



Healthy minds

Promoting emotional health and well-being in schools

**Better
education
and care**

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Executive summary

This report examines the vital role played by schools in promoting the emotional well-being of their pupils. It analyses practice based on evidence gathered from visits by Her Majesty's Inspectors (HMI) to 72 schools and reports on the impact of the guidance provided to schools four years ago by the Department of Education and Skills (DfES) and the National Healthy Schools Standards (NHSS), agreed in 1999.^{1,2} Both clarify the importance of good provision to ensure that schools meet the needs of pupils with mental health difficulties.

Schools' lack of knowledge of the DfES guidance results from a missed opportunity to improve the quality of provision for pupils with mental health difficulties. The large number of schools visited for this survey who were not working towards meeting the NHSS is of serious concern. Only just over half of them were aware that such standards existed. Of these, only a very small minority of schools were working towards or had met the criteria for providing for pupils' emotional health and well-being. One barrier was the low level of awareness of the importance of the issue.

It is unsurprising, therefore, that training for staff on mental health difficulties was found to be needed in three quarters of the schools. Most training tended to focus on strategies for managing pupils' behaviour rather than on promoting positive approaches to relationships and resolving conflicts.

Despite such a lack of awareness in schools of mental health issues, there was good practice in one third of the schools in the survey, including:

- an ethos which valued and respected individuals
- a serious approach to bullying and pupils' difficulties with relationships, and swift resolution of problems
- good arrangements for listening carefully to pupils' views
- the involvement of parents in identifying problems and making provision for their children.

Good joint working between health services, social services and schools was at the heart of effective planning and provision for individual pupils. Although multi-agency working was becoming better established within local education authorities, it was unsatisfactory in a quarter of the schools. Schools, parents and pupils were not always aware of how they might gain access to services. The best arrangements included regular meetings attended by a range of professionals, where work was coordinated, referrals made and difficulties followed up.

¹ *Promoting children's mental health within early years and school settings* (DfES 0121/2001), DfES, 2001.

² *Promoting emotional health and well-being through the national healthy school standard* (NHSS), NHS Health Development Agency, 2004.

Health services, social services and schools used different terms to describe mental health difficulties. The lack of a common language added to difficulties in recognising and meeting pupils' needs. Schools identified about one in twenty pupils with mental health problems, although the Department of Health suggests a figure nearer one in ten.

Arrangements for pupils to refer themselves for support and help were popular with them, as well as effective. This was particularly so where a pupil was struggling emotionally but where the school had not noticed changes in the pupil's behaviour. Mentoring and support from peers was also very effective at providing a listening ear and opportunities for positive friendships.

The report concludes that schools should make the promotion of pupils' emotional health and well-being a priority and ensure all staff are aware of the guidance available.

Key findings

- ❑ The best schools promoted good emotional health and well-being by valuing and respecting every individual.
- ❑ Very good whole-school systems to eradicate bullying reduced the risks of pupils developing mental health difficulties.
- ❑ Few schools used national guidance to plan and provide support for pupils' emotional well-being. Training for staff on mental health difficulties was unsatisfactory in just over a third of the schools visited. Most training tended to focus on strategies to manage pupils' behaviour rather than on promoting a positive approach to relationships and conflict resolution.
- ❑ Most LEAs were responding to the need for improved joint working by establishing one directorate for all children's services. However, the changes were not yet reflected in changed practice in schools.
- ❑ Partnerships with external agencies were unsatisfactory in nearly a quarter of the schools visited. Although they were good in a third, these were nearly all primary or special schools and pupil referral units (PRUs). Secondary schools found it most difficult to make arrangements for multi-agency working a priority and they rarely took the lead in improving this aspect of their work. The lack of common language between education, health and social services professionals contributed to the difficulties in establishing good partnership working.
- ❑ Primary and special schools were more successful than secondary schools in tackling emotional health and well-being through whole-school initiatives.
- ❑ Primary schools who were piloting the new materials provided by the Primary National Strategy to promote social and emotional well-being, dealt effectively with issues of pupils' mental health.

- ❑ Particularly good arrangements for working with parents included initiatives such as parenting classes and home visits, where parents could talk openly about their concerns and their children's behaviour.
- ❑ Other effective provision involved pupils' self-referral, peer support and flexible approaches by schools to modifying the curriculum and timetables.
- ❑ Services to deal with mental health across an area were not always equitable: where a pupil lived determined, at least to some extent, which services were provided.
- ❑ Even where services were available, schools, parents and pupils were not always aware of how they could be accessed.
- ❑ Local and national voluntary organisations played an important role in working with schools and local authorities to provide services. They were often better at monitoring and evaluating the impact of their work, since they depended on such evidence to attract further funding.

Recommendations

Local authorities and other agencies should:

- ensure that services for pupils with mental health difficulties are co-ordinated effectively within their area and that access to services is clear to schools, parents, children, young people and other service users
- commission, where appropriate, the services of voluntary organisations.

Schools and other settings should:

- use the DfES national guidance on mental health difficulties to develop clear procedures, that are known and used by all staff, for identifying and supporting pupils
- ensure that issues concerning mental health are tackled successfully, either through the National Healthy School Standard (NHSS) programme or the PSHE curriculum
- establish arrangements for preventing bullying and promoting positive relationships and monitor their effectiveness
- work together to ensure that the DfES guidance is disseminated to all staff.

The role of schools in providing for pupils with mental health difficulties

1. Many services play an important role in promoting pupils' emotional health and well-being, including health services, social services, voluntary organisations, early years provision and schools. However, the notion of mental health difficulties carried a considerable stigma for many pupils and their parents. This, together with the need to attend a clinic, created difficulties for Child and Mental Health Services (CAMHS) in working with

young people and their parents. A few pupils in the survey said that they did not wish to attend clinics for their appointments and did not want to be labelled as mentally ill. Schools, therefore, play an important role in supporting children and young people in this area.

2. Guidance provided by the DfES in 2001 aimed to help teachers and others, working alongside mental health professionals, to promote children's mental health and to intervene effectively.³ It provides a useful description of the nature of pupils with mental health difficulties and a thorough overview of the issues relating to joint working between health services, social services and education. It suggests helpful strategies for schools to use. Few schools, however, were aware of the guidance which should have provided a good opportunity to improve the quality of provision for pupils with mental health difficulties.
3. A survey referred to in the DfES guidance indicated that about 10% of pupils experience clinically defined mental health difficulties. The schools visited, however, identified only between 4% and 6% of pupils overall with some form of mental health difficulty, indicating some under-identification. This might go some way to explaining why schools struggle to manage the behaviour and attendance of some pupils, if they are not correctly identifying their difficulties and providing for them.
4. The 1999 Mental Health Foundation publication *Bright futures* defined children who are mentally healthy as able to:
 - develop psychologically, emotionally, intellectually and spiritually
 - initiate, develop and sustain mutually satisfying personal relationships
 - use and enjoy solitude
 - become aware of others and empathise with them
 - play and learn
 - develop a sense of right and wrong
 - resolve (face) problems and setbacks and learn from them.⁴
5. Health services, social services and schools all use different terms to describe pupils and their conditions. There are many definitions of the term 'mental health difficulty' ranging from the highly categorised, commonly used by many health services, to those based on more descriptive terms which are prevalent in schools and other educational settings.
6. 'Mental health' and 'mental health difficulties' are more commonly used terms within health and social care. Schools and local authorities are increasingly using the term 'emotional health and well-being' in relation to both the care they take of pupils and the curriculum they provide.

³ *Promoting children's health within early years and school settings*, DfES, 2001.

⁴ *Bright futures: promoting children and young people's mental health*, Mental Health Foundation, 1999.

7. The lack of shared definitions and understanding of mental health problems, however, makes it difficult for schools to identify and discuss these pupils. In a small proportion of primary schools, boys were pinpointed as more likely to exhibit mental health difficulties, but most schools reported no pattern. Some secondary schools identified more girls who were depressed, self-harming or who had eating disorders. However, no real gender differences were apparent and boys and girls were equally likely to have mental health problems which were evident in school.

Whole-school approaches to promoting good mental health

8. The best schools promoted good emotional health and well-being by valuing and respecting every individual. In the schools visited, those which embodied a value system that embraced all children identified fewer children with mental health problems. These schools promoted many and varied opportunities for pupils to share their thoughts and feelings. They used the curriculum to develop pupils' listening skills and an understanding of other people's points of view: this culture permeated school life.

Case study

A primary school in a disadvantaged area had a caring and supportive ethos in which the personal development and emotional well-being of pupils was very effectively promoted. There was a strong emphasis on developing all pupils' self-esteem and ensuring that they had the language and opportunities to express their feelings and emotional needs.

The school council and staff were concerned that some pupils did not have friends to play with at break time. Very good initiatives, including 'Playground Buddies' and a 'Friendship Area', were introduced in response to these concerns. The school worked very hard to build up and maintain supportive relationships with parents and guardians, who felt that the school was a very safe and caring place for the children. The whole staff, including teachers, teaching assistants, administrative staff, catering staff, the site manager and cleaning staff contributed to this whole-school ethos.

9. Pupils interviewed for the survey identified a lack of friendships and bullying as reasons for emotional difficulties in school. In all the schools with good arrangements for promoting health and well-being, bullying was not tolerated at any level. Pupils were able to discuss any incidents where they felt bullied and matters were discussed sensitively and resolved speedily. In these schools the pupils specifically commented that they

were happy at school because they could talk to an adult if they had problems and know that action would be taken.

10. All schools taught a programme of personal, social and health education (PSHE). Nearly all primary and special schools discussed some elements of anger management, conflict resolution, bullying and friendship difficulties through such programmes. The provision was always at least satisfactory, and was good in over half of all schools visited.
11. Very few of the schools, however, tackled mental health difficulties specifically. These were missed opportunities to promote pupils' general emotional well-being, particularly so in secondary schools where there were generally fewer opportunities to explore such issues. Only a third of the secondary schools visited taught PSHE programmes which included topics such as bereavement, stress and bullying.
12. The Primary National Strategy has provided training and curriculum materials for schools which focus on the social and emotional aspects of learning. At the heart of the materials is the belief that positive behaviour requires an active, whole-school approach to developing children's social, emotional and behavioural skills within a community that promotes the emotional well-being of all its members. A few of the schools visited were involved in the pilot stage of this work to very good effect. These schools were teaching pupils how to understand their own feelings and those of others, persevere when things became difficult, resolve conflict and manage worries. Staff found the training helpful and were in a good position to ensure their pupils learned how to take responsibility for their relationships and their learning. Following successful piloting, the Social and Emotional Aspects of Learning (SEAL) curriculum resource was made available to all primary schools in June 2005.⁵

Case study

A Year 5 class explored what it felt like to join a new group. Pupils talked freely about their own experiences of joining clubs, moving to a new school and trying to make new friends. They used a good range of vocabulary to describe the feelings associated with newness and change, ranging from 'scared' and 'excited' to 'apprehensive' and 'excluded'. Groups then planned what they would put in a welcome pack for a newcomer to their school. They gave careful thought to the kinds of information that would be helpful and to the ways in which they, as individuals, could be supportive.

13. No similar national programme was observed in secondary schools although one is currently being developed. Overall, secondary schools

⁵ The SEAL resource box can be ordered from Prolog, Tel. 0845 602 2260, dfes@prolog.uk.com (ref: DFES 0110 – 2005 KIT), or viewed and ordered from the Teachernet website: www.teachernet.gov.uk/seal.

were less successful than primary and special schools at tackling issues of emotional health and well-being through whole-school initiatives.

14. In over half of the secondary schools visited, behaviour policies created stress or tensions for pupils. For example, in one school, exclusion was a common response to difficult behaviour; as a result, the pupils felt undervalued. Schools made only very limited efforts to provide a suitable curriculum to meet these pupils' emotional and learning needs. In one learning support centre within a school, pupils were taught by unskilled staff in poor surroundings which contributed to their low self-esteem. In a PRU, Year 11 pupils involved in a transition programme jointly run with the youth offending team reported that they were sent home on study leave two months before their official leaving date, even though they were not taking any formal examinations. They felt unwanted and this has had a negative effect on their self esteem, behaviour and attendance.
15. A significant minority of the secondary schools found ways to promote emotional well-being through their behaviour policies. For example, one large secondary school was developing ways to ensure that older pupils remained engaged with their school, even though they were soon to leave. A group of Year 11 pupils received two days' training to develop skills of listening and helping pupils to find their own solutions to problems. The pupils subsequently provided a non-threatening opportunity for pupils who were experiencing difficulties to confide in someone and share their problems. The trained listeners received an external accreditation award for completing their training.
16. One barrier to improving provision for pupils' emotional well-being was the low level of awareness amongst staff of its importance. Hardly any schools were aware of the comprehensive guidance issued by the DfES in 2001.⁶ Even fewer schools had provided any staff training to raise awareness of the issues and the strategies described in the guidance.
17. Training for staff on mental health difficulties was unsatisfactory in just over a third of the schools visited and good in only just under a quarter. Most training tended to focus on managing pupils' behaviour rather than on promoting a positive approach to relationships and resolving conflicts. However, a few secondary mainstream and special schools were developing an approach to conflict resolution based on 'restorative justice'. This ensured that, where there were conflicts, all points of view were aired and discussed. The pupils valued this: they felt they could 'have their say' and that their views were respected. The training programme for staff was effective: teachers and support staff felt able to implement the programme successfully.

⁶ *Promoting children's mental health within the early years and school settings*, DfES, 2001.

18. The National Healthy Schools Standard (NHSS) is at the core of the government's healthy schools programme.⁷ It was introduced in October 1999 to support the teaching of PSHE and citizenship in schools and to provide schools with practical ways to create a safe and productive learning environment and minimise potential health risks. One of its eight key areas of activity is emotional health and well-being (including bullying). Of serious concern, however, was the large number of schools in the survey who were not working towards meeting the standard. Only just over a half were aware that the NHSS existed and, of these, only a very small minority were working towards or had met the criteria for emotional health and well-being in their school.
19. Small schools often had informal but effective arrangements for recording and discussing concerns about pupils' well-being. Staff quickly perceived changes in pupils' behaviour, demeanour or progress. An important feature of these effective schools was the quality of the communication between staff, for example between class teachers, teaching assistants and the special educational needs co-ordinator.

Recognising and providing for individual needs

Working in partnership with other agencies

20. All schools and LEAs recognised the importance of working well with professionals from the health and social services. Joint working with these other agencies was crucial in planning and providing for pupils' individual needs. The challenge, however, for professionals from a range of disciplines was to achieve a common understanding of the problems of pupils with mental health difficulties. The following case study shows the benefits of effective joint working.

Case study

A counsellor in a secondary school was working with a pupil who had referred herself for support. The pupil's mother did not know this. A mental health worker from CAMHS, who worked in a local clinic, was also working with the pupil and approached the counsellor to see if they could work together with the pupil and parent. The counsellor discussed this with the pupil who gave permission for her mother to be contacted. Both professionals became engaged in supporting the parent and child. The consistent approach agreed between the adults ensured more straightforward discussions and properly agreed resolutions to problems.

21. Many of the local authorities visited were in a period of reorganisation as they set up Children's Services to meet the requirements of the Children

⁷ The NHSS is funded jointly by the DfES and the Department of Health, hosted by the Health Development Agency (HDA). It forms part of the government's drive to reduce health inequalities, promote social inclusion and raise educational standards through school improvement.

Act 2004. Practice is beginning to develop to establish the joint planning and working at the heart of this legislation. For example, one LEA was developing multi-agency patch teams and common referral procedures were being considered. Despite this, the survey showed that there was a long way to go to ensure that the legislative intentions result in better practice in schools.

22. Partnerships with external services were unsatisfactory in nearly a quarter of the schools visited and significant improvements were required in two thirds of them. Only a few of the secondary schools had good arrangements for multi-agency working. Relationships between schools and social services were particularly variable.
23. Unsatisfactory relationships between schools and other agencies were typified by:
 - the unavailability of social workers, even for urgent cases
 - schools' inflexibilities in approaching the planning of programmes to meet the needs of some of their pupils
 - frequent staff changes
 - long waiting lists for referrals
 - reliance on personal informal contacts rather than agreed systems
 - issues relating to geographical boundaries which remain unresolved.

In the third of schools where multi-agency work was good, all the agencies had found ways of resolving such difficulties.

24. The most effective strategies which promoted good joint working included regular, frequent meetings attended by all agencies. Pupils' needs were discussed and plans agreed and recorded.

Case study

A Vulnerable Students' Panel effectively identified students experiencing emotional health difficulties and provided appropriate multi-agency support for them. The panel met monthly and included representatives from a range of agencies. It was chaired by a deputy headteacher and a psychiatric nurse who was the manager of the school support centre. All school staff were informed confidentially about the students who had been discussed and this dissemination aided further identification. Decisions made by the panel ensured that agencies were deployed to work most effectively in their areas of greatest competence and avoided unnecessary duplication of effort. Importantly, the school and agency representatives were charged with taking action and reporting back on its success at the next meeting. In this way each organisation was accountable to the panel.

25. Identifying one person to be responsible for co-ordinating and liaising with health and social services helped communication and ensured important information about pupils was disseminated effectively.
26. In a few LEAs, networks of professionals working in the same area met regularly to share effective strategies. They learnt about each other's working practices and this promoted a shared understanding of issues. There was good practice in schools where a wide range of professionals including counsellors, therapists, social workers and psychologists were employed by the school.

Case study

A primary school had formal procedures for logging concerns about a child's academic, personal, social or emotional development. A nurture group also provided a way of identifying pupils who might have mental health difficulties. The school used short-term charitable funding to employ a family officer. She maintained close links with families identified as being in crisis and was therefore easily able to identify pupils at risk of developing difficulties in their emotional health and well-being. This approach encouraged partnership working so that parents referred their child to the family officer, headteacher or special educational needs coordinator if they had concerns.

27. Regular visits by other professionals helped schools to identify pupils who might be experiencing mental health difficulties.

Case study

The headteacher attended the school's breakfast club every day and a mental health worker attended once a week. The club provided an effective method of identification through direct observation of children and regular communication with parents.

28. Sometimes other agencies initiated the joint working and the schools grasped the opportunity to participate.

Case study

A consultant paediatrician at a local hospital initiated collaboration amongst different schools to promote emotional literacy amongst pupils. The initiative was inspired by an attempt to deal with bullying, cited as a problem by many children who attended the hospital. The project, now in its fourth year, involved pupils from a primary school, special school, high school and the local tuition service.

The project's activities were based on posters which depicted problems faced by pupils. They were encouraged to develop listening skills,

understand the perspective of others and to negotiate and compromise. Hospital staff encouraged the use of a common language by colleagues and the project fostered strong links between the health and education services.

The result was fewer individual referrals to the hospital. Pupils who experienced bullying were usually referred directly to the project for support.

29. The pupils who were least mentally well were those who were withdrawn or depressed and who were underachieving as a result. Schools commonly identified pupils whose attendance was unsatisfactory and who did not participate fully in school life. Typically, these pupils had few or no friends and were isolated in the play ground. However, they presented few challenges to teachers and, too often, their problems were not followed up. Few schools saw non-attendance, lateness or falling behind in course work and homework as indicative of deeper problems.
30. Schools relied too much on informal methods to identify vulnerable pupils. Primary schools, particularly, insisted that they were able to identify such pupils easily because they knew their pupils very well.
31. Only a minority of the secondary schools used information from pupils' previous schools to help recognise those who might experience mental health difficulties.

Relationships with parents

32. A key to effective identification and provision lay in schools' relationships with parents. Links with parents and other agencies were closest in the early years. Home visits, where parents could talk openly about their concerns and their children's behaviour, and initiatives such as parenting classes, supported the identification of any problems or difficulties. As pupils grew older, schools found it harder to sustain such relationships, although there were examples of very good practice in primary, secondary and special schools. The main characteristics of good practice were:
 - home visits by teachers and other support staff
 - training for parents in developing healthy minds
 - parental support groups
 - regular meetings and telephone contact
 - co-ordination with other agencies so that parents had to attend only one meeting.
33. Parental support groups were particularly common in the schools visited. In the following case study, the support groups were run by a local CAMHS team based in the school. The workers were able to talk to teachers while they were in the school and to ensure that information about individual pupils was discussed with them when appropriate.

Case study

A group of six parents met for ten two-hour sessions. The aim of the group was to help parents enjoy rather than simply manage their children. Parents learned how to play games and stimulate their children, thus strengthening their relationship. They particularly appreciated the opportunity to share their concerns with other parents who understood the problems. One parent reported, 'You realise you're not on your own; you don't feel so bad'. The project was in its infancy, but there were signs that it was helping parents to develop confidence and to help each other do better.

34. Difficulties in working with parents stemmed from:
- late diagnosis of a pupil's problems
 - uncoordinated support from a range of agencies
 - poor information provided for parents about whom to contact
 - inadequate account taken of parents' childcare arrangements, so that they sometimes had difficulties in attending meetings
 - negative feedback to parents about their children
 - parents' perceptions that the school had 'given up' on their child.

One parent observed, 'Nobody ever said what was available; you had to find out for yourself or hear it from someone else'.

35. Most, but not all, of the pupils identified with mental health difficulties also had emotional, social and behavioural difficulties (EBSD). Some had more than one such difficulty. Ofsted has reported recently on the provision for these pupils and its effectiveness.⁸ This report focuses on the provision required for pupils who do not necessarily have special educational needs but who require additional emotional support to succeed at school.

Informal arrangements

36. Half the schools in the survey operated self-referral or drop-in schemes run by peer counsellors, youth and community workers, school nurses, in-school counsellors and those from voluntary organisations. These arrangements enabled the pupils to identify themselves and seek the help they wanted and needed.

Case study

A secondary school appointed a health practitioner who dealt with a wide range of issues: developing self-esteem, anger management, relaxation and stress management. Pupils were able to make their own appointments and the work was completely confidential. She also did

⁸ *Managing challenging behaviour* (HMI 2363), Ofsted, 2005.

some teaching. This made her more accessible and reduced the stigma for pupils of 'knocking at the door'.

37. A very small minority of primary schools offered pupils opportunities for self-referral to staff. In these schools, pupils could draw or write about themselves in a 'reflections book' or a 'feelings book', make use of a 'bullying box', and write or talk directly to the headteacher or the PSHE co-ordinator. Pupils who had such opportunities reported that this was supportive and gave them confidence. A Year 6 pupil said of her 'reflections book': 'It helps me to have a confidential conversation with my teacher about things that are worrying me.'
38. A programme of education about values also helped pupils to talk freely and openly about their feelings. Each pupil was given a book in which they could write or draw a picture about the things that had made them happy or sad. Teachers monitored the books regularly to ensure that a pupil's personal difficulties were identified early; they were powerful additions in a school where the ethos was already strongly supportive of pupils' emotional well-being.
39. Clubs and after-school activities also enabled schools to support vulnerable pupils in a way which reduced the stigma of referrals.
40. In one primary school, 50 pupils regularly attended the 'happy/sad' club, where they talked about positive or negative experiences that concerned them. Clear ground rules had been established, which were understood by pupils, such as respecting what had been discussed and not gossiping. Pupils could put a photograph in a scrapbook of people that were special to them. The teacher usually led a short, directed session based on an appropriate text and provided an opportunity for meditation and reflection. The high number attending reduced the possibility of negative labelling and pupils had good opportunities to share their thoughts and feelings openly with their peers.
41. Pupils often commented that they particularly valued opportunities to talk and be listened to. The extent to which pupils with mental health difficulties have problems in making and sustaining friendships may explain, to some extent, the success of peer support schemes.
42. Nearly half the primary schools visited had effective initiatives which were based on pupils helping each other to resolve difficulties. One school focused on socially isolated pupils by appointing 'playground angels'. The 'angels' had weekly meetings with a teacher and were also represented on the school council. Pupils involved in these activities felt that they helped them to show responsibility towards younger children and to develop into mature and sensible people.

43. Others schools focused on the difficult point of transition between primary and secondary school. Pupils who struggled to make friends were considered by a few primary schools to be particularly at risk of experiencing problems. These schools developed a range of peer support programmes, as in the following example:

Case study

A group of Year 4 pupils were considered to be at risk of difficulties on transition and the school decided to make provision in collaboration with the local secondary school. Year 8 pupils were invited to apply for posts of pupil mentors. They were interviewed and successful applicants were trained. Over two years, the primary pupils visited the secondary school at least once each half term for lessons, lunchtimes and social activities. On each occasion they were met by their individual mentor and had time to discuss issues with them. Primary pupils really enjoyed the programme. They were very clear how the transitional programme had helped them to prepare for secondary education.

44. Two thirds of the secondary schools visited had good peer counselling, support and mediation systems. Peer mentors who had themselves experienced difficulties in the past commented on how much they valued helping younger pupils who were also experiencing problems. The most successful schemes provided thorough training for the pupils offering the support, as well as careful monitoring from the teachers responsible for it.

Provision through professional referral

45. Referral systems differed widely. In one area, the consultant psychiatrists responded to requests for information about pupils; the service accepted referrals from any involved professional. More commonly, however, panels of professionals considered referrals. The latter arrangement had some advantages in that there was discussion and agreement on the type of intervention which was most likely to succeed. However, this arrangement also tended to create delays in responding to pupils' needs.
46. Not all professionals were clear about how referrals should be made, and who ought to make them, for particular types of provision. This lack of clarity meant that pupils who might have benefited from services were not given access to them since the school was unaware that it could make such a referral.
47. Schools and pupil referral units (PRUs) did not always receive an equitable service from other agencies, especially where education, social services and health services had not agreed how resources should be allocated and work prioritised. It was common to find that a CAMHS worker was based in a school in one part of a local authority, while, in the same authority,

another school had to make referrals to a panel. The schools were unaware of why these differences existed.

48. The most common types of provision were:
- counselling
 - family work
 - mentoring and support workers who visited the pupils regularly and provided advocacy and support through discussion and activities
 - a modified curriculum and timetable
 - nurture groups and sanctuary space.
49. This provision was largely effective when it was matched well to the assessment of the pupils' needs. However not all schools were able to attract the additional resources required to provide these types of opportunities. Larger schools had more funding to be able to establish support centres specifically for pupils with mental health problems.
50. Local and national voluntary organisations played an important role in working with schools and local authorities to provide services for children and young people with mental health difficulties, and they were often represented on local CAMHS strategy groups. In some local authorities, partnerships with voluntary organisations provided helpful services for schools and parents, such as counselling and family therapy. Voluntary groups were often better at monitoring and evaluating the impact of their work since they depended on such evidence to attract further funding.

Case study

In one local authority a charity had been working in some schools for five years. For an annual fee, the school received a large amount of support from the charity which provided an art therapist and a dance instructor who worked with pupils identified by the school and provided counsellors, supervised by team leaders, from the charity.

Notes

This survey is based on the findings of a survey of 72 settings in eight local authorities. The settings and almost all the authorities were selected randomly to represent a mixture of shire and unitary authorities. One authority was chosen because of known good work in the area of mental health.

Her Majesty's Inspectors (HMI) visited early years settings, primary and secondary schools, pupil referral units, hospital schools and settings, maintained and independent schools for pupils with EBSD and learning difficulties, and specialist provision for pupils who had been bullied. HMI observed lessons and other activities, scrutinised policies and records and held discussions with 269 pupils and 115 parents. Discussions were also held with a range of local authority staff, headteachers and senior managers, teachers, teaching assistants, learning mentors, and representatives of voluntary organisations. They also met CAMHS regional development workers.

Further information

Publications

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www.rcpsych.ac.uk

Royal College of Psychiatrists

www.socialexclusionunit.gov.uk

Mental health and social exclusion

www.standards.dfes.gov.uk/primary

DfES guidance on developing children's social, emotional and behavioural skills

www.teachernet.gov.uk/management/atoz/n/nhss/

National Healthy Schools Standard