affecting foetal cognitive and intellectual impairment, prenatal stress and physiological outcomes: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3356611>
- Child anxiety and depression, symptoms of ADHD, conduct disorder and prenatal stress: <https://www.ncbi.nlm.nih.gov/pubmed/17923988>

It is clearly preferable that families are supported holistically from conception, in order to achieve higher levels of physical and mental wellbeing for themselves and their children. The negative cycle of intergenerational poor mental health must be broken and the focus placed firmly upon prevention strategies rather than nurturing a blame culture. However, the 2018 green paper: <https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper> concentrates upon older children, giving no direct mention of the 0-2 age range.

The First Joint Report by the Education and Health and Social Care Committees (9th May 2018 www.parliament.uk as above) makes this point, suggesting that the green paper be amended to include *'more co-commissioning between adult and child mental health services for the whole family, especially in perinatal mental health support,'* and also *'the need for preventative action in stimulating and protecting early years brain development, supporting loving and respectful inter-parental relationships and enabling secure attachments with parents and carers.'*

Financial priorities are also in need of revision. Currently, only around 1% of the CAMHS budget is spent on the under twos although the subsequent cost of perinatal depression, anxiety and psychosis incur long-term outcomes to society of around £8.1 billion for each one-year cohort of UK births. If perinatal problems were identified and treated swiftly, many serious long-term human and economic consequences could be alleviated: <http://eprints.lse.ac.uk/59885/>.

The present level of services is inadequate. In 2015, approximately 85% of localities did not have specialist perinatal mental health services as recommended by the NICE guidelines. Services and programmes should be addressed via a two-pronged strategy; for those with severe mental health problems including postnatal depression as well as parents with moderate mental health needs. Parents would then be supported whilst learning how to recognise and respond to their children's needs. Paid maternity and paternity leave have been found to be linked with improved maternal and child health, lower maternal depression, lower infant mortality, increased rates of breastfeeding and general positive wellbeing: <https://link.springer.com/article/10.1007/s00148-003-0159-9>

A number of excellent initiatives that are capable of wider roll-out include the following:

Mellow bumps/Mellow infants:

<http://www.mellowparenting.org/our-programmes/mellow-bumps/>

This six-week duration group, developed originally in Scotland, is antenatally delivered at 20-30 weeks' gestation. It supports families with additional health and social needs, offering ways in which to decrease mental antenatal stress and increase the capacity for social interaction by enhancing brain development and attachment.

Rock a Bye:

<https://www.bristolearlyyears.org.uk/health/health-visitors/maternal-health/>

Rock a Bye groups are creative interventions designed specifically for women with severe and moderate mental health issues. They consist of dance movement therapy for postnatal women and their babies. PND (which usually presents during the first three months and can last up to twelve months) significantly inhibits the early development of positive relationships between mother and infant. Rock a Bye groups are targeted at mothers with infants under one and regular attendance at the intervention has been shown to enhance confidence and skills whilst being more cost-effective than services introduced at a later stage.

Solihull Resource Pack:

<http://s571809705.websitehome.co.uk/Images2/antenatal%20&%20apg%20with%20costs%20revised%2012.12.pdf>

This resource pack, authored by midwives and antenatal practitioners, contains information about relationships and development. The resource encourages parents to record their own emotional journey to parenthood, revealing possible factors that may impact their own and their infant's emotional wellbeing. Interviews with the same practitioner are held at the 28th week of pregnancy and again at 6-8 weeks postnatally. The pack assists professionals in accessing the views and experiences of parents, thus enriching their own professional conduct.

What about the children?:

<http://www.whataboutthechildren.org.uk/>

A group of professionals advocating and campaigning on the behalf of young children, sharing concern about the importance of emotional wellbeing and adverse childhood experiences.

1001 Critical Days:

<https://www.1001criticaldays.co.uk/>

The 1001 Critical Days Manifesto highlights the importance of intervening early and valuing the importance of conception through to the age of two years. It emphasises the value of early intervention and preventative measures with families during both the antenatal and postnatal period, drawing attention to the importance of attachment and emotional and social wellbeing between parents and their children. It supports connecting local mental health services and in acting early, outcomes for children and into later life can be positively enhanced. This includes channelling information and supporting parents and families from conception.

Adverse Childhood Experiences (ACEs):

There is also strong evidence that adult mental health problems begin in childhood or adolescence – and emerging evidence that adverse childhood experiences in infancy may have negative impacts on future mental health and wellbeing outcomes. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222573/>). A British cohort study showed that teenagers who had common mental disorders (CMDs) were more than two and a half times more likely to have a CMD at age 36, compared with mentally healthy teenagers. For teenagers with persistent CMD, they were over six times more likely to have CMD at age 36 and 43, and four times more likely at age 53: <http://news.nursesfornurses.com.au/Nursing-news/wpcontent/uploads/2015/02/Mentalhealthdisordersandageofonset-1.pdf>

Recommendations:

- 2.1 Expand proposals in the 2018 green paper to include strategies for working with parents and infants during the antenatal, postnatal and 0-2 years time spans
- 2.2 Allocate a higher proportion of the CAMHS budget to the under two year old age group
- 2.3 Ensure that all women and parents have regular access to professionals who are specifically trained in specialist perinatal health services both in home, medical and community settings
- 2.4 Government to promote paid maternity and paternity leave as being associated with better maternal and child health, lower maternal depression, lower infant mortality, more breastfeeding and an increase in general wellbeing
- 2.5 Government to study established schemes, targeted intervention and groups that work well and cascade good practice widely rather than devoting time and resources to reinventing the wheel
- 2.6 To further connect and jointly commission adult perinatal mental health or drug abuse services, with children's services: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/642/64206.htm#jdTextAnchor027>

3. EARLY YEARS SETTINGS: CHILD MENTAL HEALTH AND WELLBEING

Early years experiences can impact mental health throughout childhood and beyond. A mentally healthy child has a clear sense of identity, self-worth and the ability to form positive relationships. A wide range of interrelated factors are influential including individual, family, wider societal and environmental issues.

The Government green paper '*Transforming children and young people's mental health*' (referenced earlier) contains little about early years provision and commissioned and researched interventions are largely targeted towards primary and secondary school pupils. Yet early years settings provide key opportunities to identify children with incipient mental health problems (many linked to attachment) and address problems via sensitive interventions with parents and carers.

Barnardo's supports over 272,000 children, young people, parents and carers in the UK every year. They help parents with very young children via Children's Centres, parenting programmes, play services and nurseries. The following practice example (2018) is indicative of Barnardo's work with parents of early years children:

'Diane was feeling very worried about the behaviour of her two year old son, who was struggling to communicate and who would get frustrated easily. She was also feeling isolated and had financial problems.

Diane was referred to one of our early support services, where she received one-to-one support at home and at the local Children's Centre. Her Barnardo's worker supported her when her son was given a diagnosis of Autism Spectrum Disorder (ASD). They helped her to understand the diagnosis, to explore new ways to play with her son, and to access a fund to buy sensory toys. The support made their lives easier at a critical time, and gave Diane the confidence she needed to move forward.

Diane now feels more in control and more able to try different strategies to meet her son's needs. She has enrolled in her local parent/carer forum so she can learn to advocate for her son. She has also started to help other parents by volunteering in the service's parent support group, which has widened her own support network too.'

Barnardo's report '*The Case for Early Support*' (Rallings J & Payne L 2016) highlights the importance of early attachment in children's future mental health outcomes, demonstrating that when a baby's development lags behind the norm during the first year of life, the child is much likelier to regress further than to

catch up with those who have had a better start. Early relationships are shown to be essential precursors of later social behaviours and the report found that around 26% of UK babies (198,000) are estimated to be living within complex family situations of heightened risk. Key factors were substance misuse, mental illness, domestic violence and 36% of serious case reviews involved a baby under the age of one.

Research illustrates the strong emotional benefit to the child of paid parental leave: <https://link.springer.com/article/10.1007/s00148-003-0159-9> but for many parents this is not a viable option and evidence from some sources demonstrates levels of parental dissatisfaction with external childcare settings. According to *'The Good Care Guide'* parental reviews rating nurseries as 'poor' or 'bad value for money' increased from 9.3% in 2012 to 12.8% in 2016 with reasons for a negative rating including:

- Staff not complying with parent's specific dietary requirement instructions
- Staff members speaking 'poor English'
- Nurseries being unduly 'money' as opposed to 'care' oriented
- Insufficient child learning at nursery
- Staff refusing to potty train children
- High staff turnover
- Poor hygiene
- Small rooms and limited stimulation
- Lack of compassion in cases of bereavement/illness
- Safety failures.

<https://www.nurseryworld.co.uk/nursery-world/news/1160305/parents-say-childcare-quality-is-falling>

Early years settings are required to focus upon promoting a 'key person' approach to enable the establishment of a stable base and close relationship model for each child: https://foundationyears.org.uk/files/2017/03/EYFS_STATUTORY_FRAME_WORK_2017.pdf. However, Sue Palmer (*Palmer, S (2015) 'Toxic Childhood'*) maintains that in many settings this requirement is counteracted by high staff turnover.

'All the research shows that up to the age of two, children need consistent loving care and you're less likely to get that in a nursery where staff turnover can be high.'

The Education Policy Institute (*'Developing the Early Years Workforce. What does the evidence tell us?' 2017*) has cited an increasing reliance in early years providers on unpaid volunteers (10.8% of staff in nurseries; 7.8% in non-school settings)

raising inevitable questions about their deployment, skills and overall effect on the quality of provision for children.

The UK Chief Medical Officers have said that physical activity is a crucial component in the psychological wellbeing of an early years child (*'Start Active, Stay Active; A report on physical activity for health from the four home countries' Chief Medical Officers, 2011, Department of Health*). However evidence shows that physical activity levels in UK early years childcare settings are very low (*'UK Physical Activity Guidelines for Early Years (Walkers): information for stakeholders, early years practitioners and health professionals', British Heart Foundation*).

One study concluded that although some excellent physical environments were offered in childcare settings, little time was spent in play of the required moderate or vigorous intensity (*Temple VA, Naylor P-J, Rhodes RE & Higgins JW, 2009, 'Physical activity in family child care'. Applied Physiology, Nutrition and Metabolism*). This correlated with a lack of opportunity to use play and physical activity to form positive attachments and relationships and thereby develop the foundations of physical, social and emotional wellbeing that will be beneficial later in the life course.

Feelings and ways of expression can be explored through play, and physical activity in natural environments has been shown to alleviate the symptoms of ADHD in some children. A survey published by the National Association of Schoolmasters and Union of Women Teachers reveals that by age four, some children already show signs of mental health problems, including symptoms of anxiety, panic attacks and depression: <https://www.telegraph.co.uk/education/2018/04/02/children-young-four-showing-signs-mental-health-problems-teachers/> adding further weight to the importance of the child's experience in early years settings. Yet a crucial window of opportunity will be missed unless there is a shift in spending priorities at Government level.

The vast bulk of evidence points to the fact that child mental health will not be 'transformed' to meet the 2018 green paper aspirations unless due attention is paid to the quality of what is offered in early years settings. To a large extent, this will depend on the amount of available money and the current prognosis is not auspicious.

The Children's Society has estimated that early support services are expected to be cut by 71% between 2010 and 2020; from £3.2 billion to less than £1 billion (*The Children's Society, 2016 'Government spending on early support for children slashed by 71%'*): <https://www.childrensociety.org.uk/news-and-blogs/press-releases/government-spending-on-early-support-for-children-slashed-by-71>. The absence of long-term planning and the growing cuts to funding have led to a shift

in spending patterns with local authorities concentrating on short-term support at the point of crisis and spending less on early support/intervention and prevention.

Department for Education figures have revealed that Children's Centres have had funding cut by 47% since 2010; from £1.2 billion to an estimated £0.6 billion during 2016/2017 (*Department for Education, 2016. 'Expenditure by Local Authorities and Schools on Education, Children and Young People's Services in England, 2015-16'*): <https://www.gov.uk/government/statistics/la-and-school-expenditure-2015-to-2016-financial-year>

Organisations such as Barnardo's have responded by integrating previously separately commissioned strands of work, extending the age range catered for by centres and collaborating with private and voluntary sector partners to secure services. Some positive outcomes of this switch have been seen, and one example is Barnardo's partnership with Newport City Council in Wales to develop a new integrated family support service. The service had the overall mission of reducing cost to the local authority via integration and re-imagining the whole system for children, young people and families. Since its inception, the service led and managed by Barnardo's and working in partnership with Newport has exceeded all targets originally set, and has saved costs by effectively engaging with vulnerable young people and families at the right time and the right place, ultimately reducing the number coming into the care system: http://www.barnardos.org.uk/strategic_partnerships_cu.htm. The Case for Early Support report (*as above*) however, shows that initial financial outlay on early years support saves money in the long term. The Early Intervention Foundation (EIF) published figures analysing the cost of late intervention in 2016 which showed state spending of nearly £17 billion per year in England and Wales on late intervention; amounting to about £287 per person.

The largest individual costs are:

- £5.3 billion spent on Looked After Children
- £5.2 billion associated with cases of domestic violence
- £2.7 billion spent on benefits for young people who are not in education, employment or training (NEET).

The cost of late intervention is spread across different areas of the public sector with the largest share born by:

- Local authorities (£6.4 billion)
- The NHS (£3.7 billion)
- Department for Work and Pensions (£2.7 billion).

The proportion of the health budget spent on preventive health measures in England in 2015 was 5.2% (Fitzsimons P & Chowdry H (2016), 'The Cost of Late Intervention: EIF Analysis 2016' Early Intervention Foundation).

The Government's stated resolve to address child mental health is both welcome and timely:

'Recent research suggests that children are more likely to suffer from mental health issues than 30 years ago.' Mind, 2015

But the absence of proposals for the early years in the 2018 green paper could seriously dilute the effect of the £1.7 billion that the Government does propose to allocate to mental health services for the benefit of UK children and young people. The consensus from a wide range of professional sources is that the foundation for good mental health is laid down in the early years of life.

It therefore makes sense to invest in it:

'By the time all children begin school they vary in cognitive skills, communication and social development. Therefore, if their early experiences have been negative then the Government's pledge to support their wellbeing could be interpreted as an empty promise which will fail to address the root cause of some mental health issues': https://www.pacey.org.uk/Pacey/media/Website-files/PACEY%20general/Emotional_wellbeing_literaturereview-Dec2015.pdf

Recommendations:

- 3.1 Health and education professionals to receive initial training and CPD in attachment and brain development
- 3.2 Accessible and 'reader friendly' guidance in early years mental and emotional wellbeing to be made available for parents
- 3.3 Further professional training and requirements for childminders and those responsible for children under two years of age
- 3.4 Government to commit additional resources to early years support
- 3.5 Place an emphasis on active play in settings and the home that are clearly linked to better social and emotional wellbeing, brain and language development

4. CHILD MENTAL HEALTH AND WELLBEING PROVISION WITHIN THE EDUCATION AND HEALTH SERVICES

The green paper *'Transforming Children and Young People's Mental Health,'* pledged to address the mental health needs of UK children and young people; highlighting that *'children with a persistent mental health problem face unequal chances in life'* and stating that *'this is one of the burning injustices of our time'* (reference above).

Produced jointly by the Departments of Education and Health, the paper depicted an essential role for schools and colleges in promoting good mental health for children and young people; pinpointing early intervention as a means of nipping potentially adverse issues in the bud. The approach built upon findings in the Health and Education Committees' joint report, which maintained that schools and colleges have *'a frontline role in promoting and protecting children and young people's mental health and wellbeing'* and that mental health and education services should work collaboratively to improve outcomes (*'Heads together, Mentally Healthy Schools'*): <https://www.mentallyhealthyschools.org.uk/>

The link between school-related stress and a high level of health complaints was made in a report commissioned by The National Union of Teachers:

'Children and young people are suffering from increasingly high levels of school-related anxiety and stress, disaffection and mental health problems. This is caused by increased pressures from tests/exams; greater awareness at younger ages of their own 'failure'; and the increased rigour and academic demands of the curriculum....

Increasingly, children and young people see the main purpose of schooling as gaining qualifications because this is what schools focus on' (National Union of Teachers *'Exam Factories. The Impact of Accountability Measures on Children and Young People'* 2015): https://www.teachers.org.uk/sites/default/files2014/exam-factories_0.pdf

The report finds negative impacts on the breadth of the curriculum (focus on what is tested, neglect of humanities and the arts); on students' perception of education (pass exams, be prepared to compete in the jobs market); on children's self-esteem (they believe at a very young age that they can fail); on teacher-pupil relationships; and on mental health. All these elements in combination result in a toxic mix and a vicious circle.

According to the Exam Factories report, *'both primary and secondary pupils said that they learned more effectively in active and creative lessons because they were more memorable'*. These lessons require more time (which is in short supply) and again, pupils' learning and achievement suffer.

The report records findings demonstrating that school and examination pressures were the largest causes of stress and anxiety amongst children and young people. There was a 200% increase in counselling sessions by Childline related to exam stress between 2012-2013 and 2013-2014. According to a survey, 68% of children said that they felt pressured at the time they took their SATS.

Disaffection and demotivation were found in all age groups and types of school when pupils were aware (and unfortunately, most were) that they were performing less well than others in the class. Significantly *'five and six-year olds who failed in a task were more likely to make global negative self-judgements (I am no good).'*

The charity Young Minds (*'Mental Health Statistics' 2018*): http://www.youngminds.org.uk/about/whats_the_problem estimated that three pupils in every UK classroom have a diagnosable mental health disorder such as anxiety or depression and some comments by participants in Barnardo's focus groups suggest that many school environments neither promote good mental health, nor enable pupils to safeguard their own wellbeing and that of others. Isolation, confusion and fear were feelings shared by the respondents:

'All teachers should see the warning signs. When I was suffering from depression and was self-harming, no teachers spotted the signs.'

'I think it is very important that primary schools get taught about it too. My mental health problems started when I was at primary school. It was scary because everyone around me had no idea about it. I would tell the teachers about how I was feeling and they would just say I'm going through changes. I didn't really get help about it until I was in Year 9 in secondary school and even then people didn't really know about it.' (Barnardo's focus groups with young people, February 2018)

Childline has reported that school and educational problems were related directly to suicidal thoughts and Sharp (Sharp A, 2013 *'Exam culture and suicidal behaviour among young people'* *Education and Health*, 31(1): 7-11) has argued that:

'There are clear indications ... that the pressure to perform in an increasingly micro-managed, accountable education system may be playing a part in developing mental health problems and suicidal behaviour.'

There have been reports of EYFS/Year 1 children suffering from night terrors, sleep walking and other sleep disorders and both primary and secondary school teachers have reported depression, panic attacks, self-harm, eating disorders and thoughts of suicide among their pupils. One condition that has been identified as an increasingly prevalent by-product of an unhealthy school culture is ADHD which has been shown to correlate with high stakes testing. Young children for whom the paper/pencil/chair/table/ traditional regime is developmentally inappropriate, are also diagnosed and sometimes medicated for ADHD. Unfortunately, as detailed in 'Bold Beginnings': https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663560/28933_ofsted_-_early_years_curriculum_report_-_accessible.pdf Ofsted remains firmly committed to pinning 4-5 year olds to tables and chairs.

However, a growing body of evidence points toward the beneficial effects of alternative strategies. An estimated 4.4 million children in the United States suffer from ADHD and research findings indicate that most would benefit from a low-cost, side-effect free way of managing their symptoms. The study '*Could Exposure to Everyday Green Spaces Help Treat ADHD? Evidence from Children's Play Settings*' (Andrea Faber Taylor, Frances E (Ming) Kuo, 4th August 2011): <https://onlinelibrary.wiley.com/doi/full/10.1111/j.1758-0854.2011.01052.x> examines whether routine exposure to green space, experienced via children's everyday play settings, might yield ongoing reductions in ADHD symptoms. Data on 421 children's ADHD symptoms and usual play settings were collected, using a national internet-based survey of parents and the findings indicated that such settings make a difference in overall symptom severity in children with ADHD. Specifically, those who play regularly in green space settings exhibit milder symptoms than their counterparts who play in built outdoor and indoor environments and this is confirmed in all income groups and for both boys and girls.

The Government has been urged to intervene to tackle the dramatic rise in the number of extremely young children (some aged just three) who are self-harming: <http://www.itv.com/news/2018-02-09/teachers-demand-support-amid-dramatic-rise-in-children-as-young-as-three-who-are-self-harming/>. There has been '*a 27% jump in hospital admissions for self-harm by children aged three to nine in England in just five years*' and children are seen to '*punch and scratch themselves, bang their heads against walls and aggressively pull out their own hair*'. Teachers regard themselves rather in the light of front-line combatants; doing their best in all circumstances but lacking the wherewithal to make progress and pitifully short of anything even approaching an acceptable level of resources with which to make a difference.

The NSPCC has released data (under Freedom of Information laws) from 53 of the 66 health trusts recognised as providers of mental health support to children. It shows that schools in England have referred 123,713 children for specialist help since 2014-15 with more than half the referrals concerning children at primary schools. The youngest was only three years old at the time of referral. Reasons for referral included anxiety and depression with some children purportedly on the brink of suicide. In response, Sarah Hannafin, a senior policy advisor for the National Association of Head teachers said:

'More pupils are suffering from mental health issues and there is much more awareness in schools for spotting potential problems and intervening early to get support.'

'However, more than a third of these referrals are not accepted – schools have referred these pupils because they are concerned about their mental health and know that the child needs more specialist support than could (and should) be offered by school staff.'

'However, many of these children are not meeting the thresholds set by CAMHS – many are concerned about how high these thresholds are.'

'The other concern is about what support these children can then get if they have been turned down by CAMHS.' www.bbc.co.uk/news/education-44-83625

In addition, research by the Carnegie Centre of Excellence for Mental Health in Schools at Leeds Beckett University demonstrates that the prognosis for teachers' own mental health is a growing cause for concern. Findings from a research survey of 775 teachers revealed that 77% introduced the issue themselves, believing that poor teacher mental health impacted negatively upon pupil progress and achievement. Teacher mental health itself would therefore merit attention from Government in its own right: <http://www.leedsbeckett.ac.uk/news/0118-mental-health-survey/>

One of the influential factors impacting children's mental health in school settings is the way in which the structure of their day has evolved. An increase in the occurrence of emotional disorders and incidents of self-harm: <http://www.journalofplay.org/issues/3/4/article/decline-play-and-rise-psychopathology-children-and-adolescents> has been directly linked to the decline of play as an essential component of school activity: <https://www.psychologytoday.com/us/blog/freedom-learn/201001/the-decline-play-and-rise-in-childrens-mental-disorders>.

A drop of around 90% since the early 1980s in time each week <https://www.youtube.com/watch?v=8Q2VnCbTw0&t=2s> simply spent outside playing, between the ages of seven and twelve, has had a serious negative impact on children's mental and physical wellness overall. To embed the sustainable OPAL programme in every primary school in England over a 10-15 year period would cost somewhere around £90 million, based on roughly 17,000 primary schools and current costs. Until the environment of streets, parks and open spaces can be reshaped to enable children to play acceptably safely outside again, we should ensure that at least in schools, there is more than an hour every day of high-quality, wide ranging, challenging and enjoyable freely chosen play available to every schoolchild.

Parents are clearly arriving at similar conclusions. An Australian mother (Lizzy Williamson) makes this comment about the undesirability of over-scheduling in the wider context of children's lives:

'We should be encouraging them to be free to play and have free time and use their imagination. I understand why they do it, but the less pressure we can put on kids after school the better. A lack of free time is not great for children's mental health and they need time where they can just go and be children and not have to worry about school for five minutes' ('The Daily Mail,' March 2018: <http://www.dailymail.co.uk/femail/article-5547473/New-research-reveals-kids-stay-school-extra-hour.html>)

One of the organisations making the case for a healthier balance in the school day is OPAL (Outdoor Play and Learning). Its current programmes (operative in over 200 UK schools) prioritise and value play and help schools to achieve more productive playtimes. 'OPAL schools' record a definite upturn in pupil mental and physical wellbeing, resilience, engagement and happiness.

Jim Dees, Headteacher at West Lodge Primary School, Pinner in London has noticed the beneficial change made by pursuing the OPAL programme in his school and said:

'We wanted to promote children's problem-solving skills, their resilience ... 20% (60 minutes) of the school day is playtime and now pupils come in engaged and ready to learn. The pupils who've traditionally struggled socially and emotionally now are fully engaged, making new friends and our teachers have popped out and been astounded at the changes in those previously insecure children': <https://www.youtube.com/watch?v=LEQBGTmFH7Q>

Similar observations are made by Eve Alderson, Head teacher of St. Bede's RC Primary School, Sacriston, County Durham:

'Bullying and behaviour were real issues because there was nothing to do before OPAL. Children are calmer now, which makes my job much easier. There are fewer issues to deal with and pupils are happier, with more self-esteem. In today's society, children don't get to go out and to play much so having better playtimes in school have affected many things in their lives': <https://www.youtube.com/watch?v=S-L2qCc-5>

A substantial amount of national and international research links children and young people's regular participation in physical activity with signs of improved psychological health. Mind has listed some of the mental health benefits of physical activity as:

- Reduced anxiety and happier moods
- Reduced feelings of stress
- Clearer thinking
- A greater sense of calm
- Increased self-esteem
- Reduced risk of depression
- Making friends and connecting with people
- Having fun
- Challenging stigma and discrimination.

<https://www.mind.org.uk/information-support/tips-for-everyday-living/physical-activity-sport-and-exercise/health-benefits/#.Ws05-i-ZNzg>.

The Youth Sport Trust has been commissioned across a number of areas to deliver innovative prevention programmes for children's mental health called Active Healthy Minds. The approach involves working with local mental health partners and teaching schools to use physical education, sport and physical activity to impact on school-related stress and anxiety and help to deliver whole school attainment and outcomes. To date, programmes such as Get Exam Fit have been seen to have a significant impact on reducing referrals to wellbeing support within and beyond the school and supporting young people in achieving as predicted or better in their external public examinations.

<https://www.youthsporttrust.org/get-exam-fit>

This approach has now been piloted in Greater Manchester, extended by the reach to primary schools and including pupil referral units and special schools and is underpinned by Young Mental Health Champions who take a proactive role in

supporting and mentoring their peers. This approach is part of Greater Manchester's Health and Social Care Strategy and delivered in partnership with Place2Be, Bright Futures Teaching Alliance and 42nd Street.

<http://www.gmhsc.org.uk/sports-stars-back-project-to-help-greater-manchester-kids-stay-mentally-healthy/>

However, as yet, the full potential of the widely heralded Primary PE and School Sports Premium remains under-realised by the Department for Education although a number of external organisations are making a positive difference to levels of pupil physical activity by engaging in partnership arrangements with schools. One of these is the Greenhouse Sports charity which affords young people from disadvantaged, under-served areas of London, the opportunity of participation in high-quality extracurricular sports programmes.

Participants pay nothing and school eligibility is contingent upon 67% of pupils living in postcodes classified as 'high-deprivation' according to the Department for Housing, Communities and Local Government's 'Income Deprivation Affecting Children Index' (IDAC). Special Educational Needs schools also qualify for partnership. In addition to the benefits of regular physical activity, a mentoring relationship with Greenhouse Sports coaches supports the participants' mental health and wellbeing. All Greenhouse Sports coaches are 'Mental Health England First Aid' trained.

The Daily Mile (started in 2012 in order to redress poor fitness levels in primary-age children) has been adopted successfully by many UK schools. It is recommended by the Government in the Child Obesity Strategy (2016) and The Daily Mile Foundation cites excellent feedback from participating schools and research by the Universities of Stirling and Edinburgh about its positive impact on memory, mood, age group mixing, growth of child confidence and resilience.

'In-school' mental health support services for children are recommended by the Government, but in reality, existing provision is inadequately funded and services are frequently outsourced due to further enforced budget cuts. Referrals to external counselling services are prevalent and a 'knock on' adverse consequence is that waiting lists increase elsewhere whilst a damaging cycle of children being passed 'from pillar to post' is created.

'It was described that the current system to try and access support outside of school was a nightmare and a very long process which was not suitable for getting help as soon as possible' (Barnardo's focus groups with young people, February 2018).

To bridge a provision gap, many schools use existing lay staff members to offer support with mental health issues to their students; however because the majority of teachers are not professionally trained counsellors, the outcome could be more harmful than beneficial.

On 17th March 2015, the Government's report of the work of the Children and Young People's Mental Health Taskforce identified a need for collaboration between NHS services, local authorities and schools in the provision of mental health services. Health services such as CAMHS are reported to be overstretched and inaccessible (*Care Quality Commissioner, 2018 'Are we listening? Review of Children and Young People's mental health services'*): http://www.cqc.org.uk/sites/default/files/20180308b_arewelisting_report.pdf

However, in a climate characterised by Government recommendation rather than statutory provision, charities such as Barnardo's are becoming increasingly involved in helping to foster collaborative partnerships to supply mental health services to children. The ones listed below represent examples of best practice.

Barnardo's partnership with Oxford Health NHS Foundation Trust (*Barnardo's submission to the Government green paper 'Transforming Children and Young People's Mental Health Provision' March 2018*) is designed to deliver interventions to support children and young people with low level mental health difficulties. It has helped to improve accessibility to specialist services and reduce the number of missed appointments. The service was shaped by the experience of users and their contributions include:

- Revamping the CAMHS website with significant input for children and young people such as the provision of videos, more age-appropriate, relevant information and a site that is road-tested for its accessibility
- Monthly meetings for children and young people, some of whom have developed and delivered information at a school-based emotional health and wellbeing conference
- Mental health awareness training for some young people resulting in them becoming mentors/ambassadors in their schools. They have been involved in developing leaflets and about services and also an introductory letter to be issued to new users prior to each appointment
- Input into re-vamping waiting areas at health premises to make them more calming and therapeutic
- The participation of children and young people in interview panels for a variety of posts including one to appoint a new Director
- The involvement of parents through forums.

A similar partnership exists with the Bradford Care Trust (*submission to Government green paper as above*) and the charity promotes 'whole school' approaches to mental health and wellbeing such as the Barnardo's Northern Ireland Time 4 Me service (*Barnardo's Impact report, 2017*).

Barnardo's PATHS PLUS approach combined PATHS (a 'whole school' teacher-delivered prevention programme) with Friendship Group (a programme for children who are experiencing social problems in the classroom) offered jointly by Barnardo's staff and a co-leader from the school (*Barnardo's, 2016 'Key findings from the PATHS Plus programme delivered by Barnardo's in the UK. Belfast - Barnardo's Northern Ireland': http://www.barnardos.org.uk/barnardos-pathsbriefingpaper_web.pdf*). Feedback included evidence of improved levels of mental health, emotional regulation and self-management.

The Birmingham Education Partnership (*Birmingham Education Partnership, 'Newstart and Mental Health'*): <https://www.bep.education/home/wellbeing-enrichment/new-start/> is led by a partnership board comprising representatives from Clinical Commissioning Groups (CCGs) the Voluntary Community Sector (VCS), children's services and other partners who oversee Newstart: an example of schools running their own mental health and wellbeing/resilience programmes.

The Barnardo's Action with Young Carers Liverpool service is part of Liverpool CAMHS and provides a robust, integrated, 'whole family' framework to bring adult and children's services together, creating resilient and resourceful families. It has been commended as an example of taking a whole family approach to the identification, assessment and support of young carers. As part of the partnership, each secondary school now has a designated mental health lead with the future aim being to have one in every primary school as well. The leads also align with a young carers' lead in every school. This vulnerable group of children and young people are more likely than their peers to feel isolated and suffer from consequent mental health issues including depression, self-harm and eating disorders triggered by the impact of their caring role. They are also more likely to be victims of bullying (*Barnardo's 'Still Hidden, Still Ignored – who cares for young carers?'*): http://www.barnados.org.uk/still_hidden_still_ignored

In conclusion, a worrying omission in the green paper is any recognition of the gap in mental health provision for young people who find themselves in the 'transition' stage between leaving school and fully entering adult life. They may be about to start a Further Education course, begin an apprenticeship or embark upon a degree and find themselves in limbo with no help to negotiate potentially destabilising life changes. The Government must treat the transition phase as a 'stand alone' period in its own right, devising systems to help young people and their families at this unique and challenging time

Recommendations:

- 4.1 Health and education professionals to receive initial training and CPD in attachment and brain development and the impact of Adverse Childhood Experiences (ACEs) and trauma-informed practice
- 4.2 Accessible and 'reader friendly' guidance in early years mental and emotional wellbeing to be made available for parents
- 4.3 The adoption of a 'whole school' approach to the provision of mental health services for children and young people which also encompasses and addresses the mental health and wellbeing of teachers and adults in the school environment
- 4.4 Government to commission further research into the impact of high quality physical activity interventions in achieving positive mental health outcomes in children and young people
- 4.5 Specifications, protocols, directives and incentives required for the sharing of children's mental health data to be clarified in order to facilitate collaborative working between health, education and social care concerns
- 4.6 Counselling to be provided as integral to all educational settings. The Department of Health estimate that a targeted therapeutic intervention delivered in school costs around £229 but derives an average lifetime benefit of £7,252, thus producing a cost benefit ratio of 32-1
- 4.7 All counselling to be delivered by suitably trained practitioners who are on a Professional Standards Authority Accredited Register or included in the HCPC register: <http://www.playtherapyregister.org.uk>
<http://www.nationalcounsellingsociety.org/accredited-register/>
- 4.8 The training of such practitioners to include specific training in safeguarding, mental health, child attachment and development and awareness of the impact on children and young people of social media and the internet
- 4.9 The Government to recognise the importance of play in supporting children's mental and physical wellbeing and for this to be reflected in the structure of the school day
- 4.10 There is a need to re-think the content, aims and structure of the curriculum, given that even the advisers who worked on primary curriculum content and testing now have reservations: <https://www.theguardian.com/education/2017/may/09/fronted-adverbials-sats-grammar-test-primary>
- 4.11 The Government to provide policies and systems to help young people in the 'transition' phase between leaving school and obtaining access to full adult mental health services.

5. TRAINING NEEDS OF HEALTH AND EDUCATION PROFESSIONALS

Every teacher will probably be required to meet the mental health needs of up to three children in their class at any one time (*Place2Be, BACP, UKCP and NAHT (2018) 'Providing mental health supporting UK schools'*). This equates to around 8% for Primary school teachers and 12% for their Secondary school counterparts (*Department for Education (2017) 'Supporting Mental Health in Schools and Colleges: Quantitative Survey'*). Children's individual challenges vary and a teacher's professional competence and confidence in responding to them is crucial.

The '*Future in Mind*' report (*Department for Education 2015*) emphasises that individuals working with children and young people must be appropriately and professionally trained in their development and be trained to:

- Recognise the value and impact of mental health in children and young people; its relevance to their particular professional responsibilities to the individual and how to facilitate an environment that supports and builds resilience
- Promote good mental health to children and young people; educating them and their families about the possibilities for effective and appropriate intervention to improve wellbeing
- Identify mental health problems early in children and young people
- Offer specific support to children and young people with mental health problems, their families and carers (possibly involving liaison with a named, appropriately trained individual responsible for mental health in educational settings)
- Refer appropriately to more targeted and specialist support
- Use feedback gathered meaningfully on a regular basis to guide treatment interventions both in supervision and with the child, young person or parent/carer during sessions
- Work in a digital environment with young people who are using online channels to access help and support. (*Department of Health, 2015:64*):
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

However, there is a widespread feeling amongst teachers that their own training is inadequate, leading to insufficient child identification and support (*Patalay P & Fitzsimons E, 'Mental ill-health among children of the new century: trends across childhood with a focus on age 14', Centre for Longitudinal Studies, 2017*).

The Department for Education's report (*'Supporting Mental Health in Schools and Colleges: Quantitative Survey', 2017*) highlighted a number of key findings. 49% of

schools had a designated mental health lead and were also more likely to have wider provision and systematic approaches in place, enabling staff to identify the needs of young people in the setting. Even without a designated lead, nine in ten schools offered some staff training in supporting children with mental health and well-being needs and in 68% of institutions this training was compulsory.

Activities to support the training needs of teachers within school included:

- Colleague-delivered 'in school' training
- Mental health services such as CAMHS
- Online training
- Other training providers.

Initial Teacher Training programmes (ITT) span a number of areas in which an individual must demonstrate competence in order to be granted Qualified Teacher Status, but child mental health and well-being references are frequently obscured within the wider educational framework. However, statutory documents such as the Special Education Needs and Disability Code of Practice (*Department for Education and Department of Health 2015, 'Special Educational Needs and Disability Code of Practice: 0 to 25 years'*) the National Curriculum (*Department for Education, 2013, 'The National Curriculum in England'*): <https://www.gov.uk/government/publications/national-curriculum-in-england-framework-for-key-stages-1-to-4> and the Teachers' Standards (*Department for Education, 2011, 'Teachers' Standards'*) mention the following areas of knowledge that in combination, outline teacher training about mental health:

- Mental health as a special educational need
- Health and wellbeing
- Policy and strategic purposes within schools
- Legal statutory roles and responsibilities of a teacher in order to support children's diverse needs
- Parent partnership and multi-agency providers to support child mental health.

However, child mental health messaging (neither explicit, coherent nor detailed) is confused.

For example, the National Curriculum Framework in England (*as above*) states that every state-funded school in England must offer a curriculum which '*promotes the spiritual, moral, cultural, mental and physical development of pupils at the school and of society*'. Yet no statutory curriculum area directly addresses the teaching of mental health. Within the curriculum, mental development is commonly associated with cognitive development (e.g. mathematics, where mental skills are

repeatedly cited in the study specification). 'Wellbeing' is referenced once in the purpose of study for Design and Technology. The mention of 'health' is more frequent across the subject range but there is no requirement for teachers to be taught about mental health in the statutory delivery of the subject curriculum.

The Department for Education considers Personal, Social, Health and Economic Education (PSHE) to be a necessary (albeit currently non-statutory) component of all pupils' education. A joint report by the House of Commons Education and Health Committees (2017), welcomes the Government's commitment to make PSHE a mandatory subject in schools and colleges. However, this must not be a tokenistic gesture, but a policy that places curriculum teaching within an environment that supports wellbeing across the whole school. Mental health and wellbeing are implicitly recognised within the teachers' professional body of knowledge as contained within the statutory Teaching Standards and in his review of Initial Teacher Training (ITT) Sir Andrew Carter recommended that:

'ITT should provide new teachers with a grounding in child and adolescent development including emotional and social development, which will underpin their understanding of other issues such as pedagogy, assessment, behaviour, mental health and SEND. ITT should also introduce new teachers to strategies for character education and supporting pupil wellbeing' (Department for Education, 2015 'Carter review of initial teacher training').'

For secondary education, Carter recommends that ITT should equip new teachers to:

- Identify the boundaries of child adolescent behaviour and what is a cause for concern
- Know when and how to make appropriate reference to more specialist support.

This has been further highlighted by a Health Committee inquiry recommending that the DfE should include a mandatory module on mental health in ITT and be followed up by ongoing professional development for teachers once qualified (*Health Committee, Third Report of Session 2014-2015, Children's and adolescents' mental health and CAMHS, House of Commons*).

Below are some examples of current good practice in the absence of statutory procedure:

PLACE2BE:

This UK children's mental health charity provides schools with training to improve the emotional wellbeing of pupils, families, teachers and school staff within their

community. They also raise awareness and promote resources to schools to help improve children's mental health. In 2018, Place2Be publicised their 4th Mental Health week using the theme of #BeingOurselves with online resources for schools and community group use: <http://www.childrensmentalhealthweek.org.uk/schools-and-youth-groups>

An economic evaluation of Place2Be's school-based mental health service has found that the potential benefits of across-the-board mental health counselling in primary schools are worth six times the original outlay, according to an analysis by Pro Bono Economics; estimating that the £4.2 million spent by the charity on one-to-one counselling in primary schools in 2016-17 could potentially create benefits of £25.9 million in total. The consequent lifetime benefit per child equates to:

- £3,568 in higher lifetime earnings
- £2,050 in savings to the Government from increased taxes and lower spending on public services
- £88 in benefits to other people; mainly due to a reduction in smoking.

Chief Executive of Place2Be, Catherine Roche responded to the analysis saying: *'We believe that all schools should be able to access evidence-based mental health support for their pupils, but they cannot do it alone.'*

Investing in school-based support, as well as training for school leaders and teachers will not only help children here and now, but will have a long-term benefit for them and the wider economy well into the future.'

ITT Good Practice:

The Atticus Alliance's Mental Health Awareness Course: The Pendlebury Centre Pupil Referral Unit (Atticus Alliance partner school) offers a 5 day accredited Mental Health Awareness course to all its trainees. Bespoke training in social and emotional needs, classroom management, wellbeing and autism is provided amongst other child developmental matters in a way that feeds into the wider ITT. The Alliance works across training partners and has additional strong links including with the University of Manchester, Manchester Metropolitan University and an Alliance of 21 schools: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399957/Carter_Review.pdf

Bromley Mindfulness in Education:

This inclusive teacher/pupil project encompasses the London Boroughs of Bromley, Lewisham and Greenwich and is facilitated amongst others by Zia Brooks; Assistant Headteacher at a South London comprehensive school. The training programme supports teachers and pupils by equipping them with mindfulness and resilience tools to improve their own mental health and wellbeing.

Strategies to Improve School Lunchtimes:

Amidst growing awareness that the school lunchtime 'out of classroom' period can be actively detrimental to child mental health and wellbeing, some practitioners and educators are concentrating upon encouraging settings to provide all school children with the opportunity of a one-hour break at lunch with time to both eat and play (Ed Baines, Senior Lecturer in Psychology and Education; Institute of Education; Paul Aagaard, Director, Recipe for Change). This entails adopting a 'whole school' approach and facilitating a supportive environment to boost mental health, wellbeing and resilience through freely chosen play.

The need to train teaching professionals in mental health matters extends beyond the child. The rationale behind a trial to discover the relative effectiveness of training and support packaging in recognising and combating teacher mental health problems stated:

'Secondary schoolteachers are at increased risk of stress, depression and anxiety compared to the general working population. Failure to support teachers adequately may lead to serious long-term mental disorders, poor performance at work, sickness, absence and health-related exit from the profession. It also jeopardises student mental health, as distressed staff struggle to develop supportive relationships with students and such relationships are protective against student depression': <https://www.journalslibrary.nihr.ac.uk/programmes/phr/13164606/#>

Whilst it is understood that knowledge of child mental health is of vital importance to the teaching profession, no 'joined up' statutory guidance currently exists to ensure that all teachers are equipped with the skills and resources to support young people with adverse mental health conditions. Teachers require knowledge of mental health in a variety of forms including how to support children, how to teach children about mental health, understanding of multi-agency support availability and ways in which to manage their personal mental health and wellbeing.

Play Therapy UK has identified training frameworks based specifically on training 3600 play therapy practitioners but maintain that these are relevant to all professionals working in the area of children's mental health. They identify practitioners as Play Therapists, Child Psychotherapists, Counsellors for Children and Clinical Psychologists; all of whom may work in some capacity within schools; or to whom external referral may be made. The professional requirement recommended by PTUK is a Level 7 postgraduate course, validated by a UK university and accredited by a professional organisation managing an Accredited Register or statutory regulator.

Leeds Beckett University in partnership with PTUK (and its accredited training organisation APAC) is currently training 300 new Play Therapists at postgraduate level per year in 13 UK venues. As the largest UK provider of such training they believe that the main obstacle is the difficulty that individuals have in affording a typical sum of £8,000 to qualify as a Registered Play Therapist.

Recommendations:

- 5.1 ITT programmes to ensure that mental health forms part of core content curriculum for ITT
- 5.2 A revision of the Teachers' Standards to explicitly highlight that teachers show evidence of knowledge in child mental health before obtaining Qualified Teacher Status
- 5.3 All schools to allocate a designated lead for child mental health to oversee staff training and multi-agency partnership; to determine whether the person should be a qualified professional *or* a teacher specifically trained for the role and to ensure that the post holder is in receipt of remuneration commensurate with the level of responsibility and attendant seniority
- 5.4 Schools to access free training and resources to ensure that teachers maintain a current and contemporary knowledge of mental health awareness in young people
- 5.5 ITT mental health training for teachers and CPD to embed strategies to improve the mental wellbeing of teachers
- 5.6 The lunchtime period and its part in the encouragement of child mental health and wellbeing to be included in individual school development plans as an Ofsted requirement
- 5.7 Training grant/funding for employers and/or individuals, possibly on a matched-funding basis to be made available for therapists, to include children's counsellors
- 5.8 A statutory requirement for all those working as therapists with children to have successfully completed a professional course that meets QAA standards
- 5.9 QAA to be encouraged to develop a Subject Benchmark Statement for Children's Mental Health that subsumes the competencies that have been defined to date by the professional organisations working in this field.

6. IDENTIFYING AND TACKLING SOCIAL AND ECONOMIC INEQUALITIES, CULTURAL AND ETHNIC DIVERSITY AS THEY INFLUENCE CHILD MENTAL HEALTH AND WELLBEING

Statistics from the Race Disparity Audit: (*Race Disparity Audit Summary Findings from the Ethnicity Facts and Figures, October 2017, updated March 2018*: <https://www.gov.uk/government/publications/race-disparity-audit>) show a firm correlation between ethnic background and poverty in the UK:

'Asian and Black households and those in the 'Other' ethnic group were more likely to be poor and were the most likely to be in persistent poverty' and 'Around 1 in 4 children in households headed by people from an Asian background or those in the 'Other' ethnic group were in persistent poverty, as were 1 in 5 children living in Black households and 1 in 10 White British households.'

The Children's Society report (*March 2016, 'Poor Mental Health: The links between child poverty and mental health problems'*) added to the socioeconomic picture by identifying research by the Chartered Institute of Environmental Health which *'demonstrated that there is a significant relationship between poor housing and mental health problems in children'* and The Board of Science (*'Health at a price. Reducing the impact of poverty', June 2017*) has also found that children living in low-income households are three times likelier to suffer from mental health problems than their more affluent peers.

The figures themselves make a compelling case for early intervention approaches. 50% of mental health problems are established by age 14 and 75% by age 24 (*Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE, 2005, 'Lifetimes Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication' Archives of General Psychiatry, 62(6), doi:10.1001/archpsyc.62.6.593*) and yet 70% of children and adolescents who experience mental health problems have not received appropriate interventions at a sufficiently early age. It is clear that the present situation does not serve children well and improvement must be considered as an essential rather than optional requirement. As a starting point, the presence of a professionally qualified counsellor in every school would allow children from all backgrounds (regardless of their particular ethnic or economic heritage) to receive early direct support which would go some way towards ameliorating the trend of the current shocking statistics.

There are stark disparities in spend between CCGs throughout the UK according to the Royal College of Psychiatrists: <http://www.rcpsych.ac.uk/mediacentre/pressreleases2018/sammhfundingstory.aspx>. The data below has been adjusted to take account of inflation.

In England:

- 62% of mental health trusts (34 out of 35) at the end of 2016-17 reported lower income than the comparative amount for 2011-12
- Only one trust saw a rise in income during the entire five financial years
- Nine mental health trusts saw their income fall during the five years, including three in Yorkshire and Humberside.

Elsewhere in the UK:

- In Scotland, less money was spent by health boards on mental health in 2016-17 compared to 2009-10 in real terms
- In Northern Ireland, mental health investment by the Health and Social Care Commissioning Board in real terms is less than it was two years ago
- In Wales, mental health investment in real terms is lower than for the 2010-11 period.

The Royal College of Psychiatrists also suggested that the current funding situation (altered by the 2013 Health and Social Care Act) is opaque, because it is now the responsibility of the CCGs to allocate money to mental health trusts and other providers. Additional funding streams are also distributed via GPs, local councils, private providers and the voluntary sector. The Royal College explains that although commissioner spending is monitored by NHS England's mental health statistics 'dashboard', high-quality data for those other funding organisations is not published regularly (21st February, 2018): <https://www.independent.co.uk/news/health/mental-health-trusts-uk-funding-government-cuts-royal-college-psychiatrists-a8219486.html>

CCGs themselves identified a specific need to ring-fence Children and Young People's mental health budgets. The Mental Health Commissioners Network of NHS Clinical Commissioners (NHSCC) argued the special case in a letter to the Department of Health in 2016:

'Normally as commissioners we would strongly argue against ring-fencing funding as local commissioners need to be able to interpret national policy in the light of the needs and priorities of their local populations. On this basis good decisions can be made to enhance the health of, and improve the services for, local people.

There are two reasons why we feel the CYP mental health funding is an exception. Firstly, CYP mental health has been underfunded and financially squeezed for many years, in all senses a 'Cinderella' service. The figures concerning this are well known to you and I will not rehearse them here, however, the need to invest heavily

in CYP and particularly their mental health has been well recognised in a number of recent documents. (7th March 2016, NHSCC letter to the Department of Health): <https://www.nhsc.org/latest-news/ring-fencing-camhs/>

The credibility of the argument is amplified by the fact that the NHSCC claim to have more than 90% of CCGs in England as paid-up members. Ring-fencing mental health budgets for children and young people would go some way to ensuring that they receive the services and support that they need from a young age. The Children's Commissioner Report: <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/10/Childrens-Commissioner-for-England-Mental-Health-Briefing-1.1.pdf> shows that the vast majority of NHS mental health spending goes towards those with the most severe needs. Their analysis shows that:

- 38% of NHS spending on children's mental health goes on providing in-patient mental health care. This is accessed by 0.001% of children aged 5-17
- 46% of NHS spending goes in providing CAMHS community services; accessed by 2.6% of children aged 5-17
- 16% of NHS spending goes on providing universal services. There is a need to support the one in ten children who are thought to have a clinically significant mental health condition but are not accessing CAMHS. The money must also support a (currently unknown) number children with lower-level needs, who would be less likely to develop a more serious mental health condition if they were provided with timely support.

By contrast, early interventions are far cheaper to deliver as the figures below indicate:

- £5.08 per student – the cost of delivering an emotional resilience programme in school
- £229 per child – the cost of delivering six counselling or group CBT sessions in a school
- £2,338 – the average cost of a referral to a community CAMHS service
- £61,000 – the average cost of an admission to an in-patient CAMHS unit.

Early intervention is highly cost-effective in preventing the escalation of conditions. The Department of Health estimate that a targeted therapeutic intervention delivered in a school costs about £229 but derives an average lifetime benefit of £7,252, giving a cost-benefit ratio of 32-1. However, it is important that all involved understand precisely what 'early intervention' means. It does not mean intervening pro-actively when people are young; it means intervening at the first

signs of an incipient problem. Similarly 'early intervention' should not become in practice, 'crisis intervention' due to inadequate financial resourcing.

Physical activity is increasingly recognised for its additional emotional and mental benefit and The Daily Mile (delivered in an increasing number of UK schools) is fully inclusive, affording all children an opportunity to participate regardless of individual circumstance or background. It has been proved to be helpful to children on the autistic spectrum and those in SEN settings. However, there is need for funded research to explore further the link between physical activity, wellbeing and mental health, following a 2017 report by The Centre For Social Justice ('Off the Scales: Tackling England's Childhood Obesity Crisis') detailing links between poor mental health and obesity as they impact children living in adverse social and economic circumstances in deprived areas.

Recommendations:

- 6.1 Mental health budgets to be ring-fenced to ensure that children receive the services and support that they need from a young age
- 6.2 Government to prioritise early intervention in all matters concerning services to support the mental health of children and young people
- 6.3 Government to fund research into the links between physical activity, wellbeing and mental health and use findings to develop mental health services within school and the wider community.

7. SERVICES IN THE COMMUNITY AND LOCAL AUTHORITY PROVISION AND RESOURCING

Community-based organisations, services and interventions are integral to both the prevention of adverse mental health conditions and positive psychological development in children and young people (*Weissberg RP, Kumpfer KL, & Seligman ME, 2003 'Prevention that works for children and youth: An introduction, Vol 58, No. 6-7, American Psychological Association*). The community can potentially provide non-stigmatising opportunities for skills to flourish, emotional health to improve and social networks to grow as evidenced by the schemes below.

On the Record (OTR) Bristol defines itself as a *'mental health movement mobilised to support and defend the mental health, rights and social position of young people'* and views mental health in the light of a social manifestation; rather than focusing purely upon individuals. OTR prizes diversity, relationship and partnership building and offers a variety of projects, workshops and therapies to promote mental health, wellbeing, self-care and personal development. Rather than supplying mental health treatment to passive patients, they offer a strengths-based approach by concentrating upon positive youth development. Young people are encouraged to play an active role in the running and development of the organisation and OTR also liaises with schools and NHS mental health services via an integrated offer that is designed to meet and manage the needs of local adolescents.

The social enterprise Mytime Active aims to enhance the health and wellbeing of its core communities by facilitating physical activity, dietary improvement and social participation. As part of a wider project to promote physical activity in sedentary young females (which has well-documented benefits for both physical and mental health) a 20-week community street dance programme was delivered in a deprived area of London. In addition to boosting physical activity levels in adolescent girls, mentors supported them to explore themes of body confidence, self-esteem and resilience. With the backing of several national and local performing arts organisations, Mytime Active has run Arts Train (a programme for the creation and performance of original work specifically targeted at adolescents in the community who would not otherwise have access to such opportunities) for over 10 years. Participants include young people outside the traditional education system, or at risk of exclusion from local mainstream schools and those with emotional and behavioural difficulties:

'Music helps me express myself, get stuff off my mind and manage my anger.'
(*Young person aged 16*)

'I have gone from a young person on the project to a volunteer and I am now an assistant tutor, helping other young people with lyric writing and performance skills. The project has really turned my life around.' (Assistant Tutor, aged 19)

Play is widely acknowledged as fundamental to children's wellbeing and whilst free, unstructured, outdoor play is one of the key ways in which they learn and grow, restricting play opportunities is likely to have profound and adverse effects upon children's physical and mental health both now and in the future (*Play England, 'A World without play: a literature review', January 2012*):

www.playengland.org.uk/media/371031/a-world-without-play-literature-review-2012.pdf. Play is an integral component of a holistic approach to children's mental and physical health and wellbeing.

The current policy climate however, is not favourable to play, and research undertaken by the Association of Play Industries has uncovered a steep decline in playgrounds across England. 214 have been closed with a further 234 currently earmarked for closure by local authorities: <https://www.api-play.org/news-events/nowhere-play-campaign/>. This represents an alarming downward trend in provision. There is no longer a dedicated funding stream for playgrounds from central government (or grants from the voluntary sector) and thus the burden for play provision has landed squarely on the desks of local authorities whose budgets are already perilously over-burdened. 20% of children are recorded to be suffering from mental illness and the trend is ever upward. Without adequate access to play, they are less likely to develop the important emotional, social and cognitive skills required to protect them from anxiety, depression and other mental health problems (*APPG on a Fit and Healthy Childhood, 'Play' p52*): www.api-play.org/upload/public/news-stories/APPG-Play-Report141015.pdf

Fields in Trust's latest research reveals for the first time at national level, a direct and statistically significant link between public parks and green spaces and health and wellbeing: <http://www.fieldsintrust.org/Upload/file/170919-FIT-Value-Research-Summary.pdf>.

However, despite demonstrable mental and physical health benefits, parks, playgrounds and green spaces across the UK are under threat, with 93% of park managers reporting cuts to their budgets over the past three years: <https://www.hlf.org.uk/state-uk-public-parks-2016>.

The new Government proposals for child mental health (*green paper 2018 as before*) and specifically the references to early intervention, have received the equivalent of two cheers from local authorities and charities in East London boroughs. However, a cash injection of £300 million may be insufficient to tackle the high levels of mental health issues and the complexities of the diverse

communities in an area which includes Tower Hamlets with the highest rate of estimated mental health disorders in children across all the London boroughs and Hackney in the top ten (Public Health England). Lewisham and Croydon, along with most of the rest of London have high levels of mental health issues in children compared to the rest of the country.

Hackney provides an NHS psychology service called First Steps for children and young people aged 0-18 and their families; aiming to tackle difficulties relating to behaviour, emotions and relationships early before they worsen or become too firmly entrenched to manage. The team (over 25 Family and Child Practitioners, including Clinical Psychologists, Mental Health Nurses, Assistant Psychologists and Administrators) works with Children's Centres and GP surgeries across Hackney to ensure that the service is convenient and accessible for local families.

First Steps is an early intervention service, offering individual sessions as well as groups for parents; the work is collaborative, open-minded and respectful in dealings with children and families and attuned to diverse cultural and religious community needs. An interpretation service is available when needed and the type of issues that the team offers help with includes:

- Sleeping problems
- Tantrums
- Fussy eating
- Toilet training
- Relationships with siblings and peers
- Challenging relationships between parent/carer and child such as feeling too distant or close; experiencing negative emotions; finding it hard to play or to set limits and boundaries
- Aggressive behaviour
- Disagreements between parents or other family members about parenting
- Wider family worries following illness, bereavement or other matters affecting all family members
- Changes at home or at school which may influence a child's emotions and behaviour.

The 2018 green paper includes proposals to set a four-week waiting time for children requiring specialist help and introduce new mental health support teams in schools and it is hoped that around one in four schools will have this provision in place by 2022. In Hackney, Councillor Jonathan McShane, Cabinet Member for Adult Social Care and Devolution said:

'We and the City and Hackney Clinical Commissioning Group are currently designing a service to place mental health workers in schools, which we plan to

start from April 2018. One of the key priorities in our Children and Adolescent Mental Health Services transformation plan is also to improve waiting time and access to services.

We believe any government plans that align with our own local objectives will have a positive impact on mental health among children and adolescents in the borough': <http://www.eastlondonlines.co.uk/2017/12/verdict-plans-boost-child-mental-health-services-inadequate-deprived-communities/>

There remain doubts that the borough's BAME young people will receive the full support that they need. Samantha Francis, founder of Find a Balance (a mental health charity designed to offer support to young people in the black and ethnic minority population) considers that BAME children will be unlikely to reach out to the new school services because of the persistent stigma surrounding mental illness in the BAME community. She therefore advocates the adoption of services that are essentially bespoke and holistic. The Tower Hamlets CCG has noted a clear link between deprivation and poor mental health outcomes requiring a higher level of resources to match need. Richard Paccitti, the Director of Croydon Mind, whilst welcoming the green paper, has also raised concerns, expressing uncertainty about the capacity of school support teams to cope with the burgeoning number of children's mental health problems ranging from eating disorders to bullying and self-harm.

In January 2018, the Local Government Association invited all Directors of Children's Services in England to participate in a snapshot survey about the challenges facing local authorities supporting children and young people with complex mental health needs; specifically Looked After Children, those in contact with the youth justice system and those living with families on Child Protection or Children in Need places.

The survey aimed specifically to gather information about the current state and level of support, including the interface between NHS provision and social care/youth justice services. A 20% response (from a total of 31 councils nationwide between 12th January – 5th February 2018) suggest that the results should be regarded with some degree of caution; however it was encouraging to see an increase in early intervention services as a direct result of the roll-out of the Government's Future in Mind strategy (Department of Health 2015). Local authorities participating demonstrated a continuous improvement agenda with an ambition to increase resources where possible for children with complex needs mainly through reconfiguring existing services. Most Local Authorities had specific CAMHS support in place for Looked After children, varying in type.

However, there remains a worrying shortfall of sufficient and timely provision due to lack of NHS (tier 4 bed) provision or delay in accessing these and/or appropriate CAMHS services. Therefore, many local authorities and partners are dealing with some children and young people who have a high level of need, displaying a high level of risk to themselves and/or others without the requisite expertise, appropriate placement or clinical input. Some Local Authorities in these instances reported using welfare secure provision (i.e. a children's home that is locked, under section 25 of The Children Act 1989) for CYP who were waiting for an NHS tier 4 assessment or an NHS tier 4 bed. Services are still not reaching all the children and young people with complex mental health needs who should be in receipt of expert support.

As such children and young people have the highest levels of need, an urgent requirement must be the establishment of a system that is modernised and fully fit for purpose; able to respond to children and young people at the earliest point of need being identified so that most can be helped and those requiring longer specialist provision are identified early and can access it without delay.

Recommendations:

- 7.1 A national commissioning model for welfare secure placements, with urgent action to increase capacity across the country. It should be designed to fully integrate commissioning for all tier 4 (CAMHS) provision across health, social care and youth justice
- 7.2 Strategic alignment of all programmes and priorities that are relevant to vulnerable groups at national level to contribute to the delivery of an integrated response from Children's Social Care (CSC) youth justice and health
- 7.3 Resources to support children and young people's mental health services to be allocated holistically and with regard to demographic need
- 7.4 Government to make a clear statement of support for play as an essential component in children's physical and mental health, backed by a programme of investment in playgrounds and play spaces. Just £100 million would provide over 1,600 playgrounds and play spaces and reverse the decline typified by playground and play space closure.

8. INTERNATIONAL AND DEVOLVED UK MODELS OF PRACTICE

A comprehensive mental health action plan from The World Health Organisation (WHO) was adopted by the 66th World Health Assembly in 2013. The plan sets out a framework for strengthening capacities in countries to address the mental health needs of children and adolescents and the WHO encourages the adoption of a lifecycle approach in the implementation of mental health policies and strategies.

Worldwide, 10-20% of children and adolescents experience mental disorders; half of these by the age of 14 and three quarters by the mid 20s. Neuropsychiatric conditions are the leading cause of disability in young people in all regions and if untreated, severely impede children's development; educational attainment and ultimate potential to pursue fulfilling and productive lives. The WHO recognises that children with mental disorders face major challenges concerning stigma, isolation and discrimination as well as a lack of access to health care and educational facilities and this is in violation of their basic human rights.

The Comprehensive Mental Health Action plan 2013-2020 has four main objectives:

- To strengthen advocacy, effective leadership and governance for child and adolescent mental health
- To provide comprehensive, integrated and responsive mental health and social care services in community-based settings for the early recognition and evidence-based management of childhood mental disorders
- To implement strategies for promotion of psychological wellbeing, prevention of mental disorders and promotion of the human rights of young people with mental health disorders
- To strengthen information systems, evidence and research.

Each objective is accompanied by one or two specific targets, which provide the basis for measuring collective action and achievement by Member States towards global goals. A set of core indicators relating to the targets as well as other actions have been developed and are being collected via the Mental Health Atlas project on a periodic basis. Primarily, the action plan calls for changes in the attitudes that perpetuate the stigma and discrimination that have isolated people since time immemorial and calls for an expansion of services in order to promote greater efficiency in the use of resources.

The quality and range of mental health services for children and young people varies by country. In the United States, 1 in 5 children have a diagnosable mental health disorder but only 21% of those affected actually receive needed treatment: *American Academy of Paediatrics*: <https://www.aap.org/en-us/advocacy-and->

[policy/community-advocacy/Pages/Community-Advocacy.aspx](#). Across the USA there are serious shortages of paediatric sub-specialists and child mental health providers leading to decreased utilization of essential treatment, long waiting times and excessive distances travelled to sources of care.

The AAP has campaigned for Congress to adopt policies to promote children's mental health by:

- Developing a robust workforce of child and adolescent mental health specialists
- Facilitating the ability of primary paediatricians to provide early identification and treatment for children with mental health disorders
- Improving school-based mental health services and support systems
- Promoting State-wide child psychiatry access programmes such as the Massachusetts Child Psychiatry Access Project and the Behavioural Health Integration in Paediatric Primary Care in Maryland programme
- Supporting Paediatricians' efforts to assess and manage the mental health needs of children from infancy through adolescence via telephone consultation, continuing education and resource and referrals.

In Europe, a pan-European study from The Economist Intelligence Unit (*'Mental Health Integration Index'*: <http://bit.ly/1pPwHKV>) assesses countries' degree of commitment to people with mental health needs and Germany tops the list, due to the strong healthcare system and generous social welfare programme which has fostered re-integration into society. The countries at the head of the Economist Index have moved treatment and support for mental illness away from hospital-based care to care which includes integration in society. The UK ranks second to Germany, followed by Denmark, Norway and Luxembourg. The UK's high placing is largely down to a long-term progressive commitment at policy level to mental health care and enhancing the position of people with mental health problems in society. The scores also correlate strongly with the proportion of GDP spent on mental health. Aviva Freedman, who edited the report, concluded:

'True integration will require a transformation in understanding mental illness and overcoming stigma. Perhaps the most important finding for the index is therefore that its top countries share a long-term, widely supported commitment to change. Once that is in place across all Europe, progress may be slow but it will follow.'

In Germany, mental disorders comprise 9.8% of all illnesses and are the 4th most frequent. Within the German Health Interview and Examination Survey for Children and Adolescents (KiGGS), the parents of 14478 children and adolescents aged 3-17 answered a Strengths and Difficulties Questionnaire (SDQ) which

assessed behavioural problems and strengths in the areas of emotional problems, hyperactivity, peer problems and pro-social behaviour. Results pointed to a clear need for early detection and prevention of mental health problems; especially appertaining to hard-to-access groups like those with low socioeconomic status and migrants.

School interventions in Germany are oriented to mental health promotion and dealing with drug addiction. Integrative Organisation in care of children and adolescents with mental disorders in Germany, it is a project supported by the Ministry of Health. It attempts to qualify the integrative approach in therapy with several other non-medical institutions, especially youth welfare services and school. The Interdisciplinary Organisation of help and prevention for children with a mental handicap supports a holistic approach to promote the mental health of children and adolescents with special needs, emphasising the crucial role of parents and carers. 'MindMatters' is a Programme for the Promotion of Mental Health in Primary and Secondary Schools that follows the overall aims of mental health promotion and the prevention of mental illness within the framework of health promoting schools.

Another school project 'Crazy? So What!' covers Mental Health, Mental Health Promotion, Prevention and Anti Stigma Work in Schools. The project is based upon results of modern stigma research: contact with people who experienced mental illness, as well as information and education with the aim of swiftly reducing the prevalence of stereotypes, anxieties and distance. For young people and young adults in Germany, suicide is the second highest cause of death after accidents. The younger age groups, especially females between 15-25 years, have the highest suicide rates.

In the United Kingdom, The Royal College of Paediatrics and Child Health (RCPCH) has made recommendations across the devolved nations to improve child health with specific instructions to *'maximise mental health and wellbeing throughout childhood'* (*'State of Child Health' 2017*). One in four UK people experience a mental health problem, but despite mental health continuing to be an increasing societal issue, public spending is focused almost entirely on coping with the crisis rather than prevention. The quality of services is not of a uniform standard and there are instances of unduly long waiting lists and in some regions, lack of specialist support. Other differentiated country findings of interest are listed below:

WALES

Welsh teenagers have the worst life satisfaction rates in the UK (*'MindEd'*):

<https://www.minded.org.uk>

The 'Together for Children and Young People' (T4CYP) programme:

<http://www.wales.nhs.uk/documents/Framework%20For%20Action.pdf> launched by the Welsh Assembly Minister of Health and Social Services in February 2015, is an NHS initiative supported by a number of multi-agency partners. It addresses three key areas of mental health; prevention, protection and remedy through:

- Supporting early years development
- Promoting the wellbeing and resilience of all young children
- Early identification and intervention
- More specialist services.

The programme aims to ensure that all frontline services are ACE aware (Adverse Childhood Experiences) and where necessary, use trauma-informed practice. A current partnership with Barnardo's Cymru, the Wales Police and Crime Commissioners, Public Health Wales and Constabularies, utilises significant Police Transformation funds to develop ACE-aware or trauma-informed policing.

The Welsh Government has required local authorities to make reasonable provision of counselling services for children and young people aged between 11 – 18 and Year 6 pupils. The Welsh Assembly School Based Counselling Operating Toolkit, 2008: <https://gov.wales/topics/educationandskills/schoolshome/wellbeing/schoolcounselling/?lang=en> is an excellent model for all UK school-based counselling. The toolkit includes standards and guidance to enable counselling providers and schools to deliver high standard, safe and accessible services.

Education is regarded as crucial in identifying and supporting children and young people with emotional needs and emerging mental health issues. The new Welsh curriculum for Wales has six 'Areas of Learning and Experience'; one of which is focused on Health and Wellbeing and includes healthy relationships. In September 2017 a school pilot was launched in three areas. A dedicated CAMHS practitioner will be recruited for the pilot schools to provide teachers with advice and guidance on ways in which to respond to children with emotional and mental health needs.

SCOTLAND

One in ten children start school in Scotland exhibiting social, emotional or behavioural difficulties (*RCPCH, 2017, 'State of Child Health Recommendations for Scotland'*) and children from low income families and those who live in deprived

areas are disproportionately affected. The Scottish mental health approach is driven by a belief in early intervention and focuses on the early years, children and adolescents and social and economic disadvantage.

The Scottish Children's Services Coalition (SCSC) campaigns to improve services for children and young people who are vulnerable due to special educational needs, being Looked After, socioeconomic disadvantage and/or have poor mental health. They want waiting time for those accessing support from CAMHS to be reduced to below 18 weeks and an increase in beds for inpatient care; particularly for children who have additional risk from forensic history or physical and learning disabilities: <https://www.thescsc.org.uk/campaigns/child-and-adolescent-mental-health-services-camhs/>

The Scottish Government's Mental Health Strategy 2017-2027 highlights prevention and early intervention for children. Its key ambitions are to achieve:

- Appropriate access to emotional and mental wellbeing support in schools for every child
- Evidence-based parenting programmes
- Interventions to address behaviours and mental and emotional issues in young people
- Mental health and wellbeing support for young offenders
- Mental health training for non-specialists across health and social services providers
- First aid in mental health to become as common as physical first aid.

The strategy is based on the premise that by starting well, young people will go on to live well (*Scottish Government 'Mental Health in Scotland – a 10 year vision' July 2016*) but is radically hampered by inadequate levels of funding.

NORTHERN IRELAND

Barnardo's NI 'Time 4 Me' operates in nearly 50 schools in Northern Ireland and is a leading provider of primary school based counselling. The service aims to increase emotional wellbeing in order to improve learning potential by providing children with tools and strategies to maintain resilience and wellbeing for the future. Children reported that talking to adults was a useful coping strategy in addition to learning new techniques to reduce anger and anxiety. This strategy represents a significant early intervention to maintain wellbeing and mental health into adulthood.

The Bamford Review on Mental Health (*Ferguson A, 'Bamford Review of Mental Health and Learning Disability', May 2006*) highlights a lack of data about mental health problems in children and young people in Northern Ireland. An Assembly research paper on mental health (*Russell R, 2014 'Health Inequalities in Northern Ireland by Constituency'*) further showed that 11 health-related indicators (including the appearance of mood and anxiety disorders) were most prevalent where there were higher pockets of social and economic deprivation. In 2010, a strategy was launched (*'A Strategy for the Development of Psychological Therapies in Northern Ireland'*) whereby a stepped model of psychological intervention and care was proposed to support children who presented with one or more of a comprehensive list of conditions including:

- Physical and mental health illness
- Trauma and bereavement distress
- Eating disorders
- Substance abuse
- Acquired brain injury and other neurological problems
- Autism spectrum disorders
- Learning disabilities
- Care-related problems.

The four-tiered step care model of intervention adopted Bamford principles that mental health services for children should be provided for young people up to the age of 18 and, where possible, ensure early identification in infants where other secondary health indicators are flagged up. Further priority in Northern Ireland is also being given to children with special educational needs and physical and mental learning disabilities.

Recommendations:

- 8.1 The adoption of a multi-disciplinary approach to children and young people's mental health, utilising experts from a range of professionals and agencies including health, education, social work and the third sector
- 8.2 A 'no wrong-doer' approach to be embedded into all strategies for mental health and wellbeing with a commitment to ensure that young people receive the appropriate type of help at the appropriate time
- 8.3 School improvement plans to specifically address child mental health and wellbeing and a 'whole school' agenda to be adopted covering all aspects of schooling
- 8.4 All mental health policies should address three central areas of prevention, protection and intervention and be free at the point of need for all young people until the age of 18

- 8.5 Support for children and young people with other health or physical and mental learning indicators to be reinforced by specialist health care providers in all educational settings
- 8.6 Training in mental health and CPD to be made available for all non-specialists in education, health and social services
- 8.7 Targeted mental health support to be provided for all young people who have been through the justice system or who are identified as being at risk of offending.

9. THE INFLUENCE OF INDUSTRY, ADVERTISING AND THE MEDIA IN PROMOTING CHILD MENTAL HEALTH

Industry, advertising and the media play a crucial role in the promotion of positive child mental health. Some of the key issues and responsibilities are outlined below.

Industry

The digital world is now an inescapable, significant and integral part of children's lives (Frith E, 2017 '*Social Media and Children's Mental Health: A Review of the Evidence*' Education Policy Institute). The Government's 2017 Internet Safety Strategy (green paper, HM Government) emphasised the importance of digital companies adopting a principle of 'think safety first' and therefore, during the development of products, safety features should be part of the product design process and include internet safety, cyber security and data protection. Digital companies should ensure that simple reporting mechanisms are built into their products with rapid response times to complaints. Some companies have already introduced 'walled garden' versions of their digital platforms which are suitable for children; good practice which should be rolled out across the sector.

Social media and other digital companies have a duty to facilitate the rapid removal of inappropriate content from their platforms; including material of a pornographic, homophobic, biphobic, transphobic or violent nature. This also includes inappropriate advertising or live streaming and other content which serves to normalise self-harm, suicide and eating disorders and digital companies also need to react more quickly to cyber bullying by suspending the accounts of perpetrators and reporting the abuse immediately.

Digital companies should be aware of content which may result in appearance-based comparisons; in turn triggering concerns about body image (Royal Society for Public Health, 2017, '*#StatusOfMind, Social media and young people's mental health and wellbeing*'). Examples include content which promotes the use of cosmetic surgery. Digital companies have a responsibility to attach warnings to this content so that children and young people are informed of the associated dangers. They also have a responsibility to inform young people about the dangers of not respecting their own bodies.

The online dating industry has an important responsibility to review processes for ensuring that the user base is over the age of consent and the accounts which belong to people under the age of consent should be terminated. These companies also have a responsibility to report cases where those above the age of sexual consent communicate with under-age young people.

The sport industry has already promoted the positive impact that physical activity can have on mental health; however it also has a responsibility to highlight the link between body image and mental health conditions such as depression, anxiety and eating disorders. Similarly, the beauty industry has a responsibility to highlight the risks of cosmetic surgery to children and young people. Idealised images which dominate the global beauty industry tend to emphasize (and therefore validate) the stereotype of fair skin and straight hair (*British Youth Council, 2017 Youth Select Committee*) which can provoke negative issues of body confidence. Both sectors should ensure that they are fully inclusive by demonstrating that diverse bodies are represented in their industries.

The health sector is highly experienced in providing specialist support to children and young people with the most severe mental health needs; however, many young people do not meet the criteria for referral and their needs must be met in schools by education professionals. Closer collaboration between both the health and education sectors is therefore essential if the needs of children and young people are to be effectively met in a school setting. For example, the role of the Mental Health Support Teams which have been proposed in the recent green paper (*'Transforming Children and Young People's Mental Health Provision'*) is a welcome example of how mental health and education specialists might work alongside each other. Further examples of collaborative working should also be explored.

Advertising

The regulatory body for the advertising industry is the Advertising Standards Authority. It plays a critical role in promoting body positivity but research indicates that advertisements often portray body confidence in relation to idealised images of beauty (*Firth as above*). Females are often depicted via images of slender bodies which are used to represent beauty and perfection and these images and messages can result in young girls and women developing low body confidence which can trigger depression, anxiety and the development of eating disorders (*British Youth Council; Frith as above*). Images and messages about slender, 'perfect' bodies are internalised and thus can encourage children and young people to develop unrealistic expectations about their own bodies.

Research suggests that females may be more susceptible to poor body image than males but boys and young men can also be affected (*British Youth Council as above*). Advertisements which portray the 'perfect' male body, often depict muscular strength as a key characteristic and research suggests that this can lead to males developing an obsession with muscle building and feelings of dissatisfaction with their own bodies.

Research also suggests that young people from minority groups may also be affected by body dissatisfaction; for example those identifying as Lesbian, Gay, Bisexual or Transgender (LGBT). Young people identifying as LGBT may face discrimination for not conforming to the gendered body expectations of the cisgender majority (*British Youth Council*) and this can cause low body-esteem. Body dissatisfaction can then lead to the development of 'risky' behaviours which may include smoking, drug, steroid and alcohol use and either over-exercising or not exercising enough. Body dissatisfaction can impact negatively upon relationships, education and wider life outcomes.

The Advertising Standards Authority has an important role to play in challenging adverts which perpetuate and entrench stereotypes through depictions of idealised images of gendered bodies. The Authority also has a crucial role to play in ensuring that images of diverse bodies are represented which reflect people's everyday lived experiences in society. This includes ensuring that bodies of people representing minority groups (for example disability, sexuality, race, ethnicity, non-gender conforming) are represented equally in relation to non-minority groups. The ASA should also challenge assumptions in advertisements that slender or muscular bodies are ideal or preferred body types.

Media

The media has a responsibility to highlight key issues in relation to child and adolescent mental health through its various channels of communication. Its influence lies in its audience reach and the increasing variety of media platforms means that information can be disseminated efficiently to children, young people, parents and educators.

In targeting children and young people, the media can influence their understanding of mental health. It can educate young people about their social, physical and mental health and highlight the fact that mental health can fluctuate over time; that poor mental health is not necessarily permanent and that there are steps that individuals can take to improve their own mental health and emotional wellbeing. The media can also play a critical role in signposting children and young people to sources of support. Through television, radio, magazines, newspapers and social platforms, the media can play an important part in developing mental health literacy and young people can be exposed to the experiences of other young people with mental health needs.

Whilst there are ways in which media content can have a positive impact upon the mental health of children and young people, the recent furore over the proposed screening of a 'Netflix' drama series about a teenage suicide (*'13 Reasons Why'*) is indicative of the pitfalls. The online version of the programme is set to coincide

with the GCSE and A level examination period for UK students and professional opinion has been scathing:

'The Royal College of Psychiatrists said the timing was 'callous,' warning that suicide rates among young people rise during the exam season and that the drama could trigger a further increase. Teachers' leaders said it was 'disturbing' and 'regrettable' particularly given concerns about a crisis in young peoples' mental health,' ('The Guardian,' 12th May, 2018).

The way in which children and young people interact with the media has altered over time because of the growth of technology. Research suggests that this is now an integral part of young people's lives and that over a third of those aged 15 in the UK are extreme internet users (*Firth as above*). Media platforms can play a significant role in highlighting to children and young people both the positive and negative impacts of internet use (including social media) on their lives. For example, they need to understand the negative relationship between social media use and life satisfaction (*OECD, 2016 PISA 2015 Results Students' Wellbeing Volume 111: <http://www.oecd.org/education/pisa-2015-results-volume-iii-9789264273856-en.htm>*) and the relationship between social media use, sleep quality and sleep deprivation (*Scott H, Gardani M, Biello S, Woods H, 2016 'Social media use, fear of missing out and sleep outcomes in adolescents': <https://www.researchgate.net/publication/308903222>*).

The media has a role to play in highlighting cyber bullying and can provide advice to children and young people on how to respond to it. In addition, given the normalisation of self-harm and suicide through the introduction of live streaming and sites which normalise eating disorders, the media has a duty of care to highlight the dangers of these to young people.

Media platforms play a critical role in educating children and young people about their responsibilities as digital citizens to the digital community. Through its various platforms, the media can support the development of young people's digital literacy skills so that the effects of exposure to harmful content are minimised. Crucially, children and young people need to keep themselves safe online. The media can play an important role in educating them about the dangers of sexting, grooming and sharing too much personal information with others. In addition, the media has a critical role to play in boosting body confidence through promoting images of diverse bodies and challenging stereotypes of slender and muscular gendered bodies.

The media can play an important role in developing parents' and educators' mental health literacy. It can highlight warning signs, provide information and

strategies for supporting children and young people with mental health needs and it can offer signposting for further information and advice.

Recommendations:

- 9.1 The digital industry should build safety features into all products which are designed for children and young people as part of the design process
- 9.2 The digital industry should react more quickly to abuse by removing the accounts of perpetrators and reporting the abuse. It should remove inappropriate content rapidly
- 9.3 The advertising industry should ensure that advertisements do not promote low body-esteem
- 9.4 The media should play an even greater role in developing people's mental health literacy and highlighting issues in relation to the mental health of children and young people; adopting a pro-active stance towards the screening or otherwise of potentially sensitive material at stress points in young peoples' lives (i.e. the examination calendar) and entering into dialogue with the Government about these issues

10. THE IMPACT OF SOCIAL MEDIA AND SCREEN TIME

'No other media has so re-defined the terms of our social lives; self-esteem, when we believe we are missing out, and the perception that others agree with us.' (Agnes Javor, Independent Counsellor)

Few would disagree, including possibly Health Secretary, Jeremy Hunt, who met social media company leaders in 2017 to discuss his concern that misuse of the technology may be adversely impacting children's mental health. He suggested that the Government's forthcoming response to the Internet Safety Strategy consultation could include new legislative powers and has asked the Chief Medical Officer to instigate a review into the impact of technology on children and young people's mental health. His letter to internet company leaders said:

'I am concerned that your companies seem content with a situation where thousands of users breach your own terms and conditions on the minimum user age.

I fear that you are collectively turning a blind eye to a whole generation of children being exposed to the harmful emotional side effects of social media prematurely.

This is both morally wrong and deeply unfair to parents who are faced with the invidious choice of allowing children to use platforms they are too young to access, or excluding them from social interaction that often the majority of their peers are engaging in.

It is unacceptable and irresponsible of you to put parents in this position':
<http://www.bbc.co.uk/news/uk-43853678>

According to the Office of National Statistics (ONS 2016, 'Internet access – households and individuals: 2016': <https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/bulletins/internetaccesshouseholdsandindividuals/2016>) the proportion of people using the internet daily rose from 35% in 2006 to 82% in 2016 and social media use has risen broadly in line with internet use. Recent studies report Discretionary Screen Time (DST) in children aged under two as *'high and appears to increase steadily across age groups'* (Goh SN, et al, 2016 'Sociodemographic, home environment and parental influences on total and device-specific screen viewing in children aged 2 years and below: an observational study,' *BMJ Open*.6:e009113.doi:10.1136/bmjopen-2015-009113). At the other end of the youth spectrum, Ofcom reports that the average UK 16-24 year-old is now *'spending more time on media and communications than on sleeping'* (Ofcom, 'The Communication Market Report',

2016: <https://www.ofcom.org.uk/research-and-data/multi-sector-research/cmr/cmr16>).

At standard UK screen-time levels, by the age of seven, the average child will have spent nearly one full year of 24 hour days on Discretionary Screen Time (DST). By the time they reach 18, this has risen to over three years and, by age 80 would tally an incredible 18 years of their lives (*Dr Aric Sigman, 2012, 'Time for a view on screen time,' Arch Dis Child 2012;97(11):935-942.doi:10.1136/archdis-child-2012-302196: <http://adc.bmj.com/content/97/11/935>*). Many young people are 'digital natives'; they have never known an internet-free world and it has been suggested that social media is more addictive than cigarettes and alcohol (*Hofmann W, Vohs D, Baumeister R, 2012 'What people desire, feel conflicted about, and try to resist in everyday life': <http://journals.sagepub.com/doi/abs/10.1177/0956797612437426>*).

This has not produced a generation of happy and self-confident young people. Professor Jean M Twenge, lead scientist of three new large-scale studies involving over 1.1 million children concludes that 'iGenerators' (born around 1995) are on the verge of the most severe mental health crisis for young people for decades (*Twenge, J.M. et al. 2018a. Decreases in Psychological Well-Being Among Adolescents After 2012 and Links to Screen Time During the Rise of Smartphone Technology. Emotion <http://dx.doi.org/10.1037/emo000403> , Twenge, J.M. et al 2018b. Increases in depressive symptoms, suicide-related outcomes and suicide rates among US adolescents after 2010 and links to increased new media screen time. Clinical Psychological Science. 6(1). 3-17*). She contends that the ubiquitous smart phone has contributed to an adverse climate and Mandy Saligari, Head of the Harley Street Charter rehabilitation clinic, has compared giving children a smart phone to doling out a gram of cocaine. She encounters 16-20 year olds seeking treatment for addiction but some clients are much younger. Many 13-14 year girls consider sexting to be completely normal only becoming 'wrong' when adults find out: <https://www.independent.co.uk/enw/education/education-news/child-smart-phones-cocaine-addiction-expert-mandy-saligari-harley-street-charter-clinic-technology-a7777941.html>.

Meanwhile, Conservative Minister Liz Truss has been dubbed the 'phone jailer' by her family because:

'I have a box which I lock up and put my daughter's mobile phone in...It's not just the internet, it's screen time overall. It's part of being a good parent. I think social media companies can play a part and help parents in that job': <http://www.bbc.co.uk/news/uk-43853678>

Social media and the internet have benefits too. Young people use them to make social connections, seek advice and access help with homework (*Frith E, 'Social*

Media and Children's Mental Health: A Review of the Evidence, Education Policy Institute, 2017). The internet removes geographical, financial and cultural barriers and can enrich and support young people in their academic, social, cultural and political and identity development. Social media can be a powerful platform for self expression; allowing young people to project a positive identity and can enable minority groups such as those who self identify as LGBTQ+ to connect and create a sense of community despite geographical distance. There is also evidence to suggest that friendships can be strengthened through social media interactions (Lenhart A, 2015 Chapter 4: *Social media and friendships*: <http://www.pewinternet.org/2015/08/06/chapter-4-social-media-and-friendships/>).

Research shows, however, that excessive internet use can impact detrimentally upon life satisfaction. Health professionals worry about disproportionate amounts of Discretionary Screen Time (DST), the time of night that it occurs and a range of potential mental health outcomes; from clinical depression, body dissatisfaction and eating pathologies to screen dependency disorders (SDDs). Public Health England states:

'The evidence suggests a 'dose-response' relationship where each additional hour of viewing increases the likelihood of experiencing socio-emotional problems.' (PHE, 2014 *'Impact of digital culture. Written submission to Commons Select Committee on Child and Adolescent Mental Health'*, CMH0085: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/childrens-and-adolescent-mental-health-and-camhs/written/7562.pdf>).

The Office of National Statistics has reported an association between longer periods of time spent using social media and poor mental health, including psychological distress, and there is also a connection between sleep and mental health. Several studies have demonstrated that increased social media use is linked with poor sleep quality in young people (Sampasa-Kanyinga, H et al, 2018. *'Use of social media is associated with short sleep duration in a dose-response manner in students aged 11 to 20 years,' Acta Paediatrica. 107(4) April: <https://doi.org/10.1111/apa.142100>*).

Over a third (37.3%) of young people aged 15 in the UK are classified as 'extreme internet users'; defined by the OECD as being an individuals who use the internet for more than six hours outside school on a typical weekend day (OECD, 2016 *'PISA 2015 Results Students' Well-being' Volume 111*). The 16-24 age groups are most prolific with 91% using the internet for social media (ONS 2016). Facebook is the most popular platform, followed by Google+, LinkedIn, Pinterest, Instagram and Snapchat (Royal Society for Public Health (PSPH), 2017 *'#StatusOfMind Social media and young people's mental health and wellbeing'*). Activity is likely to be private; conducted in bedrooms or via personal smart phone, making parental

monitoring difficult. Instant messaging via social media platforms is becoming increasingly common among young people (Frith 2017).

Cyber bullying, intense social comparison and competition, online rejection, peer influence and emotion-loaded interactions are adverse outcomes of social media use. Added to this, sleep deprivation (as a result of excessive Discretionary Screen Time (DST)) may precipitate some psychiatric disorders and exacerbate existing mental illness. A study by Oxford University's Department of Psychiatry reported '*strong evidence that insomnia is a causal factor in the occurrence of psychotic experiences and other mental health problems*' (Freeman D et al, 2017 '*The effects of improving sleep on mental health, OASIS: a randomised controlled trial with mediation/analysis*', *The Lancet Psychiatry*, 4(10), 749-758: <https://www.science-direct.com/science/article/pii/S2215036617303280>; Lyall et al 2018. Association of disrupted circadian rhythmicity with mood disorders, subjective wellbeing, and cognitive function: a cross-sectional study of 91 105 participants from the UK Biobank. *The Lancet Psychiatry*, 15th May 18: [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(18\)30139-1/abstract](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(18)30139-1/abstract)).

Neurobiologists suspect that sleep deprivation causes epigenetic changes in the brain affecting the function of serotonin (a brain chemical which helps regulate mood) and have implicated '*Ubiquitous technology (which) creates an environment that promotes sleep deprivation*' (Watson et al, 2014). Also, the growing links between evening Discretionary Screen Time (DST) and clinical depression can be partly explained by the way that screens may reduce sleep quality (Yoshimura M et al, 2017 '*Smartphone viewing distance and sleep: an experimental study utilizing motion capture technology*' *Nature and Science of Sleep*. 9, 50).

More information is needed about the impact of social media on young people's body esteem. Existing research has shown that when young females in teens and early twenties view Facebook for only a short period of time, body image concerns are higher than compared to non-users (Tiggeman M, Slater A, 2013, '*The internet and body image concerns in preteenage girls*', *The Journal of Early Adolescence*, Vol 34, Issue 5, pp.606-620.10.1177/0272431613501083 39). The popularity of 'selfies', wealth of photoshopped images, celebrity images, and the prevalence of so-called 'perfect' bodies can result in low body esteem and intense body surveillance.

Websites which normalise self-harm and eating disorders and sites promoting distressing content (such as the live streaming of suicide) are becoming increasingly popular and can promote the growth of unhealthy behaviours. 'Addiction' is the term used to describe the growing number of children and young people who are engaging in a number of different screen activities in a dependent and problematic manner. In order to cover the range of such behaviours, the term Screen Dependency Disorders (SDD) has recently been

introduced (Sigman A, 2017. *Screen dependency disorders: a new challenge for child neurology*. *Journal of the International Child Neurology Association*. ISSN 2410-6410: <http://jicna.org/index.php/journal/article/view/67>). SDDs may include internet addiction disorder, internet gaming disorder, video game addiction, mobile phone dependence and social network site addiction.

Childhood is a time of significantly greater changes in brain anatomical connectivity and structure and as with substance addictions, it is possible that intensive routine exposure to certain screen activities during critical stages of child brain development may alter gene expression in the brain, resulting in structural and functional changes that could lead to SDDs, particularly in children with a genetic predisposition.

Faced with these challenges, the 'explanation' that computer gaming problems, for example, represent a simple culture clash (internet-savvy youth versus technologically phobic dinosaur elders) must be regarded as dangerous, if it is preventing policy makers from studying the serious neurobiology research findings that tell a very different story:

'These brain changes may be good for screen media industries, but not for children's mental health.' (Sigman, 2017)

When making a case for action sooner rather than later, policymakers might look no further than at the words of Sean Parker, former Facebook president, who regrets his own pivotal involvement in an organisation that flourished by '*exploiting a vulnerability in human psychology*' to keep users addicted: http://www.theregister.co.uk/2017/11/10/sean_parker_i_helped_destroy_humanity_with_facebook/. The overriding question is therefore: could/should major companies be regulated?

Waiting for an outbreak of voluntary regulation is probably futile, as Jeremy Hunt has discovered. The right of individuals to lead a digital life must be carefully balanced against the extent to which they fulfil their responsibilities as digital citizens to the digital community. Schools and parents must play a major role in protecting children and young people from harm; but so too must the digital industry. In essence, the burden of 'proof' must be reversed. It should now be upon those who advocate the status quo (high Discretionary Screen Time (DST), starting young) to demonstrate that high and/or premature exposure to DST poses no health and development risks to children.

If and until that can be conclusively proved (current research furnishing strong evidence to the contrary) then, child mental health policy must adhere to the long-

established precautionary principle as the safest and most prudent approach to protecting child health and wellbeing.

Recommendations:

- 10.1 Policy makers and associated organisations should adopt a clear public health position on children’s age of initiation to Discretionary Screen Time (DST), along with the amount and time of day for DST as the prudent approach to good child mental health until more is known
- 10.2 Government must prioritise raising parental awareness of the potential risks of excessive internet use and ensure that all messaging is conveyed by health/education professionals (properly equipped and with CPD opportunities regularly updated) from antenatal care onwards
- 10.3 The National Curriculum to include digital literacy and digital citizenship and schools to provide age-appropriate curriculum content which focuses on developing these skills
- 10.4 Schools to develop peer support and digital ambassador schemes to support digital curriculum content as above
- 10.5 The digital industry should have a statutory requirement to report and remove abuse within strict timescales, suspend the social media accounts of perpetrators and interrupt the user’s experience in response to inappropriate searches
- 10.6 App store providers should build in safety features from the outset to prevent children’s exposure to harmful content
- 10.7 Government to promote greater opportunities for physical activity both in school and the wider community (thought to lead to a reduction in Discretionary Screen Time (DST) and the risk of Screen Dependency Disorders (SDD) in children and young people)
- 10.8 Policy makers to familiarize themselves with the influence of the technology industry in lobbying, funding research and influencing media depiction of Discretionary Screen Time (DST) and Screen Dependency Disorders (SDD) and be vigilant in detecting and publicising conflicts of interest
- 10.9 Policy and guidance in this area to be overseen and owned, by the Department of Health, *not* the Department for Digital, Culture, Media and Sport or Department for Education.

11. CHILD MENTAL HEALTH: THE WAY FORWARD

The Government green paper (*'Transforming Children and Young People's Mental Health Provision'* DoH/DfE, 2017) highlighted the leadership and management of mental health provision in schools. Some schools may already play a critical role in providing young people with appropriate support, and examples of good practice should be disseminated. However, children's mental health should not be a casualty of geography, inadequate training and insufficient funding and the green paper as it stands is a starting point, no more; requiring revision.

Placing services to support mental health and emotional development at the heart of all schools makes sense but resources are essential to facilitate a 'whole school approach' as identified by Public Health England in 2015 (*'Promoting children and young people's emotional health and wellbeing: A whole school and college approach'*). It would be a step in the right direction for school leadership teams to prioritise child mental health via the inclusion of a professionally trained Designated Senior Lead for Mental Health. The role would entail taking responsibility for developing universal provision of mental health for the whole school community at all times and the post-holder would be supported by a specific, appropriately trained Governor who would hold responsibility for monitoring the quality of provision for mental health throughout the school. The Mental Health Governor's remit would include holding the Designated Senior Leader for Mental Health to account.

Within school, the PSHE curriculum should educate young people about recognising and managing their feelings, coping with conflict and supporting others in need. Schools should be required to provide a curriculum which develops children's mental health literacy skills across a range of mental health needs including managing anxiety, stress and depression as well as more serious needs such as eating disorders and how to develop resilience to adverse situations. A specifically digital curriculum should teach pupils about online safety and the potentially dangerous situations inherent in online dating, grooming, sexting, pornography and revenge pornography. A national digital curriculum should also develop digital literacy skills and the rights and responsibilities of digital citizenship. Mental health should also be embedded in the content of other subject areas and in extracurricular activities to stimulate pupil motivation and personal safeguarding and pupils should be regularly consulted and given opportunities to influence the content of policy proposals which may have impact upon their mental and social and emotional welfare. It is important to re-position physical education within the curriculum as a key contributor to children's mental health and emotional wellbeing as well as their physical capacity. Play should also be embedded in a holistic approach to policy around children's mental and

physical health. It is fundamental to children and integral to who they are and what kind of people they will become.

Over the past two years, The Youth Sport Trust have been commissioned to deliver bespoke health and wellbeing strategies for schools to address the current stress, anxiety and wellbeing crises that young people face. Active Health Minds uses a universal, targeted and integrated approach to improve the physical and emotional wellbeing of pupils within schools, selecting interventions to address specific issues. The main points are that:

- School provision should focus on the physical, social and emotional development of young people that prevent future mental illness as opposed to service provision alone that supplies a 'sticking plaster' solution.
- Provision should be part of an integrated approach to mental health, working with pastoral leads and community services that complement and support the curriculum
- The curriculum must be more balanced with equal emphasis on subjects that naturally develop the social and emotional wellbeing of pupils (such as PE, sport and play) as well as traditional academic content
- Young people should be developed as Mental Health Champions to act as peer mentors; unlocking the stigma and secrecy of mental health and giving young people a voice and a vehicle for change
- Commissioning of interventions for the mental health of children and young people should work to a collaborative model, bringing together organisations that can help to address physical, emotional and social needs. The Mentally Healthy School pilot in Greater Manchester is an innovative approach to commissioning national, regional and local voluntary sector organisations to improve the mental health of young people through whole school review, workforce development, targeted interventions and the use of physical and emotional wellbeing techniques.

Effective, in-house counselling services can provide a model for wellbeing within schools and should be fully funded, supported and delivered in any national strategy for child mental health. The Welsh Assembly School-Based Counselling Operating Toolkit (2008) provides an excellent model, capable of UK roll-out. The National Counselling Society (NCS) recommends that all education settings should have at least one (ideally more) counselling practitioners in-house or directly available to be referred to at the point of need. Counselling services benefit child mental health in the following key areas:

- Preventative intervention – often identifying early changes to a child's behaviour or emotional, physical or mental wellbeing

- Provides an assessment process for children in need; assessing the level of risk whilst identifying any ongoing needs
- Counselling within schools complements other approaches to support the health and wellbeing of learners
- Counselling services provide early intervention measures which can be linked with legislation requirements in safeguarding
- Counselling services can work systematically with other skilled professionals or practitioners or specialist services, supporting the child or young person
- Counselling can act as an interim, parallel or post provider to CAMHS support.

It is essential that only therapists on a PSA Accredited Register may work in a counselling capacity with children. Inspection agencies such as Ofsted and the CQC must be empowered to check that unregistered, unqualified, unsupervised and unsafe practitioners are not being employed or contracted. All teachers and other professionals working with children should be trained to identify those who display one or more of the twenty most common problems based on reliable data so that referrals can be made to the school counselling team, or where appropriate, CAMHS and other sources of help.

The future provision of counselling in all schools, developing a whole school ethos for mental health with strong community links, promoting emotional wellbeing in children and young people and preventing the development of mental health problems should be a major priority for government. Delays in identifying and meeting emotional and mental health needs can have detrimental effects on all aspects of children's lives; including their ultimate chance of attaining their potential and leading happy and healthy lives in a productive and supportive society.

In conclusion, the All-Party Parliamentary Group on a Fit and Healthy Childhood would agree with the statement of the Education and Health and Social Care Committees (*'The Government's Green Paper on mental health: failing a generation,' 9th May 2018 as above*):

'Mental health sits within a complex landscape, and with this policy area as with many others, there must be effective coordination with other initiatives from across Government when building a new strategy.'

The 'new initiative' that we would propose is the creation of The Department for Children, headed by a Secretary of State with the responsibility of cross-departmental audit and scrutinised by a new Select Committee.

In that way, a revised green paper leading to a Child Mental Health Act will deliver and *be seen to deliver* in the interests of children, young people and their families.

Recommendations:

- 11.1 Joint action across government to improve co-ordination of the wider system of mental health support for children and young people by establishing a top level Inter-Departmental Group on Children's Mental Health with external representatives as appropriate. The group should ideally be convened by a Cabinet Minister for Children
- 11.2 The provision and universal requirement of qualified counselling services in all schools across the UK; Ofsted and the CQC to have responsibility for ensuring that unregistered, unqualified, unsupervised and unsafe practitioners are not being employed or contracted
- 11.3 School funding for child mental health services to include resources for engaging parents whose children receive therapy via a therapeutic coaching programme
- 11.4 Agree the specifications, protocols, directives and incentives required for the sharing of children's mental health data to make it easier for health, education and social care professionals to work more closely and effectively together (joined up care) and to improve practice through dissemination of practice-based evidence
- 11.5 Ensure that CAMHS have the resources for earlier and long-term intervention
- 11.6 All teachers to receive training in child mental health as part of initial training and CPD with all programmes to include emotional wellbeing, child mental health and child development
- 11.7 Supervision to support the wellbeing of teaching staff and mental health practitioners
- 11.8 PSHE curriculum to proactively support mental health and wellbeing from early years to secondary and further education
- 11.9 A focused and holistic approach in health and education to engender both positive empowering emotions and normalise emotions such as feeling of sadness or loss
- 11.10 Embodying play in a holistic approach to policy around child mental and physical health and this to be free, outside and unstructured activity where children are allowed to use not only their physical skills but also their social, emotional and cognitive abilities
- 11.11 Reorienting the subject of physical education as integral to the social and emotional development of every child and not just to their physical capacity.