Childhood Bereavement Network response to Children and Young People's Mental Health Green Paper: Consultation Questions

Transforming children and young people's mental health provision: *A Green Paper*

This document is intended for ease of reference and should not be used as a response form.

To respond to the consultation, you can complete the online consultation questions at https://engage.dh.gov.uk/youngmentalhealth/. The consultation will be open for 13 weeks and will close at noon on 2 March 2018.

Overview

Improving support for children and young people's mental health is a top priority for this Government. This green paper on children and young people's mental health aims to ensure that those who need it are able to access the right help for their mental health, in the right place and at the right time. It focuses on earlier intervention and prevention, particularly in or linked to schools and colleges.

We welcome all responses to the consultation including from those who have experience of mental ill-health or know someone close to them who has such experience. The consultation focuses on how the proposals in the green paper will be implemented.

This consultation has 21 questions. However, you do not have to answer all of them. Only answer those questions you want to or those which are relevant to you.

You can save your responses and return to complete the survey at any time. The survey will be open for 13 weeks, in alignment with Cabinet Office guidance, and will close at noon on 2 March 2018.

About you

Are you responding as an individual or on behalf of an organisation?

Individual	
Organisation	x

What is the name of your organisation? Childhood Bereavement Network (National Children's Bureau)

What sector is your organisation?

Education - state-funded	

Education - independent	
Mental health services - NHS	
Mental health services - private	
Health services	
Social services	
Academia	
Local authority	
Charity or non-government organisation	x
Prefer not to say	
Other, please specify: ____	

Charity or non-government organisation with representation from above categories in consultancy capacity

Why are you interested in telling us your views about children and young people's mental health?

Personal interest	
Work interest	x
Both	
Other, please specify: _____	

If your interest is personal, are you a:

Young person (up to 15 years old)	
Young person (16-25 years old)	
Parent or carer of a child or children	
Someone with experience of mental health issues, but have never used mental health services	
Someone who is currently using mental health services	
Someone who has used mental health services in the past	
Family or friend of someone with mental health issues	
Other	

If your interest is work-related, do you work in:

Education – state-funded	
Education - independent	
Mental health services - NHS	
Mental health services - private	
Health services	
Social services	
Academia	
A local authority	
Charity or non-government organisation	
Other, please specify: _____	x

Consultation Questions

Question 1:
The core proposals in the green paper are:

- All schools and colleges will be incentivised and supported to identify and train a Designated Senior Lead for Mental Health who will oversee the approach to mental health and wellbeing
- Mental Health Support Teams will be set up to locally address the needs of children and young people with mild to moderate mental health issues, they will work with schools and colleges link with more specialist NHS services
- Piloting reduced waiting times for NHS services for those children and young people who need specialist help

Do you think these core proposals have the right balance of emphasis across a) schools and colleges and b) NHS specialist children and young people's mental health services?

Please give your answer below (max 250 words)

We agree that children and young people's mental health is the whole workforce's business and that reform is needed at universal, targeted and specialist levels.

Around 1 in 29 school-age children and young people (5-16) have been bereaved at some point in their childhood of a parent or sibling (roughly one per class). Bereavement is not a mental illness itself, but does increase children and young people's risk of emotional and mental health difficulties, both in childhood and into adulthood.

For children facing or following the death of a close family member, schools play a key role in their network of support. We would like the Designated Senior Lead for Mental Health to be a mandatory role, which also takes responsibility for responding to the needs of bereaved children in school, as part of a flexible pastoral support system. This should involve communication and choices with families about how information should be shared, including across class/school transitions; how support should be provided – including from the proposed MHSTs working in partnership with local voluntary sector services; staff training and support.

Some bereaved young people will need specialist CAMHS provision. However, we are aware of issues with thresholds to CAMHS services, and reports of CAMHS referring children on to local voluntary sector child bereavement services if there is a bereavement anywhere in the

child's history, even if their level of mental health difficulties mean that they need support at specialist CAMHS levels. This just serves to delay treatment and reduce trust among young people and families, and intensifies family system-related mental health problems.

Question 2:
To support every school and college to train a Designated Senior Lead for Mental Health, we will provide a training fund.

What do you think is the best way to distribute the training fund to schools and colleges?

Please rank the following in order of preference:

Set amount of funding made available to each school, for them to buy relevant training with	
Funded training places made available locally for schools to book onto	
Funding allocated to local authorities and multi-academy trusts to administer to schools	
Funding distributed through teaching school alliances	

If you wish, please provide any further information on why you have ranked in this order of preference (max 250 words)

Ensuring consistency and standards will be key, whatever distribution method is preferred. There is a need for flexibility, but not at the expense of high quality training which is carefully evaluated, including its impact on children and young people's outcomes.

Attachment, separation and loss are key issues in relation to children and young people's mental health and these underpinnings should be included in any training, even when focused on specific issues.

Question 3:
Do you have any other ideas for how the training fund could be distributed to schools and colleges? (max 250 words)

Mental Health Support Teams

Question 4:
Trailblazer phase: A trailblazer phase is when we try out different approaches

Do you know of any examples of areas we can learn from, where they already work in a similar way to the proposal for Mental Health Support Teams?

A school in the South West will soon be directly employing CYP IAPT Wellbeing Practitioners, who would usually be employed in health but working in schools. The school is aiming to use a wide range of interventions including one to one work, group interventions using a psychoeducational approach across the school community and linking with other agencies. Although these training posts are for one year,

the school is determined that following evaluation where significant impact is demonstrated that these posts will be sustainable and essential.

There are some interesting examples from Northern Ireland including communities in schools, one stop shops and extended schools provision. The Belfast Full Service Community Network (FCSN) involved a cluster of 20 nursery, primary and post-primary schools. Family support hubs and therapeutic hubs for adults may also offer useful insights.

Colleagues in Scotland have been taking a family systems approach to dealing with health crises, providing early intervention for parents with cancer/palliative care needs.

Details for all these initiatives are available on request.

Please give your answer below (max 250 words)

Question 5:
Different organisations could take the lead and receive funding to set up the Mental Health Support Teams. We would like to test different approaches.

Which organisations do you think we should test as leads on this? Please rank the following organisations in order of preference:

Clinical Commissioning Groups (CCGs)	
Groups of schools	
Local authorities	
Charity or non-government organisation	
Other: Potentially a mix of representation in the form of a commissioning group	

Question 6:
Mental Health Support Teams will work and link with a range of other professionals and we would like to test different approaches.

From the list below, please identify the three most important 'links' to test in the way they would work with Mental Health Support Teams:

Educational psychologists	
Local authority troubled families teams	
Local authority children and young people's services	x
Local authority special educational and disability (SEND) teams	
School nurses	
School-based counsellors	
Charity or non-government organisation	X
Youth offending teams	
Other: _____	X

Question 7:

Mental Health Support Teams and Designated Senior Leads for Mental Health in schools and colleges will work closely together, and we will test this working through the trailblazer phase.

Out of the following options how do you think we should measure the success of the trailblazer phase? Please pick your top three:

Impact on children and young people's mental health	x
Impact on quality of referrals to NHS Children and Young People Mental Health Services	
Impact on number of referrals to NHS Children and Young People Mental Health Services	
Quality of mental health support delivered in schools and colleges	X
Amount of mental health support delivered in schools and colleges	
Effectiveness of interventions delivered by Mental Health Support Teams	X
Children and young people's educational outcomes	
Mental health knowledge and understanding among staff in school and colleges	
Young people's knowledge and understanding of mental health issues, support and self-care	
Numbers of children and young people getting the support they need	
Other: _____	

Question 8:

Trailblazer phase: A trailblazer phase is when we try out different approaches

When we select areas to be trailblazers for the Mental Health Support Teams, we want to make sure we cover a range of different local factors. What factors should we take into account when choosing trailblazer areas?

Please rank the following in order of importance:

Deprived areas	2
Levels of health inequality	1
Urban areas	
Rural areas	
Areas where children and young people in the same school/college come under different Clinical Commissioning Groups (CCGs)	
Other: _____	

Question 9:
How can we include the views of children and young people in the development of Mental Health Support Teams?

Please provide your answer below (max 250 words)

Within schools, school councils or forums will be able to provide input and insight into the development and operation of Mental Health Support Teams.
At a local authority level, local youth councils or young people's Healthwatch may be able to input. A range of resources are available to support young people's engagement in service development and improvement.

Piloting a waiting time standard

Question 10:
Waiting time standards are currently in place for early intervention for psychosis and for eating disorder services.

Outside of this, are you aware of any examples of local areas that are reducing the amount of time to receive specialist NHS help for children and young people's mental health services? Can we learn from these to inform the waiting times pilots?

Please give your example(s) below (max 250 words)

Schools and colleges

Question 11:
Schools publish policies on behaviour, safeguarding and special educational needs and disability.

To what extent do you think this gives parents enough information on the mental health support that schools offer to children and young people?

All of the information they need	
Most of the information they need	
Some of the information they need	x
None of the information they need	
Don't know	

Please tell us more about why you think this (max 250 words)

We believe that schools could be a useful source of information not just about the support they offer to young people, but also about the nature of mental health difficulties (and broader life challenges such as bereavement) and what young people and parent can do themselves to keep themselves healthy. This psycho-education forms part of a whole school approach, involving the PSHE curriculum and the pastoral support system.

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Question 12:
How can schools and colleges measure the impact of what they do to support children and young people's mental wellbeing?

Please give your answer below (max 250 words)

We would recommend a coordinated approach such as that offered by the Child Outcomes Research Consortium (CORC) which offers access to a range of standardised tools and reporting mechanisms, including benchmarking against national data. The tools should include

- Data on demographic information and presenting issues and
- Service use including signposting and onwards referral
- Pre- and post-intervention measures
- Confidential feedback forms
- Focus groups to explore the mechanisms of how an intervention works.

Vulnerable groups

Question 13:
In the development of the Mental Health Support Teams, we will be considering how teams could work with children and young people who experience different vulnerabilities.

How could the Support Teams provide better support to vulnerable groups of children and young people?

Please give your answer below (max 250 words)

We consider children facing or following the death of a parent/carer or sibling or another important person to be a vulnerable group. Many will manage with the support of their family,

friends, schools and communities, but parenting while bereaved or coping with terminal illness is a significant challenge to families and many will benefit from additional support.

The proposed Mental Health Support Teams will form an important part of the network around bereaved children and young people. This should extend to children and young people who are outside mainstream education.

A range of open access child bereavement services exist in the community, supporting children whatever the cause of death, providing a range of services including family assessment, 1:1 and group support (http://www.childhoodbereavementnetwork.org.uk/help-around-a-death/find-help-near-you.aspx). Many can offer telephone advice to schools about when to seek extra help for a child as well as training and other support.

We estimate that between 70 and 80% of local authority areas have such provision, although this may be some distance from families' homes, and there may be a waiting list. Hospices and disease-specific charities may support particular groups of young people. Funding is precarious, and many services would be overwhelmed if all the families in their catchment area needed to access them.

Where services exist, it will be critical that the MHSTs work in partnership with them to provide seamless support to young people. Where there is no local service, MHSTs may play a more active role but we would urge the use of systemic approaches and peer support alongside individual support where possible. This means that MHST staff need the skills and expertise with engage with the key adults around the child, as well as the necessary therapeutic skills (eg play therapy, counselling) and knowledge and understanding of the application of attachment and trauma.

If children and young people are provided with bereavement support in school, our members recommend careful consideration of the best way of providing this input, with space for them to wind down afterwards, eg just before break or lunch or at the end of a school day, when a key adult can collect them after their session, or making sure they have space to collect themselves to continue their day.

Support for children looked after or previously looked after

Question 14:
As we are rolling out the proposals, how can we test whether looked after children and previously looked after children can easily access the right support?

Please give your answer below (max 250 words)

Support for children in need

Question 15:
As we are rolling the proposals out, how can we test whether children in need who are not in the care system can access support?

Please give your answer below (max 250 words)

In December 2017, The Social Mobility Action Plan 'Unlocking Talent, Fulfilling Potential' announced a review of children in need. We will be arguing for bereaved children to be included as a vulnerable group in the review. We would expect the testing of the rollout to take account of any changes in the groups considered to be children in need following the review.

We would also expect the rollout to explore the experiences of groups of children who are not formally included in the category of 'children in need' but nevertheless have experiences which mean they may need additional support for a period of time.

This could be tested by a series of thematic reviews, or by collecting demographic data on the experiences of children accessing support (based on the 'selected complexity factors' section of the 'Current View' tool used in Children and Young People's IAPT services), including stressful life events. We would argue strongly that the list of experiences should include 'death of a parent/carer' 'death of a sibling'. This could be compared to population norms/experiences based on data from the forthcoming National Study of Health and Wellbeing.

Support for children and young people with special educational needs or disability

Question 16:
As we are rolling the proposals out, how can we test whether children and young people with special educational needs or disability are able to access support?

Please give your answer below (max 250 words)
Pupils in special schools are more likely than others to experience the death of a peer, and mainstream schools can learn from the expertise developed by special schools in supporting their communities.

Providing evidence for an Impact Assessment

A consultation stage Impact Assessment was published alongside the green paper. The following questions seek to gather further evidence to inform future versions of the Impact Assessment. We welcome references to any evidence, published or in development, or expert opinion on the topics set out above to help refine our final Impact Assessment.

If you have not read the Impact Assessment or do not wish to respond to these questions then please skip to the next section.

Question 17:
Please provide any evidence you have on the proportion of children with diagnosable mental health disorders, who would benefit from support from the Mental Health Support Teams

Please give your answer below

Combined answer to q17 and 18

The death of a parent or sibling affects every aspect of children's lives. Often the impact is not just the death itself, but all the further changes that it brings – new working and childcare arrangements for the surviving parent, often moving house and school.

Grief affects emotional well being. Teenagers who experienced bereavement at any age have lower emotional well-being aged 13 than those who had not been bereaved of a family member, even taking into account their emotional well-being at age 10. 'Family bereavement had continuous, cumulative effects on children's emotional and social well-being, long after the event happened'.

Two years after their parent died, children and young people have significantly lower self-esteem than their peers, and feel less able to effect change.

Not all bereaved children show their feelings, sometimes to protect others in the family. They are less likely to share their worries with a friend or family member, and have lower life satisfaction than their non-bereaved peers.

Grief is not an illness, but it does increase the risk of mental health difficulties, both in childhood and later life. Around 1/3 of bereaved children reach clinical levels of emotional/behavioral difficulties in the two years following a parent's death.

Compared to their non-bereaved peers, children whose mother or father has died are around 1.5 times as likely as non-bereaved children to have a mental disorder, 3 times more likely to develop new-onset depression, if bereaved suddenly, more likely to report depressive symptoms at the age of 30 (women), 1.7 times more likely to attempt suicide in young adulthood and more likely to be hospitalised for a psychiatric disorder.

Pre diagnosable: Children and young people who have mild or low-level needs which do not constitute a diagnosable mental health condition but are at risk of developing one and would benefit from a form of support

Question 18:
Please provide any evidence you have on the proportion of children with pre-diagnosable mild to low-level mental health problems who would benefit from support from the Mental Health Support Teams

Please give your answer below

[See above]

Question 19:
Please provide any evidence you have of the impact of interventions for children with mild to moderate mental health needs, as could be delivered by the Mental Health Support Teams. We are interested both in evidence of impact on mental health and also on wider outcomes such as education, employment, physical health etc.

Please give your answer below

Following participation in group or 1:1 inverventions, bereaved children and young people express relief, feeling unburdened and less isolated. They understand more and are less anxious. Parents felt consoled, supported, helped to cope and given space to think about what had happened and the future, increasing their confidence and capacity to support and reassure their child. They felt the family was more able to communicate about what had happened and how they were feeling (Rolls and Payne 2007).

The Family Bereavement Program, a concurrent group intervention for parentally bereaved children and their surviving caregiver, has shown significant program effects at six-year follow up on increasing self-esteem; reducing problem grief and externalising problems; reducing social detachment and insecurity (boys and older young people); improving educational expectations and average grades (younger children) (Sandler et al 2010).

Based on these and other findings, Haine et al (2008) outline the factors that affect children's bereavement outcomes and can be influenced by interventions: Increasing the child's self-esteem and healthy control beliefs; improving coping skills; supporting adaptive expression of emotions; facilitating a positive parent-child relationship and having fun together; reducing parental distress and children's exposure to further stressful events; helping children prepare for future changes.

Question 20:
Please provide any evidence you have on the impact of Children and Young People Mental Health Services therapeutic treatments

Please give your answer below

Question 21:
Is there any other evidence that we should consider for future versions of the Impact Assessment?

Please give your answer below