

PUBLIC HEALTH INTERVENTIONS – MENTAL WELLBEING OF CHILDREN IN PRIMARY EDUCATION

Draft Scope Consultation – Stakeholder Response Table

27th October –December 2006

All comments and responses relate to both the whole school and targeted scopes for mental wellbeing of children in primary education, unless otherwise stated

Stakeholder Organisation	Evidence submitted	Whole School or Targeted	Section number Indicate section number or ' general ' if your comment relates to the whole document	Comments Please insert each new comment in a new row.	Response Please respond to each comment
Amicus-CPHVA		Whole School	4.5	Please consider the role of school nurses who are working with the National Healthy Schools Co-ordinators	Thank you for your comment. We have amended the scope appropriately.

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				<p>PSHE sessions are very effective at considering esoteric questions such as 'what makes me happy'. Many children have never learnt the habit of 'choosing to be happy' and need guidance to achieve this.</p> <p>Parents often need to do 'happiness' alongside their children,. As a project, as they too have often not realised the choices they make Curriculum time is very scarce, and mental well-being is not prioritised</p> <p>There has been some work done around peer massage, much of which is not adequately written up. However, having observed it in practice in school in Mitcham, south London, it is very effective at reducing stress and improving behaviour</p> <p>Teachers are enthusiastic about peer massage, but professionals need to be involved to audit, continue training etc</p> <p>Whole school approaches may bring up a need for individual intervention</p> <p>School nurses are the key to this, so use them well; they are already heavily involved with delivering emotional health work, under the banner of 'puberty'</p>	<p>Thank you for your comments.</p> <p>This will assist us during the process of developing the guidance.</p>
		Targeted	4.5	It is essential that you take into account the role of the school nurse, in both the context of 'healthy schools' partnerships, and the context of health promotion. School nurses are ideally placed to	Thank you for your comment. We have amended the scope appropriately.

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				address whole school health issues,, as they straddle the boundary between school and health.	
				It is better if school nurses deliver interventions in partnership with the healthy schools co-ordinator	The guidance will be based upon the best available evidence and findings from the fieldwork.
				Parents may need specialist services targeted at them. Particularly when you are talking about 'choosing happiness' , parents may be the problem rather than the solution.	The guidance will be based upon the best available evidence.
				<p>Time, or the lack of it is often the barrier to an effective intervention. Emotional health is not on the national curriculum.</p> <p>Games, role play and scenarios work best for primary school children</p> <p>Team games and sports can often be used very effectively to promote social cohesion.</p> <p>The targeted school intervention will raise issues that will be brought to individual level intervention</p> <p>School nurses often hold 'drop-in' self referral sessions at lunchtime for school aged children, especially year 6. They also often see parents about emotional health issues on a one to one basis.</p>	Thank you for your comments. This will assist us during the development of the guidance.
			general	Please see 'Discovering the Future of school nursing' by Diane deBell and AS Tompkins, pub March2006 by McMillan Scott for Amicus-CPHVA.org	Thank you for this reference.
				Please see dh (England) 'looking for a school nurse' 2006	Thank you for this reference.

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ASCL			3e	Should there be comment on the apparent increase in child mental health problems	Thank you for your comment. We will amend the scope accordingly.
			4.2.1 a)	2 nd sentence should include – specialist in-house provision such as Nurture groups	Thank you for your comment.
			4.5	Include:- What is the current provision in schools?	Thank you for your comment. The ease by which schools may access specialist help is likely to be covered by what are the barriers to effective implementation.
				How easy is it for schools to access specialist help?	Thank you for your comment. Please see our response to your previous comment.
Association of Child Psychotherapists		Whole School	4.2.1	<p>It is extremely important that 'whole school' approaches are being considered within this document. In particular, it is critical that interventions will consider and focus on the 'management, development and support for teachers'.</p> <p>However, it is common for the 'need' for staff support to be noted without this being followed up with more detailed descriptions of what form this support might take, how it might work and what outcomes one might expect. This is an area needing further elaboration if there is to be any hope that it will be taken up.</p> <p>One example of this might be 'work discussion groups' for school staff. Work discussion groups provide teachers and other staff with an opportunity to think in depth about any concerns and difficulties they are experiencing in their work with pupils or class groups. These issues are discussed together and, usually, facilitated by an external consultant –</p>	Thank you for your comment. It would be useful if you could submit or direct NICE towards the sources of this information. The information could then be incorporated within the effectiveness review.


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				<p>often a child & adolescent psychotherapist.</p> <p>The aims of the groups are to help staff:</p> <ul style="list-style-type: none"> • Develop understanding about the underlying meaning of pupil behaviour • Develop capacity to identify children who are considered to be at risk and in need of more specialised assessment. • Develop understanding about the psychological factors that impact on teaching and learning • Manage the complexities of the pupil-teacher relationship; and • Feel more confident about and supported in work with worrying pupils who are at risk. <p>Projects of this nature have been developed by Brent Centre for Young People and the Tavistock Clinic. Within Brent school based projects, evaluation with over 120 staff has shown that:</p> <ul style="list-style-type: none"> • 97% were helped to persevere with challenging pupils when they felt like giving up; • 83% reported feeling less stressed after talking about challenging pupils/class groups. • Projects contribute to reduction in school exclusions. • In one school alone, over a three year period, the school reported that the 22 staff attending the fortnightly groups had a significantly lower rate of absence than the whole staff group. 	

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				<p>Balanced against the very modest cost of such an intervention, additional benefits would include the contribution to the reduction of pupil exclusions (and their consequences) and staff absence. Such an intervention, over time, would also be likely to increase the capacity for effective early identification of mental health problems in pupils by staff together with more effective capacity to handle such situations so as to enable the pupil and their family to access the most appropriate treatment. All of the above benefits also offer the possibility of considerable savings at a financial level.</p> <p>NB: Work discussion groups within schools in Brent are soon to be used as a 'model of good practice' within a DoH/DfES document to be published on 21 November.</p>	<p>Thank you for your comment. Please could you submit or direct NICE towards the sources of this information.</p>
				<p>Potential barriers to and facilitators of effective implementation really relate to the extent that these interventions are supported by the headteacher and senior management of the school. The external consultant should, therefore, ensure to have regular review meetings with the headteacher to discuss the on-going development of the work discussion groups.</p> <p>A secondary barrier to the implementation of such an intervention is, of course, funding. While, for example, the NSF for children, young people and maternity services makes explicit the need for support to Tier 1 and Two staff by CAMHS professionals, some Children's commissioners for local Primary Care Trusts have told providers that they cannot fund consultation to staff as 'the NSF is not backed with money to support its</p>	<p>Thank you for your comment.</p>

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				recommendations'.	
				In considering staff support, I would want to encourage the Institute to take seriously the fact that most teacher trainings almost entirely <i>exclude</i> child & adolescent development from the curriculum. However, almost always, it is the children, not the subject, that cause teachers most cause for concern, difficulty and stress. Teacher training organisations should therefore be encouraged to include child personality development components on their core curriculum.	Thank you for your comment.
				In conjunction with support offered to staff, it would be very important to ensure that every school has access to regular visits by a Core CAMHS professional (eg child psychotherapist, clinical psychologist, etc) who would be able to assess and work with children directly. Many children are simply unable (and sometimes unwilling) to access out-patient clinical settings. A service which is offered to them on-site in schools is therefore essential if such children are to be reached by mental health services. For most effective interventions, such a service should allow for the possibility of work with pupils, teachers, parents and families. Interventions would also facilitate the successful transfer of children and their families to out-patient settings (who would otherwise not have been able to make that transition).	We would be grateful if you could provide NICE with the details of any documents that highlight these issues.
Association of the Directors of Social Services		Targeted	4.1.1	Specific groups of vulnerable children should be identified. This should particularly include looked after children, asylum seekers, and disabled children.	Thank you for your comment. We do acknowledge these individuals and they are included within the vulnerable groups.

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			4.2.1	The necessity for a whole school approach should also be addressed, with a particular focus on the ethos and environment of the school as a critical factor in promoting positive mental well-being.	Thank you for your comment. Guidance will be produced that will address the whole school approach.
			4.5	<ul style="list-style-type: none"> • Greater emphasis needs to be given to assessment of needs as this must precede and determine the type of intervention offered. The option of specialist CAMHS should be raised when deciding who would be the most appropriate person to provide intervention. These are more critical questions to address than the issue of whether intervention should come from a teacher or specialist. The guidance should focus on matching provision with assessed need. • The role of carers should be considered (as well as parents) • Asking what type of content is effective is too broad a question. There needs to be clarity as to whether this refers to an individual child response, or a whole class or whole school approach. Content must to be tailored to need – anything which encourages an overly prescriptive approach will not be helpful. 	Thank you for comments. This will assist us during the development of the guidance.
The British Dietetic Association		Whole school	4.2.1	<p>We believe healthy eating and nutrition should be included in the scope of this document because:</p> <ul style="list-style-type: none"> ▪ there is evidence that nutrition has a direct impact on neurodevelopmental disorders e.g. attention-deficit hyperactivity disorder; dyslexia; dyspraxia ▪ there is evidence that nutrition has direct impact on cognitive development and function in school-age children ▪ there is evidence that nutrition has a direct 	Thank you for your comment. Any evidence that directly investigates the effect of diet on mental wellbeing will be considered while generating the guidance.

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				<p>impact on mood</p> <ul style="list-style-type: none"> healthy eating is a necessary component of weight management, and there is evidence that obesity is a target for bullying, which can damage mental health and wellbeing <p>We believe nutrition and healthy eating should be addressed as part of a whole school approach, complementing the current Healthy Schools Programmes and the work of the School Food Trust, to ensure that mental health and wellbeing are integrated into these programmes of work.</p> <p>In particular:</p> <ul style="list-style-type: none"> the mental health aspects of healthy eating should be included in the curriculum, especially in PHSE, food awareness and cooking skills food provided by schools (meals and all other food provision/sales) should support good health, and information about it for parents and children should include information about healthy eating and mental health schools should be alert to the risk of bullying that overweight children experience, and manage that risk, as well as supporting the prevention and management of obesity by promoting healthy eating 	
British Medical Association	Evidence 1	Whole school	General	In June 2006, the BMA published <i>Child and adolescent mental health. A guide for healthcare professionals</i> , a copy of which is enclosed. This identified the importance of schools in improving the mental wellbeing of children and young people. As such, the BMA welcomes the forthcoming guidance from NICE on promoting the mental wellbeing of	We welcome your support and thank you for the provision of the BMA document.

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	 L:\Interventions\ 12-Mental wellbeing c			children in primary schools. Our comments are the same for both the whole school and targeted approach.	
				<p>Mental health promotion is an important means of preventing mental health problems occurring, and early interventions lead to more successful outcomes.</p> <p>Schools have an important role to play in mental health promotion. The <i>National Healthy Schools Programme</i> provides support for all health promotion, including mental health. As part of this, the National Healthy Schools Standard provides a model for partnership working between health and education in promoting a healthy lifestyle to children. The promotion of emotional wellbeing is essential for national healthy school status. Government has stated that it expects that half of all schools will be healthy schools by 2006, and all schools should be working towards this status by 2009.</p> <p>The reintroduction of pre-school and early-school health inspection would be beneficial in identifying mental (and physical) healthcare needs.</p> <p>Care must be taken not to stigmatise children who are given support.</p>	Thank you for your comments. This will assist us during the development of the guidance.
			4.1.1	It is important that mental health promotion reaches all primary school children and especially those from disadvantaged backgrounds, such as looked after children and those from black and minority ethnic groups. As the guidance points out, these children are at greater risk of poor mental health, and must be included in all initiatives.	Thank you for your comment.

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			4.1.2	The BMA has concerns that the guidance does not include children who are not in school. Many children are excluded from school because of behavioural problems, which in many instances are caused by mental health problems. Excluding these children from the guidance will mean that some of the children at highest risk of poor mental health have reduced access to care.	Thank you. We recognise that there are issues that need to be addressed with regard to children not in school. There is the facility on the NICE website to suggest topics for consideration for our future guidance. Visit www.nice.org.uk/page.aspx?o=t.s.home We would expect that at some time in the future NICE will be asked to look at these issues.
				It is correct that the guidance be limited to children aged 4-11. The BMA would however recommend that similar guidance is produced for children aged 12-18.	Thank you. We recognise that there are issues that need to be addressed in other age groups such as children aged 12–18. Please see our response above about suggesting topics.
			4.2.1 (a)	All services that deal with children have a role to play in improving the mental wellbeing of children. In addition to those areas mentioned, whole school approaches should include links with health and social services. It is important that schools are able to work effectively with a broad range of providers.	Thank you. Our scope has been amended to acknowledge the links to other services such as health and social services.
			4.5	The school environment, as well as curriculum content, provides a good opportunity to disseminate information, foster good habits and raise children's awareness of mental health. Initiatives to tackle bullying, provide pastoral support and promote an equal, fair and non-discriminatory environment can all play a part.	Thank you, for your comment
				It is unclear whether the guidance will include interventions aimed at identifying children at a higher risk of problems.	Thank you for your comment. The scope will be clarified accordingly.

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				The guidance should include means of delivery of mental health promotion, and consider a range of different media.	Thank you for your comment. 'Section 4.5 key questions' addresses this issue and highlights a focus on delivery via content, frequency, length and duration of effective delivery in a primary school setting.
				Consideration should be given to interventions beyond mental health promotion, including access to and provision of appropriate care.	Thank you for your comment. We recognise that interventions beyond mental health promotion in the primary school setting have a significant impact on the mental wellbeing of children. Please see our response above about suggesting topics.
				If teachers are to deliver interventions, it is vital that they receive all necessary training for this, and that the funding is made available for training. School nurses have a key role in promoting the health of school children. The recent increase in school nurses should be continued.	Thank you for your comments. This will assist us during the development of the guidance.
British Paediatric Mental Health Group (Royal College of Paediatrics and Child Health)		Targeted	Section 3 Section 4.4	The term 'mental wellbeing' is useful, particularly for a non-specialist audience. It would be helpful to have the definition stated in this section.	Thank you for your comment. We will amend the scope accordingly.
			Section 3, line	Outcomes is in section 4.4.	Thank you for your comment. We will amend the scope accordingly.
			Section 3: a)	These figures are taken from a study of adolescents which the scope has not made clear at this point is not the target population. Hence this is potentially confusing. The scope should state that these are figures refer to adolescents and that there are no	Thank you for your comment. We will amend the scope accordingly.

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				comparable figures for children of primary school age.	
			Section 3: b)	The age range is stated here but it should be made clear that these disorders are not equally distributed throughout the age range i.e. that the figures would be expected to be lower for 5-11 year olds.	Thank you for your comment. We will amend the scope accordingly.
			Section 3: c)	'... a mental health disorder' would be a more appropriate phrase. No age range is given.	Thank you for your comment. We will amend the scope accordingly.
			Section 3: d)	Only a small percentage of diagnoses of conduct disorder is made in children of 11 or below. There should be an age range given for this statement.	Thank you for your comment. We will amend the scope accordingly.
			Section 3	If there is little specific evidence about the mental health status of this age group it should be stated.	Thank you for your comment. We will amend the scope accordingly.
			4.1.2	I am very concerned not to exclude further those not in school Definition of not in school needs to be clear at least and not to exclude those excluded so not on roll might be useful	Thank you. We recognise that there are wider issues that need to be addressed. There is the facility on the NICE website to suggest topics for consideration for our future guidance. Visit www.nice.org.uk/page.aspx?o=t.s.home We would expect that at some time in the future NICE will be asked to look at these issues.
			4.6	One target should surely be parents, and also parent organisations, voluntary organisations parent teacher groups etc	Thank you for your comment. Where the evidence allows this may be pursued.
			General	Include interventions for children with learning	Those children with learning

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				difficulties of all types	difficulties who are in school and between the ages of 4 and 11 are included in this guidance.
		Whole school	Section 4.2.1a)	<p>It is important to mention Personal, Health, Social and Citizenship Education (PSHCE) as part of the curriculum in this section.</p> <p>Whole school ethos, mission statements and aims and objectives of schools should consider mental wellbeing.</p> <p>The development of the Governing Body is also important. Training is available for Governors and should include mental wellbeing.</p>	Thank you for your comment. We will amend the scope accordingly.
			Section 4.5	<p>'What is the role of the Governing Body?' should be included. The GB is responsible for setting the strategic direction of a school and hence can raise the status of particular issues such as this.</p> <p>Health School Status: Another key question would be to ask how much of how a school attends to the development of mental wellbeing in its pupils (and staff) should be scrutinised during application for Healthy School Status. This would be another way to raise awareness and the status of mental wellbeing.</p> <p>Training and protected development time for the teacher co-ordinating PSHCE across the school would also be a key issue.</p>	Thank you for your comment. We will amend the scope accordingly.
			Section 4.2.1 a)	What about support for transition to primary school at age 4 but especially for children who have been excluded from other schools for behavioural/mental health problems, children with SEN, looked after	Thank you for your comments. As part of the review we will look at the transition to primary school at age 4.

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				<p>children and other vulnerable groups.</p> <p>Lessons taught as part of the curriculum and school ethos and environment are whole school approaches.</p> <p>Targeted approaches might include help for BME boys with their behaviour in the playground (a specific intervention used in the school at which I am governor)</p>	
			Section 4.5	The Special Educational Needs Co-ordinator (SENCO) should have training and protected time to support vulnerable children in the school.	Thank you for your comment. We will amend the scope accordingly.
The British Psychological Society		Targeted	4.2.1	<p>In considering interventions we wonder if it would be possible to expand the range of interventions to include and encourage those that health might provide e.g.:</p> <ul style="list-style-type: none"> • There is now substantial evidence to indicate that parent training courses especially the Webster Stratton program are highly effective interventions for children with behaviour problems and conduct disorders. Alongside education based interventions for pupils, encouraging CAMHS / PCTs to deliver evidence based parenting groups either in primary schools or in a way that maximises uptake by primary school based parents could be very effective • Teaching staff are extremely good at spotting difficulties children and young people are facing, and are often aware of the family stresses and struggles behind emotional and behavioural disturbance. If, as well as placing 	Thank you for your comment. The nature and detail of the interventions will be based upon the best available evidence. We would be grateful if you could provide us with details of the documents that contain this evidence.

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				responsibilities on schools, the guidance could encourage partnerships between local CAMHS and primary schools which would place some responsibility on the CAMHS to help with identification, and signposting of pupils and their families to CAMHS services, and maybe even offer initial appointments on school premises for especially vulnerable hard to reach families, this could improve uptake of services, and enhance through a holistic approach the resolution of difficulties.	
Cambridgeshire and Peterborough Mental Health Trust		Whole School	General	<p>Schools need a suitable physical space to think and work with children who have psychological issues/difficulties, often there is no sense of privacy/containment</p> <p>Schools need a psychological space for the teaching staff involved to use reflective practice</p> <p>The staff need supervision and time in their timetable for this</p> <p>Training staff in schools in psychological issues will only become useful when the above are in place, otherwise new knowledge and thinking are lost in the hurly burly of all the other demands</p> <p>Smaller class sizes would help especially where there are very wide ranges of abilities in one class, there is only so much space in one teachers head to consider so many pupils needs and situations</p>	Thank you for your comments. This will assist us during the development of the guidance.
CAMHS, North Essex Mental		Whole School	General	Please note: Comments represent the opinions of a cross section of multi-disciplinary clinicians.	

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Health Partnership NHS Trust			4.5 Cost effectiveness	<p>Implement evidence based whole school approach to manage emotional and mental well being within school environment e.g.</p> <p>C. Webster-Stratton's Incredible Years Programme – Dinosaur School targets teachers, parents pupils.</p> <p>Media promotion relating to mental health in schools. BEST's – these draw external resources into schools.</p>	Thank you for your comments. This will assist us during the development of the guidance.
			4.5 Type/content of intervention	<p>Emotional literacy as part of curriculum, effective problem solving skills.</p> <p>Universal parenting approach on starting school.</p> <p>Voluntary sector involvement – less stigmatising, greater flexibility.</p> <p>Each school should have allocated mental health support from either stat or non-stat provision. This would provide advice, offer treatment, contain staff anxiety, signpost to external mental health resources when necessary.</p>	Thank you for your comments. This will assist us during the development of the guidance.
			4.5 Frequency, Length and Duration	As short as possible with potential for further intervention if necessary.	Thank you for your comment.

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			4.5 Specialist/Teacher	<p>Teacher training to include emotional development and behaviour management,</p> <p>Consider role of school nurse, access to primary mental health workers, voluntary mental health organizations.</p> <p>Improved access to Educational Psychology.</p> <p>Presence of Behaviour Support to influence school culture.</p>	Thank you for your comments.
			4.5 Role of Parents	Home liaison officers, Open door policy, parental involvement in school environment.	Thank you for your comment.
			4.5 Barriers/Facilitators	<p>Head teacher as role model and influence of philosophy.</p> <p>Teachers focusing on control and discipline rather than culture of respect.</p> <p>Absence of knowledge of local resources</p> <p>Celebration of and space for children's differences rather than highlighting children's problems.</p> <p>Paying lip service to mental health – just a policy on the shelf.</p> <p>Extended schools enable whole community based culture.</p> <p>Budget led</p>	Thank you for your comments.

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			4.5 Adverse or unintended effects	Differing access to resources, different initiatives, no consistent approach to mental health provision in primary schools. Reduce academic pressure on children – focus on mental well being to achieve child potential.	Thank you for your comments.
		Targeted	General	PLEASE NOTE: These comments represent the views of a cross section of multi-disciplinary clinicians in our CAMHS.	
			4.5 Cost Effectiveness	In school Behaviour Support Service	Thank you for your comment. This will assist us during the development of the guidance.
			4.5 Type of content/intervention	Targeted parenting classes. Ready access to Educational Psychology for testing of young people with complex presentation. Behaviour Support Service who can signpost to specialist mental health i.e. Tier 3 Targeted interventions within school for specific problems e.g. bullying, bereavement, family breakdown. Webster Stratton Incredible Years Dinosaur School can be targeted at individual work.	Thank you for your comments.
			4.5 Teacher or Specialist	Educational Psychologists. Allocated mental health specialist (equates to Primary Mental Health worker/Tier 2 level of provision) for specific interventions with knowledge of Tier 3 services.	Thank you for your comments.
			4.5 Parents	Open door policy to understand issues beyond behaviour.	Thank you for your comment.
			4.5	Not being clear about range of mental health	Thank you for your comment.

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			Barriers/Facilitators	provision, no clear pathway for referring to specialist services.	
				Unequal provision across schools.	Thank you for your comment.
			4.5 Adverse/unintended effect	Referring on too soon or too late.	Thank you for your comment. This will assist us during the process of developing the guidance.
Care Services Improvement Partnership			2b	Suggest add Parliamentary Report on Children with a Disability	Thank you for this reference.
			2b	Suggest add Social and Emotional Aspects of Learning (SEAL)	Thank you for your comment. We will amend the scope accordingly.
			3f	Suggest add children with a disability and mental health issues, and link to Guidance just produced and perhaps the core offer of the extended services of schools and children's centres	These children are included in the scope.
			4.1.2	Suggest add "and those in FE Colleges" to the exclusions	Those in FE Colleges are automatically excluded as they are over 11 years of age.
			4.2.2	Suggest add "and the FE sector 14-18" to the exclusions	Please refer to our response to your previous comment..
			4.4	Suggest add another bullet point: feeling safe (free from abuse and bullying)	Thank you for your comment. However, we consider this is encompassed within the defined outcomes (social wellbeing).
Childhood Bereavement Network, National Children's Bureau			General	<p>The Childhood Bereavement Network (CBN) welcomes this draft scope. CBN is a network of over 300 organisations and individuals working with bereaved children and their families in the UK. We are hosted by the National Children's Bureau.</p> <p>Last week we launched <i>Grief Matters for Children</i>: a three year campaign for appropriate information and support for all bereaved children and their families,</p>	Thank you for your comments. This will assist us during the development of the guidance.

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				<p>wherever they live and however they have been bereaved. As part of the campaign, we want all schools to</p> <ul style="list-style-type: none"> • promote the well-being of bereaved children and young people through a whole school approach including proactive, flexible pastoral support and the curriculum • have a system for managing and communicating important information about children and young people's bereavements • ensure that staff have training to give them the confidence and skills to respond appropriately to the diverse needs of bereaved children and their families, including making referrals to child bereavement services • support these measures by incorporating them into relevant policies <p>For more information, please visit http://www.childhoodbereavementnetwork.org.uk/griefMatters.htm</p>	
			2 (b)	<p>The draft scope indicates that the guidance will support policy documents which include the <i>Children Act 2004</i>. It is important that the guidance looks at the impact of mental well-being on all five outcomes for children, not just 'be healthy' and 'enjoy and achieve'.</p> <p>For example, under 'make a positive contribution' the aim for children to 'deal successfully with life changes and challenges' will be of particular relevance to promoting children's resilience in</p>	<p>Thank you for your comment. This guidance will focus on mental wellbeing – for a description see section 4.4 – and aspects such as resilience will be included in the guidance.</p>

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				primary school.	
			2 (c)	<p>The important role of support staff in promoting children's well-being in schools should not be overlooked. As well as teachers and governors, the guidance should be aimed at all school staff who might be involved this work, such as learning mentors, office staff, learning support assistants.</p> <p>A study found that, when asked who in a school would be best targeted to receive information about the impact of bereavement, Special Needs Coordinators were almost as likely to suggest learning support assistants as teachers. Several recommended that <u>all</u> school staff needed this information.¹</p>	Thank you for your comment. We will amend the scope accordingly.
			4.1.1	<p>We would suggest that targeted support for bereaved children, and a whole school approach to dealing with loss and bereavement should be considered as part of the guidance. The death of a significant person can have a devastating impact on children's lives, affecting their physical and emotional health, schooling and relationships. Yet with appropriate information and support, children can learn to manage the impact of death on their lives.</p> <p><i>Prevalence</i> 4% 5-16 year olds (approximately 358,000) have been bereaved of a parent or sibling. 6% 5-16 year</p>	<p>Thank you for your comment. NICE recognises the need for targeted approaches and is developing specific guidance.</p> <p>Thank you for the references these will be included in the effectiveness review.</p>

¹ Tollast, S (2006) *Exploring special educational needs coordinators' views regarding bereavement support in schools Unpublished BSc dissertation*. University of Portsmouth School of Health Sciences and Social Work
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				olds (approximately 537,000) have been bereaved of a close friend ² . Data does not show what proportions of these children are bereaved while at primary school, but a study found that at any one time, up to 70% primary schools have a recently bereaved pupil on roll ³ .	

² Statistics compiled from Green, H et al (2004) *Mental health of children and adolescents in Great Britain* London: HMSO and *Mid-2005 Population Estimates* London: HMSO

³ Holland, J (1993) 'Child Bereavement in Humberside Primary Schools' *Educational Research* 35,3, 289-297

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<p>Date: 05/01/2007 Page: 24</p>				<p><i>Impact – mental wellbeing</i></p> <ul style="list-style-type: none"> Between 50 and 66% children and young people bereaved of a parent show distress and depressive symptoms, and these may persist over time.⁴ A study found that 2 years after the death, parentally bereaved children felt less able to effect change and had lower self-esteem than their peers.⁵ A study found that a range of mental health difficulties were more frequent among children bereaved of a parent, sibling or close friend than those not bereaved.⁶ Some studies suggest adults who were bereaved in childhood (possibly in conjunction with other factors) may be more vulnerable than the general population to psychiatric disorders, particularly depression and anxiety, which may be precipitated by further losses.⁷ <p><i>Impact – schooling</i> Families and schools report bereaved children and young people experiencing:</p> <ul style="list-style-type: none"> poor concentration lack of interest missing school further losses through having to move home and school <p>William Worden's study⁸ of 125 parentally bereaved children over the two years following a parent's death found that</p> <ul style="list-style-type: none"> 1/5 children experienced learning difficulties at school in the early months 1/5 experienced problems concentrating Children with fewer friends and those whose grief 	<p>Thank you for the references and your comments.</p> <p>This will assist us during the development of the guidance.</p>

Stakeholder Organisation	Evidence submitted	Whole School or Targeted	Section number Indicate section number or ' general ' if your comment relates to the whole document	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			4.1.1	While the guidance covers children aged 4-11, links should be made with any similar or future guidance covering younger and older children, and recommendations around transitions should be included. For bereaved children, transitions such as moving schools may cause them to 'revisit' their bereavement and this can affect their mental well-being.	Thank you for your comment.
	Targeted		4.2.1	<p><u>Links between targeted and whole school approaches</u></p> <p>We see the relevance of dividing the scope into whole school and targeted approaches, but feel that the resulting guidance will be strengthened if the two are very clearly linked.</p> <p>It will be appropriate to offer targeted support to individual pupils when they are bereaved. But the majority of young people will experience a bereavement at some point in their childhood, (78% 11-16 year olds in one study had been bereaved of a close relative or friend¹²) and so the general provision of education about loss and bereavement will be of wider relevance, helping to dispel myths and taboos.¹³ Evidence suggests that the majority of children think about death and dying and that <i>'children have a greater awareness of death than most adults would believe'</i>¹⁴ For schools not to tackle this topic can suggest to children that it is something not to be discussed, which could prevent them from seeking support if they or a friend were later bereaved.</p>	It is possible that following development, the two pieces of guidance will be brought together to form one, covering both whole school and targeted approaches.

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				<p>In addition, targeted interventions for individual pupils are more effective if located in a school which is generally supportive. For example</p> <ul style="list-style-type: none"> • Staff showing that they value targeted support can make children feel more comfortable about accessing it • Support for staff can help them to understand their role in supporting bereaved pupils and addressing bereavement in the curriculum, and reduce the anxiety around this difficult subject • Sharing strategies for targeted support (eg agreeing with a child and family how the rest of the class should be informed about a bereavement) can ensure consistency of care • Promoting peer support, educating about loss and tackling bullying can reduce the bullying and isolation which bereaved children may experience 	
			4.2.1	<p><u>Types of targeted approaches</u></p> <p>As explained, targeted support for bereaved children needs to be part of a whole school approach to dealing with loss and bereavement¹⁵. Targeted interventions can include</p> <ul style="list-style-type: none"> • 1:1 support • Peer support groups • Referrals to local childhood bereavement services • Books and resources in the library • A safe environment • Support for staff 	Thank you for your comments.

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				<ul style="list-style-type: none"> Communication with parents <p>Targeted interventions need to be discussed and agreed with the child and the family. Some children will want extra support: others will want to be treated just like everyone else, and their needs are likely to change over time.</p> <p>For suggestions about targeted support for bereaved pupils, see http://www.winstonswish.org.uk/page.asp?section=0001000100030002&pagetitle=Schools</p> <p>For published evaluations of peer support as a targeted intervention, see Ross, D and Hayes B (2004) 'Interventions with groups of bereaved pupils' <i>Educational and Child Psychology</i> Vol 21 (3)</p> <p>For evaluations of Seasons for Growth, an Australian programme of peer support around loss and bereavement, visit http://www.goodgrief.org.au/seasonsforgrowth/sfgevvaluations.htm</p>	
			4.5	<p>The question 'Is it better if a teacher or a specialist delivers the intervention' should be broadened to acknowledge the role of other staff in schools such as learning mentors.</p> <p>The question could also be rephrased to explore the effectiveness of relationships between school staff and specialists such as childhood bereavement services. Many of these services offer training and ongoing support to schools in their area, as well as a range of interventions for bereaved children and</p>	Thank you for your comment. We will amend the scope accordingly.

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				families. For details of services, see www.childhoodbereavementnetwork.org.uk	
			4.6	See 2(c)	Thank you for your comment
Christian Medical Fellowship		Whole School	4.2.1 School management and ethos	<p>These comments are made by Dr. Elizabeth Guinness CAMHS Consultant Child Psychiatrist</p> <p>I recommend the application of Systems Theory to understanding how the ethos of a school evolves. Developing a healthy ethos would be a cost effective way of promoting mental well being in school children. Systems Theory underpins family therapy which aims to readjust the family system so as to resolve psychological problems. Any group of people who live or work together will in due course form a set of dynamics (eg the hierarchy and who is in charge, what are the unwritten rules etc). A healthy system promotes the psychological well being of its members but a dysfunctional system causes its members to suffer.</p> <p>Research by Professor Rutter showed that the social health of a school as a suprasystem (a system larger than a family) is statistically significantly related to the mental well being of the children. This is independent of other variables such as the quality of teaching or of school equipment & buildings, or even of the social background of the children. (see Rutter. M. et al (1979) Fifteen Thousand Hours : London Open Books). This means that the way the school is run, the structures for communication and support up and down the hierarchy, creates an atmosphere of harmony and order which promotes learning and development in children. Children from chaotic homes benefit from the regular daily experience of a structured peaceful environment. Important factors include :-</p>	<p>Thank you for this reference and your comments.</p> <p>This will assist us during the development of the guidance.</p>

Stakeholder Organisation	Evidence submitted	Whole School or Targeted	Section number Indicate section number or ' general ' if your comment relates to the whole document	Comments Please insert each new comment in a new row.	Response Please respond to each comment
			Recommendations to NICE draft scope	<ul style="list-style-type: none"> • A competent Head firmly in charge, providing leadership. • Good access to and support from the Head for teachers • Appropriate delegation to and autonomy for teachers. • Confident classroom management and control - teacher in firm control of the children with due support if necessary. • Awareness of children's needs by teachers with ready communication and emotional support. • The 'unwritten rules' of the 'system' promote expectations of good behaviour, respect for authority and enthusiasm for learning so that peer pressure checks unruly children. • Structured and planned access for parents to teachers. <p>Use of Systems Theory (see below)</p>	
			Prevalence of mental disorder in children (general comment)	<p>Time trends in Adolescent mental health show a substantial rise in mental disorders in the past 25 years. (Collinshaw and Maughan et al 2004 report a robust study in Journal of Child Psychology and Psychiatry, 45,8.) Causes are multiple. Family breakdown is an important one but the increase was across all family types. This means there are factors within society. These are not clear yet but there are several pointers. They include social breakdown with loss of protective social customs, the powerful impact of the media, the dubious influence of youth culture, the expectations upon adolescents both academic and sexual, together with the lack of guidance and supervision. Of course a big</p>	Thank you for the reference. The guidance will acknowledge the complexity of the issue and will focus on how it may be addressed.

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				responsibility lies with the families. But what part can schools play in creating some foundations for life, some clarity and certainty? This needs to begin before the adolescent years.	
				Rapid Social Change WHO has emphasised the relationship between breakdown of traditional cultural practices & beliefs and worsening of mental health in developing countries – especially in the younger generation who are at the forefront of change. (see Guinness E.A 1992 British Journal of Psychiatry 160 Suppl. 16 'Patterns of Mental Illness in the early stages of Urbanisation'). There have been widespread changes in social structures and expectations over the last 50 years in Britain – some good, some bad, many unquantified. We should not abandon the guidelines of the past but give the next generation the opportunity to benefit.	Thank you for this reference. The guidelines will be developed using the NICE methodology, which critically assess the best available evidence.
			Teaching cultural values	<p>The PSHE (Personal Social and Health Education) is one vehicle for this. It now has an established and valuable place in schools. Indeed it is the appropriate place for introducing some of the targeted interventions which will be part of the NICE guidelines. In terms of the 'whole school approach' I suggest two considerations.</p> <p>Firstly, as discussed above, it is always the underlying value system of the school which carries more weight (the ground rules of the suprasystem) than what is actually taught. "Actions speak louder than words". What informs the culture of the school? What cultural / spiritual / religious values does it impart?</p> <p>Secondly, how much can we expect teachers to</p>	Thank you for your comments.

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				remedy either the deficits of society or the shortcomings of families? Who is responsible in any given society for imparting the beliefs and values of that culture to the next generation? It goes beyond the families, although they are vital. Traditional rites of passage have lapsed. The Church has much less influence. There is a real danger that the Media is becoming the major cultural influence – shaping what is 'politically correct' and moulding young people. Yet inevitably schools are one forum for teaching values for life. How can we enlist support for them?	
			4.2.1. Pastoral care of teachers	<p>The mental wellbeing of children is much influenced by the dynamics of their key relationships. For instance there is an established body of knowledge of the adverse impact on children of mental illness in the parent. Maternal depression especially disrupts bonding and sends powerful messages to the child that he is bad and unwanted. This becomes imprinted upon his developing brain. (see Glaser 2000 Child Abuse and Neglect and the Brain – a review, Journal of Child Psychology and Psychiatry 41, 1, p 97-116). Such children can develop Hostile Avoidant Attachment Disorder which not only makes them difficult to teach but is one of the precursors of delinquency.</p> <p>Of course the relationship between child and teacher is not of that order. However exhausted and demoralised teachers will not be able to fulfil their complex role. They also will inevitably send adverse messages to the children. Furthermore research into resilience factors in child development shows that a close relationship with a teacher is protective for children at risk (see Rutter 1985 Resilience in the</p>	Thank you for the references and your comments.

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			Recommendations to NICE draft scope	<p>face of adversity, British Journal of Psychiatry, 147, 23-51). Indeed one often finds in clinical practice that a troubled child made better progress during the school year when he had a teacher he liked. Important to him was the teacher being in good control of the class yet having time and energy to spare for him. Sadly these days teachers are becoming overwhelmed by demands over and above their primary role. Teachers need 'pastoral care'. Indeed there are agencies for this (eg Pastoral Care in Education in Scotland).</p> <p>Pastoral care for teachers and cultural / religious support from the community (see below)</p>	

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			General comment : the place of Religion in schools	<p>There is considerable controversy over the place of religion in schools – whether it be faith schools, or the requirement for a daily act of worship, or the structure and content of religious education. It seems important that there should be NICE guidelines in this because spiritual beliefs and values are closely related to psychological wellbeing. (see the Royal College of Psychiatry special interest group on Spirituality). This happens in two ways both by empowering and directing the individual and in structuring and safeguarding society (the 'salt of society'). Spiritual beliefs provide the frame of reference on which to base life both for the individual and for society. In considering what we want the children of Britain to learn as they grow up the following should be considered :-</p> <ul style="list-style-type: none"> • Religious Heritage Christianity has been the foundation of Western civilisation for centuries. Christian beliefs and imagery are woven into our British culture and language. Until recently Christian moral principles, empowered by belief in God, have protected our social structures for rearing the next generation (marriage and child rearing, guidelines for launching adolescents etc.). Indeed all major religions must have this function • In Systems terms Religious / ideological beliefs form the ground rules of the suprasystem of any given society. What is going to inform and shape the values of the school suprasystem as discussed above? What will provide the moral framework on which the school will base its principles – and the driving force for enacting them? Children will internalise these principles and carry them through life. What do we want them to be – materialism – the values portrayed by the media – or those which guided our 	Thank your for your comments.

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			Summary of suggested recommendations to the NICE draft scope document	<p>1 Systems Theory be used as a framework for assessing the ethos of a school. This could be implemented by :-</p> <ul style="list-style-type: none"> • Formulation by OFSTED of a protocol for assessing and adjusting the 'social health' of a school in Systems terms. • Family therapists are the professionals with training in Systems Theory and practice. They could be asked to consult to schools. • Understanding the ethos of a school in Systems terms should be taught in Teacher training colleges. <p>2. Pastoral care for teachers should be enshrined in the NICE Guidelines. The influence of teacher / child relationships in promoting self esteem, and in modelling identity and values for life needs to be enhanced.</p> <p>3 NICE guidelines to recommend the teaching and practice of mainstream traditional Christianity in primary schools. . The links between religious teaching and mental wellbeing are several as follows :-</p> <ul style="list-style-type: none"> • To inform the ground rules of the school suprasystem with sound God given principles which have been the foundation of our culture and which can counterbalance the destabilising influences of modern society (eg media) • To provide a wholesome approach to spirituality. • To provide a sound moral framework which will help the children to become good citizens. 	Thank you for your comment. The development of guidance will be based on the best available evidence.

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				<ul style="list-style-type: none"> To give the children a frame of reference on which to base their lives and thereby protect their mental wellbeing <p>(Comment : Extremist religious groups within various religions can radicalise young people and adversely affect their mental wellbeing. This phenomenon may create a polarity whereby all religion becomes suspect. Yet to go to the opposite extreme will create a spiritual vacuum which can be filled by worse. This NICE guideline would counteract both extremes.)</p> <p>4. Religious / cultural support from the community Schools may not have the resources to implement this NICE guideline. Moreover it is difficult for staff who do not share the faith to conduct the worship. One possible solution could be for the Head and the school governors to confer about approaching the local churches for clergy or volunteers to help conduct assemblies, run clubs, even teach RE if need be, and also celebrate the major Christian festivals (Christmas, Easter, harvest). Some schools already do this. (eg Network Leeds on the web). It strengthens links with the community in a healthy way and also gives the school extra manpower. Oversight would be provided both by the Head and school governors and by OFSTED.</p>	
Coventry and Warwickshire Partnership NHS Trust representing Faculty of		Targeted	3	<p>Around 50% of Children with a learning disability have a significant behavioural or emotional problem.</p> <p>10-20% of Children with a learning disability also have an autistic spectrum disorder.</p>	Thank you for this reference.

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Learning Disability, Royal College of Psychiatrists.				Reference: Mental health of Children with learning disabilities. Pru Allington-Smith. Advances in Psychiatric Treatment (2006) Vol 12, 130-140	
			General	<p>The impact of severe behavioural problems in children with a learning disability and/or autism cannot be over-emphasised.</p> <p>They are over represented in children excluded from education especially when they have been “included” in mainstream schools.</p> <p>Children with a learning disability (LD) often do not cope in mainstream provision. They and their parents often feel very isolated and unsupported.</p> <p>Children with a LD and behavioural and emotional problems managed in local schools often end up in placements very far away from the families. The placements are often extremely expensive and it can be hard to maintain positive family relationships.</p>	Thank you for your comments. This will assist us during the development of the guidance.
Department of Health			General	Content with what has been proposed and has no comments to make on this document.	Thank you.
Department of Health – Regional Public Health (SE) and Faculty of Public Health – Mental Health Working Group			4.2.1	<p>Re Risk Factors:</p> <ul style="list-style-type: none"> • Include interventions for preventing child abuse eg 'Safe Touch' re sexual abuse, internet safety • Include interventions for Bullying • Identify effective components of interventions eg SEALS doesn't include Protective Skills, Help Seeking Behaviour and Abuse Awareness which is in some child abuse prevention interventions • Include Parenting programmes 	Thank you for your comments. This will assist us during the development of the guidance.

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				<ul style="list-style-type: none"> Look at wider environmental factors eg Nutrition (Omega 3's/6's) and Healthy Eating Look at impact of Physical Activity on children's MH 	
			4.1.1 Target Groups	Include children with Learning Disability, Physical Disability, LAC, children with parents with mental Health problems, substance misuse, prison, domestic violence (see ACE 'Adverse Childhood Experiences' studies by Felotti et al.)	Thank you for your comment. We do acknowledge these individuals and they are included within the vulnerable groups.
			4.4 Outcomes	Include educational achievement and school attendance and other MSR behavioural and physical health and long-term outcomes including crime	Thank you for your comment. These outcomes will be included if they have been used as an indicator of an intervention.
			4.6 Settings	Consider how interventions are integrated with other Health Promotion programmes eg underpinning substance misuse etc	Thank you for your comment.
Dudley Counselling Service for Children and Young People		Targeted	GENERAL	I would like this scope to include how the role of the Counsellor in Schools can have a positive impact on the 'Targeted Approach' and provide an effective support to pupils with difficulties.	We have included reference to such specialist support in the revised scope
		Whole School	GENERAL	I would like this scope to include the role of the Counsellor in Schools and how they can provide an effective support to 'The whole school approach' by working with the school staff and parents to support the pupils.	Your comment will inform the next stage of the development of guidance with respect to support to teachers and support staff
Family Welfare Association		Whole School	4.2.1	To include the needs of support staff in addition to teachers	Thank you for your comment. We will amend the scope accordingly.
			General	SEAL (Social and emotional aspects of learning) is a curriculum based programme currently used by some schools and should be considered in this context.	Thank you for your comment. We will amend the scope accordingly.

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		Targeted	4.5	How should the psychological needs of children be screened/assessed by schools? What is the role of teachers? What training is available at present and what will be required?	Thank you for your comments. This will assist us during the development of the guidance.
			General	I would urge the team to consider the impact of nutrition on young peoples well-being. Please see 'Changing diets changing minds'-Sustain 2006	Thank you for your comment.
Gone Forever Bereavement Trust			GENERAL	These comments derive from my research at Sheffield Hallam University, examined February 2006 on 'Helps and hindrances to children's bereavement; the children's perspectives' (Cranwell 2006) This is the first such child centred study to be done in the United Kingdom, and focused on children 6 – 12 years who had a parent die other than from murder, suicide, or major incident whether of natural or human origin. The sample was 30 children.	Thank you for your comments. This information is gratefully received and will assist us in the development of the guidance.
			Section 2 (b)	The Children Act 2004. Out of 250 schools approached approx 10% replied to requests to ask parents permission to interview bereaved children. An attempt to recruit a consultation group of bereaved children was unsuccessful, Parents were not approached and children not consulted.	
			Section 2 (b)	Bullying. 20% of the bereaved children had experienced bullying directly associated with their loss.	
			Section 2(b)	Promoting children's mental health within early years and school settings. Research by the St Christopher Candle project revealed that 79% of schools have at least one child bereaved within the past two years, that 56% of teachers admit to feeling	

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				inadequate in knowing how to respond to child bereavement, while less than 10% of schools have a bereavement policy. (Shipman, Krauss, Monroe 2001) Official figures show that a child loses a parent every 27 minutes (c.20,000 a year), while 2 million children 5-15 have lost a parent, grandparent, friend, or sibling. 50% of my sample reported positive teacher responses, 20% negative, and 26.6% neutral (said nothing- showed no interest)	
			Section 2(b)	Promoting children's mental health within early years and school settings Although most of the sample wished to return to school as soon as possible, there was a strong wish expressed that teachers would not pick them out as 'different' which often occurred unwittingly ('Don't make a Father's Day card – you haven't got one')	
			Section 2(b)	Promoting children's mental health within early years and school settings. 50% of bereaved children have concentration problems for 12 months following bereavement through loss of a close attachment figure, (compared with 6% non-bereaved) while 16% usually require interventions within the next 12 months, (Black 1993)	
			Section 2(b)	Promoting children's mental health within early years and school settings. Although most children show no dysfunctional behaviour in the 12 months following a bereavement, 21% in one study showed serious problems two years following the death, problems that were not apparent in the previous two years. Many adults including bereavement support workers assume a child's needs dissipate after the first anniversary of the death (Worden and Silverman 1996)	

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			Section 2(b)	Mental health. Bereaved children are at a greater risk of other emotional problems (Rendell 2000)	
			Section 2(b)	Healthy minds Most children who experience the death of a parent at an early age find they need to 'revisit' the death as they grow and develop, a phenomenon frequently seen as morbid by adults (Jewett 1994)	
			Section 2 (b)	Our health, our care, our say. A survey of 250 children showed their belief that death should be discussed as part of the national curriculum (Johnson & Colwell 2001)	
			Section 2 (c)	Promoting the health of looked after children. Two social work managers expressed objections to teachers consulting children about taking part in my research, before they had been asked.	
			Section 3(b)	Conduct disorder 22% of bereaved children display delinquent behaviour.(Rutter 1966)	
				Conduct disorder 47% of parentally bereaved children try drugs (Social Policy Research 1995)	
				Mental disorder Rutter (1966) noted a five fold increase in psychiatric problems among bereaved children compared with the general population	
			Section 3 (c)	Gender issues. Girls who have lost a parent are 40% more like to have a teenage pregnancy (Social Policy Research 1995)	
			Section 3 (c)	Disrupted families Three of the children in my study whose parents had parted before one of them died believed that the death would not have occurred had the one who left stayed, while two believed that the one leaving had hastened the death of the other. All five who had separated parents revealed that they'd had a secret wish that their parents would reunite, which, as Parkes and Weiss (1983) point out, means that they have a double loss, the loss of the parent and the loss of hope of reconciliation.	

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			Section 3(d)	Exclusions 22% of children excluded from school have bereavement problems compared with 16% non-bereaved (Graham & Bowling 1995)	
			Section 3 (e)	Promoting the health of looked after children Foster parents who cooperated with my survey reported that social workers said they had no knowledge or literature on supporting children bereaved of a parent, nor could they tell them where to go for these.	
			Section 4 (5)	Type of content Research into outcomes of a 30 year elective programme on loss and bereavement in the USA showed <ul style="list-style-type: none"> • Fear of change and loss were reduced • Children involved performed better in other subjects than expected • Communication within families improved (Stevenson 2004) 	
			Section 4 (5)	Teacher or specialist? As the subject arouses emotions including fear teachers can only deliver this subject if trained and prepared, and have come to terms with their own mortality. My research showed that many teachers have similar 'magical thinking' to that which young children are known to have i.e. believing that a course of action such as discussing death will cause it to happen. Many schools have never implemented the recommendations of the Yule and Gold publication 'Wise before the event' (1993), outlining contingency plans for a major incident involving a school, for the same reason. My research recommends harnessing the immense	

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				amount of goodwill and experience that exists on this subject in the voluntary sector, but with appropriate training for entering schools.	
			Section 4 (5)	Appropriate interventions. Holland (2003) has designed a teaching programme for this subject for schools Various organisations run training programmes for teachers and mentors, social workers, medics and other professionals to enable them to intervene appropriately with bereaved children and those who having lingering disturbance plus behavioural problems. Such organisations include the Child Bereavement Trust, the Gone Forever Bereavement Trust, and Cruse Bereavement Care. There also various websites dedicated to this subject	
Halton CAMH		Whole School	General	Overall the draft scope document aims seem to be appropriate to gaining a better understanding of how best to promote mental well-being in primary schools	Thank you.
			4.5 Key questions	How will the promotion of mental well-being in primary education fit with other interventions such as Social and Emotional Aspects of Learning. Should the promotion of mental well-being be developed in line with such approaches as SEALS to help integrate it into school life, rather than it become a curricular topic.	Thank you for your comments. This will assist us during the development of the guidance.
Hampshire PCT		Whole School	B Page 3	Around 100,000 of the 3.8million 11-15 year olds have learning disabilities eg Autism SLD,or associated syndromes of these about 40,000 will have mental health issues, Can these young people be included in this study given that consideration is given to special education environments and ethnic minority grouping.	Thank you for your comment. There is the facility on the NICE website to suggest topics for consideration for our future guidance. Visit www.nice.org.uk/page.aspx?o=t.s.home We would expect that at some time in the future NICE will be asked to look at these

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					issues.
Hertfordshire County Council - Behaviour Support Team – EPAT			general	It will be important to ensure that targeted interventions and whole school approaches are as effective when carried out together in a variety of environments.	Thank you for your comments, references and examples – these are gratefully received.
			general	The work of Educational Psychologists is largely concerned with the promotion of mental wellbeing at a variety of levels (eg national, Local Authority, school group and individual levels. The Division of Educational and Child Psychologists at the British Psychological Society, the Association of Educational Psychologists and the university courses for Educational Psychology have evidence from a wide range of research. Journals such as 'Educational and Child Psychology' (eg Vol 22, No 3, 2005) and 'Educational Psychology in Practice' (eg Vol 17, No 4, Dec. 2001) have useful articles.	
				Examples of practice from HCC and elsewhere include: <ul style="list-style-type: none"> • Peer mentor programmes to reduce playground behavioural difficulties using a problem analysis framework (Monsen, J. and Frederickson, N. (2002) 'Consultant Problem Understanding as a Function of Training in Interviewing to Promote Accessible Reasoning' in <i>Journal of School Psychology</i>. 40, pp197-212. • 'Feeling Good Weeks' – a joint venture between CAMHS, healthy Schools and partner agencies (joining Health and Education) to promote mental health and emotional wellbeing. • Consultative support for staff to help schools 	

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				<p>manage emotional needs.</p> <ul style="list-style-type: none"> Crisis work (eg 'Pocketful of Posies' CD-Rom, Kent Educational Psychology Service, articles by Trisha McCaffery and Ben Hayes). <p>The 'Solution Oriented Schools' programme developed by Ioan Rees.</p>	
		Targeted	general	<p>Examples of practice (from HCC and elsewhere) include:</p> <ul style="list-style-type: none"> Nurture groups Quality Circles/Circles of Friends Individual, group work and training to school staff and other agencies/Local Authority staff (eg Autism Spectrum Disorders, CBT, Behavioural Management) Parenting courses (eg by Family Support Workers for present and prospective parents of pupils within a nurture group, support for parents/carers in their homes) Management of change (eg for pupils who have an ASD) Multi-disciplinary 3 session-change solution-focused approaches for families with complex needs. 	Thank you for your comments, references and examples which will assist us during the process of developing the guidance
Independent Advisory Group on Teenage Pregnancy			General	<p>I urge you to consider our concerns.</p> <ul style="list-style-type: none"> Teachers and school staff need to be supported and trained to develop the confidence and competence in providing a curriculum which promotes emotional health and well-being. The SEAL materials are excellent but are staff adequately trained? Teachers and school staff need to be supported and trained to identify early symptoms of poor mental health in the early 	<i>(late comment)</i>

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				<p>years, mental health issues in the family and to have the time, confidence and competence to support children and families at tier 1 levels. If this was done adequately it would reduce the escalation of mental health needs to tiers 2-4.</p> <ul style="list-style-type: none"> • There needs to be appropriate, accessible and available mental health services in the community. • Teachers and school staff need to feel confident that they are supported by and can make referrals to good mental health services. • And finally, early and effective intervention will 'save' children and reduce long term costs. 	
Islington PCT		Whole School	General	There is evidence from the evaluation of the successful MindMatters secondary school mental health promotion evaluation that effectiveness lies in the combination of a whole school approach as well as targetted interventions. For this reason it may be more useful to provide both guidelines as one package, or combine the guidelines.	Thank you for your comment. In the process of generating the evidence these two areas have been separated, this does not preclude the possibility of these two areas being combined when the guidance is produced.
			1.1	This title is the same as in the targetted approach guidelines and should more accurately reflect the nature of the guidelines.	Thank you for your comment, the scope will be amended appropriately.
			3.	This information should include the role of the whole school in supporting mental health promotion, or the school as a significant place of contact for children. It would be useful to include patterns or data here that reflect key public health interests in promoting mental health in school. That is, the school as a key place for intervention.	Thank you for your comment, the scope will be amended appropriately.
			4.2.1 a	Include at the end of this point... " and reward and	Thank you for your comment.

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				incentive schemes for students". Currently reads as if school policies are the only mechanisms of the whole school approach.	We will clarify this in the scope.
			4.5	The key questions presented here cross the two areas of 'whole school' approach and 'targeted' approach. I feel that these questions are more suited for the targeted approach and that more needs to be added for the whole school approach. E.g. Whether mental health promotion is in line with the school's direction or mission statement, how well it is integrated, whether it is viewed as an 'add on'.	Thank you for your comment, the scope will be amended appropriately.
		Targeted	1. Title of guidelines	It would be more useful to include the word 'interventions' in this title as it relates to targeted approaches. e.g. 'Guidance on school based interventions to promote good mental health of children in primary schools (targeted approach)	Thank you for your comment, the scope will be amended appropriately.
			4.2.1 a	I am concerned that this category is rather broad considering these guidelines are around 'targeted approaches'. There is a big difference between 'changes to school ethos' and practical interventions such as SEAL. Some methods included here would be better placed in the 'whole school' guidance e.g. school ethos, links with parents and the community, management, support to teachers etc.	Thank you for your comment. Depending on the initial review, it may be appropriate to prioritise specific interventions.
			4.4	I feel that these outcomes are broad and don't target the objective of promoting mental health in schools. In essence a key aim of mental health promotion is the prevention of mental health problems and the promotion of help seeking behaviour and supportive environments. It would be useful to see this reflected in the outcomes. I also feel that the broadness of these outcomes will make the evaluation of interventions more difficult. Outcomes need to match	Thank you for your comments. These outcomes have been chosen to ensure that the overall mental wellbeing of the child is promoted. Mental wellbeing is a priority but the prevention of mental illness may be used as an outcome.

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				the objectives.	
			4.6	Target audience should include all school staff not just teachers and school governors	Thank you for your comment, the scope will be amended appropriately.
			General	<p>It would be useful to draw on the evaluation of the Mindmatters program. This is an Australian mental health promotion program for secondary schools. It focuses on both the whole school approach as well as specific targeted interventions. Mr Trevor Hazell from the Hunter Institute of Mental Health led the external evaluation of this program. The evaluation was staged and is available on the link below. The last evaluation was done in May 2006 and is not yet posted on the website. This evaluation is available directly from Trevor Hazell. He can be contacted via email: Trevor.Hazell@hnehealth.nsw.gov.au and would be happy to answer any questions relating to the evaluation.</p> <p>http://cms.curriculum.edu.au/mindmatters/evaluation/mm_evaluation.htm</p>	Thank you for this reference.
London Borough of Redbridge on behalf of CAMHS strategy steering group		Targeted	4.1.1	It was considered that there should be guidance on specific issues for children who for whatever reason are not attending school. Although it is a small group it include some of the most vulnerable and hard to reach children	<p>Thank you. We recognise that there are issues that need to be addressed for children that are not attending school. There is the facility on the NICE website to suggest topics for consideration for our future guidance. Visit www.nice.org.uk/page.aspx?o=ts.home We would expect that at some time in the future NICE will be asked to look at these issues.</p>

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			4.2.1	Some of the interventions referred to here would seem to be better included under the Whole school guidance (e.g. lessons taught a part of curriculum.) It did not refer some key aspects of targeted approach such as direct therapeutic work with children; while we agree with a focus on preventive whole school approaches there should also be place for individual work	Thank you for your comments. We will clarify this in the scope.
		Whole School	General	This appears to be a very useful piece of work and the scope is appropriate	Thank you.
Luton Borough Council		Whole School	2 (b)	I suggest that the following Reports are added to this section: Every Child Matters (DfES 2003); Extended schools: Access to opportunities and services for all (DfES 2005); Support from the Start. Research Report 524 (DfES 2004); The impact of parental involvement, parental support and family education on pupil achievements and adjustment: A literature review. Research Report 433 (DfES 2003).	Thank you for your comment. We will take account of these documents at the next stage
			4.2.1. a)	Suggest references to Every Child Matters and Extended Schools, in particular – a) Whole school approaches across the 5 Every Child Matters Outcomes across the extended day (universal)	Thank you for your comment.
			4.4	Suggest add to bullet point: social wellbeing (good relationships with family, peers and significant others, and the opposite...)	Thank you for your comment. This is in the scope.
		Targeted	General	I suggest that the following Reports are added to this section: Support from the Start. Research Report 524 (DfES 2004) Young People, Risk & Protection: A Major Survey of Primary Schools in the On Track Areas (DfES 2006) Every Child Matters (DfES 2003)	Thank you for your comment; we will take account of these documents at the next stage.

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				On Track Multi Agency Projects in Schools and Communities: A Special Relationship (Children and Society, 20, 40-53) The impact of parental involvement, parental support and family education on pupil achievements and adjustment: A literature review. Research Report 433 (DfES 2003)	
			4.2.1. a)	Suggest reference added to lines 4-5 of this subsection: A variety of methods are used including: programmes to help children make the transition to full time primary education, make the transition to secondary school..	Thank you for your comment, the scope will be amended appropriately.
			4.4	Suggest add to bullet point: social wellbeing (good relationships with family, peers and significant others, and the opposite...)	Thank you for your comment, the scope will be amended appropriately.
			4.5	Suggest add a new bullet point: What is the evidence for the effectiveness of multi modal, multi agency interventions within primary schools?	Thank you for your comment, the scope will be amended appropriately.
Mental Health Foundation			4.1.1	The scope document states that if evidence allows, disadvantaged groups will be considered. We believe it is crucial to consider interventions for disadvantaged groups of young children within a primary setting. This is a point at which early interventions may have a high degree of success both in terms of prevention and promotion particularly for groups such as refugees and asylum seekers, young carers, and children of parents with substance misuse issues or contact with the criminal justice system.	The guidance is for all children aged 4–11 in education. This includes those from disadvantaged groups. Specific recommendations may also be produced for these groups.
			4.2.1	We believe it is important that guidance in relation to whole schools approaches include consideration of the following: A positive school culture and awareness about	Thank you for these references and your comments. This will assist us during the development of the guidance.

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				<p>mental health should be incorporated throughout subject areas and teachers given thorough and experiential training on mental health issues. Head teachers have a central role to play in developing positive mental health strategies in schools. Anti-bullying strategies should be a priority for every school and a zero tolerance policy implemented. Public mental health interventions within schools should include proactive initiatives on regular physical exercise and the importance of good nutrition. See Mental Health Foundation reports <i>Up and Running</i> and <i>Feeding Minds</i>. Programmes should not be focused on single classroom behaviour models but on generic promotion of skills that increase mental and social well-being. Whole school approaches implemented continuously for more than a year have been shown to be effective. We believe this is key, mental health promotion should not be sporadic but ongoing and carried out at a variety of different levels throughout the school. Mental Health Foundation research has shown that while teachers think there are many good initiatives in schools, they are often underfunded, inconsistently applied and are reactive rather than proactive in approach. There is clearly a need for consistent support for all schools and creative thinking in regard to promotion and prevention. It might useful to cite example of positive mental health promotion in primary schools – for example models such as circle of friends, circle time and nurture group. (See <i>Promoting Mental Health in Primary Schools</i>, Mental Health Foundation 2001)</p>	
			4.5	Additional questions might include:	Thank you for your comment these question are helpful in

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				<ol style="list-style-type: none"> 1. What are the long term economic benefits of intervention within primary education? 2. How can schools link up with other services in the community? 3. How can children be involved in promotion activities? 4. What is the most effective way of training new and established teachers? • What will be the benefit to the school of extra investment in mental health promotion? 	refining the questions in the scope.
		Targeted	4.2.1	<p>Targeted approaches should take account of the importance of identification of mental health problems in children within primary education. The scope should therefore include comprehensive training of teachers in understanding and identifying potential problems in their pupils and the importance of being aware of particularly vulnerable groups of children. The scope should include the involvement of CAMHS with schools. (See Mental Health Foundation report - Effective joint working between Child and Adolescent Mental Health Services (CAMHS) and Schools, 2003.) It might also be useful to cite example of positive mental health promotion in primary schools – for example models such as circle of friends, circle time and nurture group. (See <i>Promoting Mental Health in Primary Schools</i>, Mental Health Foundation 2001) Guidance on “..activities involving the family and/or community should explicitly present a strong case for strong links with parents and parental involvement and awareness of how to maintain mental well-being in children. As part of ‘school ethos and environment, it would be useful to explicitly state anti-bullying strategies’.</p>	Thank you for these references and your comments.

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			4.5	<p>Additional questions might include:</p> <ol style="list-style-type: none"> 1. How can schools best work with CAMHS services? 2. What are the most effective ways of engaging with parents? <p>•</p>	Thank you for your comment – these question are helpful in refining the questions in the scope.
Mersey Care NHS Trust			General	<p>These comments are informed by a piece of local research. Findings from this research can be made available when the call for evidence is made. At this stage the comments below are particularly informed by the finding that young people's mental health will benefit from a joined up approach across all agencies and care providers. This joined up approach has to be actively promoted.</p> <p>Age 11 and under – although it is understood that older age groups will be the subject of future guidance, it is considered that the whole school guidance should not have an age cut-off point. As an Adult Mental Health Trust we influence the mental health of all young people through the work we do with older adolescents and parents with mental health problems.</p>	Thank you. We recognise that there are issues that need to be addressed in older children. There is the facility on the NICE website to suggest topics for consideration for our future guidance. Visit www.nice.org.uk/page.aspx?o=t&s.home We would expect that at some time in the future NICE will be asked to look at these issues.
			General	Organisations involved in producing, disseminating and using this guidance should include Adult Mental Health Trusts for the reasons given above. The whole family and whole school approach of the guidance is to be applauded. The guidance should be actively used to address the contrary cultural issues that may persist in some adult services where other members of the family are seen for treatment and care.	Thank you for your comment.
			General	We approve of the whole family, whole school public	Thank you.

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				health approach in this field.	
			2c page 2	Professional with public health as part of their remit is considered too narrow. In adult mental health services, this could be seen as nobody's business apart from those professionals with formal responsibilities for safeguarding children. We would like as a Trust to see a greater degree of influence from this important guidance.	Thank you for your comment, the scope will be amended appropriately.
			3c page 3	Boys show more problems than girls in the age group of interest. However if a developmental approach is adopted, girls have more problems that boys in later years. Without considering these important changes, a proportion of the population with developing problems may be missed at a stage when the whole school approach could prevent further difficulties. This illustrates how adult services can contribute to young children's mental health.	The whole school approach is for both boys and girls. The statistics are given to highlight that there are specific groups that may need targeted attention as well as the whole school intervention.
			4.1.1	Avoidance of problems in later life. It would be helpful to bring in the adult services that have knowledge of what can go wrong later and the precursors to this. These organisations can provide information and also need to have a sense of real ownership of the guidance (to promote the culture change referred to above).	Thank you for your comment. At any time during the guidance organisations are free to register their interest as a stakeholder.
			4.1.2	On social inclusion grounds, we feel children who are not in school should be referred to in the guidance. They are often partial users of the school system and the approaches may be adapted for them through alternative universal or other services.	Thank you. We recognise that there are issues that need to be addressed for those children not in school. There is the facility on the NICE website to suggest topics for consideration for our future guidance. Visit www.nice.org.uk/page.aspx?o=t.s.home We would expect that at some time in the future NICE will be asked to look at these

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					issues.
			4.1.2	Support to teachers and parents. Forward-thinking adult mental health services can contribute well to this agenda for all the reasons given above. Again this is a good reason to involve them in the guidance. Mersey Care NHS Trust would like to provide further details.	We would welcome these details.
			4.4	Outcomes. These cannot be achieved without the involvement of adult services seeing the parents of the children in question.	Thank you for your comment.
			6 page 6	Related guidance. NSF for mental health where health promotion and prevention is spelled out and seen to have a public health remit for all not just individuals receiving formal adult services.	Thank you for this reference. The scope will be amended to reflect this.
			6 page 6	NSF for mental health also includes the development of services to younger and younger age groups, e.g. Eating Disorders and Early Intervention for Psychosis Services are often within AMH. Specialists may not be available in CAMHS because of the nationally accepted shortage of such professionals.	Thank you for your comment. The scope will be amended appropriately.
			6 page 7	Parent training may be undertaken by the practitioners in mental health organisations for adults. Local examples exist.	Thank you for your comment.
			4.5	Key questions are highly appropriate. We consider however that they cannot be answered without access to knowledge and information held by specialists who are often located in adult mental health settings. Questions that particularly need to be addressed from a full stakeholder approach including AMH services are particularly: teacher vs specialist? and adverse of unintended effects? Local information within Mersey Care NHS Trust will be submitted as part of the call for evidence.	Thank you for your comment. NICE methods are detailed in our process and methods manuals at: www.nice.org.uk/page.aspx?o=300576
		Targeted	General	These comments are informed by a piece of local	Thank you. We recognise that


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				research. Findings from this research can be made available when the call for evidence is made. At this stage the comments below are particularly informed by the finding that due to the shortage of trained professionals and specialists and other factors, interventions must be shared, agreed and understood across a range of organisations seeing young people, children, their families and other carers.	there are issues that need to be addressed in older children. There is the facility on the NICE website to suggest topics for consideration for our future guidance. Visit www.nice.org.uk/page.aspx?o=s.home We would expect that at some time in the future NICE will be asked to look at these issues.
			3c page 3	Without considering developmental aspects of the way problems persist into adulthood (eg more conduct disorders in boys but more eating and mood disorders in girls), a high proportion of the population with developing problems may be missed at a stage when intervention could prevent further difficulties. This illustrates how adult services can contribute to young children's mental health.	The whole school approach is for both boys and girls. The statistics are given to highlight that there are specific groups that may need targeted attention.
National Healthy Schools Delivery Unit			2c)	The audience for the guidance should be the school workforce and not just teachers. School nurses, teaching assistants, counsellors etc. are all contributors to emotional health of a school.	Thank you for your comment. The scope will be amended appropriately.
			3c)	NICE recommended to challenge the gender-related statistics on mental health. The tendency for girls to internalise emotional problems will mean significant under-reporting.	NICE recognises that the official statistics may be subject to under-reporting.
			4.1.2	The resource reasons for NICE to focus its study on children in primary schools are understood. But, to look at primary to secondary transition from one side only will mean that a particularly stressful period in education will not get sufficiently comprehensive attention.	Thank you for your comment.
			4.2.1	The whole school approach should also focus on those structures which enable a school to deliver its	Thank you for your comment. This is included in the scope.

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				policies – a well-functioning system. Recognition should be given to the contribution a school can make to attitudes and impact on stigma and discrimination	
			4.4	The outcomes should include the extent to which the health inequalities agenda is addressed. Welcome the recognition of the importance of providing children with skills – of resilience etc. The study should identify the factors which make it possible for 90% of children to lead relatively happy and well-balanced lives.	Thank you for your comment. This is included in the scope.
			4.5	Add question “What structures need to be in place to support implementation?” Add question “What outside support does a school need to be effective?” Add question “What positive and negative influences on mental health come from areas not always associated with emotional well-being – such as eating and physical activity and having a safe environment?” Add question “What is meant by risky behaviour and how does this inter-relate with children’s risk-management skills?” Should the questions be looked at separately for Key Stages 1 and 2? The question about whether it is better for a teacher or specialist to deliver an intervention should be set in the context of what skills are needed for the intervention and how these are provided through professional . Role of parents should be expanded to look at how they can be actively involved. Barriers and facilitators should be assessed and critical factors highlighted.	Thank you for your comments. This will assist us during the development of the guidance.
			4.6	Recommendations must not add to school burdens.	Thank you for your comment.

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				Those covering the role of schools must also be for Central Government given that implementation will revolve around resources – in school and outside (eg teacher training) To be viewed in the proper context, any recommendations for schools should be mapped on to the “Be Healthy” outcome of Every Child Matters.	
			General	NICE should note that the Healthy Schools Programme will be issuing two guidance documents to local programmes in support of its Emotional Health and Well-Being theme. <ul style="list-style-type: none"> By December we will issue an Audit Toolkit for schools to use to do their own self-evaluation. This will indicate the minimum evidence that will satisfy the criteria for that theme. An Emotional Health and Well-Being toolkit will be issued in Summer 2007. <p>The Healthy Schools Programme is currently out to tender for a 3 year evaluation study to commence in March. This should generate some evidence in time for the later stages of the NICE exercise.</p>	Thank you for this information.
		Targeted	3c)	NICE recommended to challenge the gender-related statistics on mental health. The tendency for girls to internalise emotional problems will mean significant under-reporting. There is also a need to pick up on when boys choose to discuss emotional issues – if later then this would more often be at the point when they have developed into mental disorders.	Thank you for your comment. We acknowledge the subtleties of interpretation of official statistics.
			4.2.1	Areas to be covered should include wider pastoral care provision, including school nurses and inputs of outside professionals. Specific examination should be made into the effectiveness of referral arrangements to specialist	Thank you for your comments, we will clarify and refine the scope accordingly.



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				services.	
National Primary Head Teachers Association			2	We represent practitioners in a variety of educational settings catering for learners aged three plus – and younger children in extended school provision. It is our view that ever increasing numbers of children are arriving in school with or developing severe social, emotional and behavioural difficulties. These are becoming more complex and extreme and manifest themselves at ever younger ages.	Thank you for your comment, which highlights the need for this guidance.
			3b	We would wish to question the validity of this data. There are concerns that levels of diagnosis do not reflect actual numbers. We feel that the problem may be more widespread than data indicates.	We acknowledge that the official statistics may underestimate the scale of the problem.
			3c	We recognise that the number of children with complex difficulties in the system in general is increasing. There are however schools where, due to the high incidence of the factors listed have to deal proportionately greater numbers than the norm.	Thank you for your comment.
			4 1.1	Given the age range of the pupils we cater for we feel that the remit of the study should extend to include children pre four years old.	Thank you. We recognise that there are issues that need to be addressed in other age groups. There is the facility on the NICE website to suggest topics for consideration for our future guidance. Visit www.nice.org.uk/page.aspx?o=t_s.home We would expect that at some time in the future NICE will be asked to look at these issues.
			4 1.2	In order to reflect recent structural changes the scope should extend across Children's Services generally.	Thank you. Please refer to our previous response.
			4 5	Role of parents should be a main priority for focus.	The focus of the guidance reflects the remit that was given

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					to NICE by the Department of Health and refers to 'producing guidance for schools'. However this does not preclude the importance of parental involvement being highlighted in the final guidance.
			4 5	The slow response to need should be considered as this frequently exacerbates the problem.	Thank you for your comment.
			4 6	The overall remit and role of Children' Services needs to be examined.	Thank you. Please refer to our response to 4.1.1..
			General	Colleagues agree that whilst there is no consistent picture regarding need and provision this area is becoming increasingly problematic. The negative impact on learning and general behaviour management caused by pupils within this cohort is having a major effect on Schools and is draining scarce resources.	Thank you for your comment.
				<p>Firstly, the Association welcomes the recognition of the need for guidance in this area. These are issues that are growing and of great concern to heads, teachers and parents/guardians which relate primarily to the inclusion agenda and more specifically to the aspects of mental wellbeing.</p> <p>We recognise that there is a time scale that gives us further opportunity to make a fuller response but on the aspect of scope it concerns us that the parameters of age 4 - 11 will cause significant difficulties if other measures and guidance isn't developed in tandem for pre school children and indeed the unborn child.</p> <p>If the guidance, when developed, caters for the</p>	Thank you. Please refer to our response to 4.1.1.

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				<p>needs of primary children, and primary schools, it runs the danger of being inadequate if the rate of flow of the problem is not stemmed. Linked to the likely increase of the problems that schools are facing is the increase in the severity of the problems. Again early intervention before the age of four is essential to prevent matters getting worse.</p> <p>This is not to say that if effective early intervention strategies were put in place there would therefore not be a need for guidance in the primary school. The need would still be there but the guidance would at least have a chance of being appropriate.</p>	
National Union of Teachers	 L:\Interventions\ 12-Mental wellbeing c			See attached document – a response of the National Union of Teachers to the Good Childhood Inquiry which I hope will also be relevant to your consultation on the draft scope for the Mental Wellbeing of Children in Primary Education.	Thank you for the attached document.
NHS Health Scotland		Whole School	3	Title refers to promoting mental well-being of children but the rationale prominently refers to mental health problems/mental illness/disorder. If the level of cited problems amongst children were of paramount concern then the scope of the guidance would need to expand to include <i>prevention of problems</i> as well as promotion of well-being. If the focus is only on promotion of well-being then the rationale should be broader to include other types of evidence, i.e. on academic performance etc.	Thank you for you comments. These outcomes have been chosen to ensure that the overall mental wellbeing of the child is promoted. Mental wellbeing is a priority but the prevention of mental illness may be used as an outcome.
			4.2.1	Slight confusion with focus seeming to be on school policy, not just individual behaviour. Of course, individual behaviour should not be the sole focus but nor should school policy – whole school approach should encompass culture, attitudes, etc.	Thank you for your comment. Depending on the initial review, it may be appropriate to prioritise specific interventions.
			4.2.1	Linking to comment made regarding section 3 –	Thank you for your comments.

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				need to be explicit here about the focus being on promotion and/or prevention as this will determine what kind of action/programmes etc would be included.	This will assist us during the development of the guidance. We acknowledge the limitations of the evidence base.
			4.2.2	Should this include 'interventions aimed at treatment of problems'? Also, depending on final focus may also include action aimed at prevention of mental illness/disorder.	
			4.3	Not clear what 'relevant comparators' would be. Further description here would be useful.	
			4.4	Depending on final focus of scope (promotion only, or including prevention), then indicators of poor mental health would need to be identified here (i.e. mental illness, or potential precursors such as poor optimism, poor life satisfaction, lack of purpose).	
			4.5	Number of points: <ul style="list-style-type: none"> • Cost effectiveness data likely not to exist – what about process information? • Teacher or specialist delivery – also include peers? • Parental role? Could be expanded to include role of wider community, services and community members. • 4-11 seems a broad age range – it may be necessary to break it down to see what works at what age. 	
Nightingale Junior School - Derby			General	Each Local Authority to have a named officer responsible for implementing guidance in schools and having an overview of mental health from an education perspective?	Thank you for your comment. Depending upon the evidence, specific elements of guidance may be produced that are applicable to bodies outside of the primary school setting.
			3 (d)	What can schools learn from these statistics?	These statistics are provided to highlight the current ethnic differences in mental health.

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			3 (e)	New proposals in the Education Act 2006 may help	Thank you for your comment. Any guidance generated will be determined by the available evidence.
			3 (e)	Should there be guidance on supporting pupils via Learning Mentors. Perhaps it should be mandatory for pupils with a diagnosed mental illness to have a key worker allocated to them?	Thank you for your comment. Please see the previous response.
			4.2.1 (a)	Need examples from schools settings of good practice. How can we contact these schools?	Thank you for your comment. We will be considering in more detail how current 'good practice' is identified and informs the development of guidance, in line with NICE processes.
			4.5	No reference made to Teaching Assistants and Learning mentors who are more likely to implement intervention programmes.	Thank you for your comment, we will amend the scope appropriately.
			4.5	Lessons could be learned from the DfES on the most effective format for implementing intervention programmes as they have developed a great deal with an education focus.	Thank you for your comment
		Targeted	General	There are a number of schools which have a session at the beginning of the day for children to 'park their problems'	We would be grateful if you could provide NICE with the details of any documents that highlight these issues.
			General	Guidance needs to refer to the school workforce rather than teachers	Thank you for your comment.
			2 c	How will guidance be sent to schools will it be by request or issued routinely to all schools. If it is on request will many schools endeavour to do this?	Once the guidance is finalised, it will be freely available on the NICE website. If obtaining the guidance from the website is not feasible, it will be possible to request a hard copy from the

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					Institute.
			4.1.1.	Does this guidance cover Pupil Referral Units (PRUs)?	PRUs are encompassed within the special education environments described in section 4.1.1. If the evidence permits, the guidance will be applicable to PRUs.
			4.4	Doesn't make it clear if it is being a bully or being bullied in the final sentence	Thank you for your comment. All forms of bullying are covered in the scope.
			4.5	When would we undertake an intervention? When a child as been diagnosed by a medical professional or if we think they might have a condition? I would imagine the majority of cases are not diagnosed until late in key stage 2.	Thank you for your comment. The finer details of the intervention(s) will be determined by the evidence.
			4.5	2nd to last bullet point doesn't refer to gender	Thank you for your comment, we will amend the scope appropriately.
			General	What would school's liability be if 'something went wrong' when undertaking an intervention programme?	Thank you for your comment. We will investigate this further during the fieldwork stage and via consultation with the relevant experts.
Professional Association of Teachers				  L:\Interventions\12-Mental wellbeing c L:\Interventions\12-Mental wellbeing c	Thank you for your comments.
Pyramid and National Council for Voluntary Childcare Organisations (NCVCCO)				One document I would like to draw your attention to is 'On Your Marks - young people in education: a guide for donors and funders' produced by New Philanthropy Capital in April 2006. New Philanthropy Capital are an organisation that researches areas on behalf of donors and funders and provides guidance on cost-effective ways that money can be deployed. On Your Marks looked at potential investments in	Thank your providing NICE with this information.

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				education and contains a section on Providing Social and Emotional Support. This section looks at a number of organisations working in the field and whether the work they are doing appears to be a good use of donors' funds. My own organisation is one of those included in the analysis. Other sections of the report that may be relevant to the NICE work include those on Bullying, Providing Support for Special Educational Needs and Supporting Teachers and Schools. The report is available on-line at http://www.philanthropy.org/ .	
Royal College of General Practitioners		Whole School	General	The practitioner guide produced by the BMA's health Board is a useful document and should be made widely available to primary care professionals as a succinct and readable summary of the salient issues in respect of good quality care to this patient group in primary care settings	Thank your providing NICE with this information.
			4.1.2	Overall would broadly welcome this guidance and agree with its headings & scope subject to acknowledging its limited remit (children of primary school age) in the hope that similar work is, or will be, carried out for older children and young people.	Thank you. We recognise that there are wider issues that need to be addressed. There is the facility on the NICE website to suggest topics for consideration for our future guidance. Visit www.nice.org.uk/page.aspx?o=t&s=home We would expect that at some time in the future NICE will be asked to look at these issues.
			4.2	I am disappointed that the scope will not include children who are not attending school since these represent a population at significantly higher risk of mental health disorders.	Thank you. Please refer to our previous response.
Royal College of Nursing			General	With a membership of over 390,000 registered nurses, midwives, health visitors, nursing students,	

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				<p>health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. The RCN promotes patient and nursing interests on a wide range of issues by working closely with Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.</p> <p>Mental health nursing is represented in all its diverse forms. This embraces clients across the life span and in settings as diverse as high security hospitals, statutory care settings and the community. Mental health nurses are engaged in these diverse areas engaging with service users, carers and families in promoting well being and recovery.</p> <p>The RCN welcomes the opportunity to review this draft scope .</p>	
			4.1.2	<p>When it talks about children not in school does this mean those who are</p> <p>a) unwell physically and are in hospital; or is it</p> <p>b) referring to children who do not go to school (e.g. Romany); or is it</p> <p>c) referring to children who either are excluded or truant.</p> <p>If a) then there are such things as hospital schools and children who are physically unwell should also be covered.</p>	<p>The guidance will cover those children would be the responsibility of a school and situations as permitted by the evidence available</p>


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				<p>If b) this could be seen as divisive.</p> <p>If c) the child's mental health may be the reason for their non attendance.</p>	
			4.1.2	The guidelines should cover all children within the age range.	Secondary school aged children is currently being considered as the focus of future intervention guidance and therefore will eventually be covered
			general	<p>Further, we think the age criterion for the guidance has significant limitations. A number of mental health problems emerge at the transitional period between primary and secondary school, such as secondary problems associated with separation anxiety disorder and other difficulties children may have as a result of moving peer groups/school etc.</p> <p>We would like to suggest that the scope for this guidance should be extended to cover the first year of secondary school, or age 12.</p>	The guidance will include children in transition both to primary education, and also to secondary education; and as the evidence available permits
			4.2.1	Will the guidance take into account private sector primary education? NICE may wish to look at the calibre of children in private schools covering large rural catchments.	Independent includes private education
			General	As stated earlier, we are concerned that the scope is based on school ages (up to age 11) that do not apply across the board. It should be noted that the age boundaries will be problematic in research terms as well as in practice.	We acknowledge the potential limitations of the evidence available with respect to age range definitions
			4.2.2	As above	As above
			4.4	Absence of physical activity and its impact are as happiness and interpersonal violence directly linked to Mental Wellbeing.	Where evidence highlights such approaches with respect to mental wellbeing it will be included

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Sheffield Healthy Schools Programme – Sheffield PCT		Whole School	2 c	The guidance should not just be aimed at teachers, but all school staff to support the whole school approach	Thank you for your comment, we will amend the scope appropriately.
			4.1.1	It is strongly recommended that specific groups of vulnerable/at risk children are included	The guidance will focus on children aged 4–11 in education. Therefore all vulnerable/at risk children in this age range at school will be included.
			4.1.2	The guidance should cover children over the age of 11 years	Thank you. We recognise that there are wider issues that need to be addressed. There is the facility on the NICE website to suggest topics for consideration for our future guidance. Visit www.nice.org.uk/page.aspx?o=t&s.home We would expect that at some time in the future NICE will be asked to look at these issues.
			4.2.1 Whole school approaches that the guidance will focus on	SEAL should be highlighted as one of the key programmes the guidance should focus on and links to the DfES should be strengthened	Thank you for your comment.
			4.2.1	Clear links and references to the national Healthy Schools programme should be made, in particular the EHWB and PSHE strands	Thank you for your comment.
			4.4 Outcomes	Outcomes for schools staff should also be measured alongside those of the pupils	Thank your for your comment. Where this is appropriate this will be covered.
			4.5 Key questions	The most cost effective way of implementation is to build on existing practice within schools to increase capacity and avoid duplication	Thank your for your comment.
				Who else in school could deliver the intervention?	Thank you for your comment,

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				This doesn't necessarily have to be a teacher or external specialist	we will amend the scope appropriately.
				How will any unintended outcomes be addressed? What actions might schools need to take	We hope the evidence will highlight solutions to these potential issues.
			General	Healthy schools and SEAL should feature strongly in the guidance in order to compliment existing activity in schools. National targets exist around the roll out of both programmes and as such should be linked to the guidance. The guidance should compliment both programmes to avoid duplication.	Thank you for your comments, we will amend the scope appropriately.
				The guidance should demonstrate it's contribution to ECM	Thank you for your comment.
				The guidance should compliment and consider the roll out the Healthy Schools EHWB Toolkit which is currently being developed	Thank you for your comment.
				Many thanks for the opportunity to comment	Thank you.
South Tyneside PCT		Whole School	General	Guidance on effective school based interventions to improve emotional health and wellbeing will be welcomed in South Tyneside. We have a multi-agency Emotionally Healthy Schools group that will encompass recommendations for practice into future action plans.	Thank you.
			General	Its unfortunate that the research will only be focussing on effective interventions targeted at children and young people, and that the research will not mirror the National Healthy Schools approach of Whole School. I think South Tyneside strongly recognise school staff, particularly under this theme of Emotional Health and Wellbeing, and we will be developing a database to attempt to identify how emotionally healthy our schools are, and this will include data from both pupils and staff where available. Surely one of the most effective interventions will involve promoting staff emotional	Thank you for your comment. Depending upon the evidence, specific elements of guidance may be produced that are applicable to other groups.

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Springfield University Hospital			General	<p>wellbeing?</p> <p>First I believe it is important to recognise the scope that young children - certainly those in Years 5 and 6 - can play in developing and promulgating messages about personal well-being and support for their peers facing difficult times. I hope that due weight is given to children as a resource who can talk about stress, sadness, self esteem, loneliness, bereavement, parental break up etc.</p> <p>Second, to cite WHO there can be no health without mental health. Behind a variety of issues - ranging from abuse and bullying to obesity and truancy - that tend to be treated as isolated problems or problems located within social structures (poverty, poor social environments, lack of cohesive family, etc.) lies a central dimension that can be identified as personal resilience, hardiness, or simply 'character', which is not reducible to structural inequality.</p> <p>Promoting mental well-being is not just about precautionary advice, addressing a list of 'vulnerabilities' arising from the ambient levels of high risk 'behaviours' that contemporary culture determines - such as sexual behaviour, drug misuse, anti-social behaviour etc. - but needs to be directed at supporting and developing personal well-being.</p> <p>Mental health, as much as intellectual skill, may prove the best single predictor of success in work, relationships and civic or social engagement. Ensuring that schools are judged and assessed against such criteria as much as their success in delivering high marks in academic subjects is crucial</p>	Thank you for your comments, this information is gratefully received and will assist us during the development of the guidance.

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				<p>to ensuring that (a) the pastoral role of schools and school teachers is acknowledged and promoted and (b) that MHP is made central to PHSE, which is in its turn assessed formally.</p> <p>The tendency to judge schools on 'whole school indicators' such as 'having an anti bullying policy' should I believe be replaced by measures that reflect the range of individual benefits delivered to children (eg number of looked after children whose scores move from below to within the average range on measures of self esteem or emotional and behavioural problems, over a one or two year period, the number of children who reported having one or no friends at the beginning of each year who had two or more friends by the end of the year, etc.).</p> <p>In short I would like to see such mental health promoting interventions judged by clear criteria that require effortful engagement by schools with the MHP agenda, and not textual practices judged against other textual practices (eg check box - has the school got an anti-bullying policy etc.)</p> <p>I am not sure if these points can be factored into this work stream - there is too little research and too little research support in the UK for evidence based MHP as yet to produce the strong guidelines that are needed. However establishig clear targets that assess changes in children, directly, and not indirect indicators of the milieu are in my view sorely needed to give MHP teeth and avoid the vapid articulation of 'mother's pie' statements (which I and colleagues make all too often!)</p>	

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Tavistock Clinic	 L:\Interventions\ 12-Mental wellbeing c			The attached submission includes material relevant to primary education.	Thank you for this information.
Tavistock and Portman Foundation Trust		Targeted	Section 4	<p><u>Specialist CAMHS in primary schools</u></p> <p>In our view, in thinking about the effectiveness of interventions with particular groups of pupils it is essential to consider the needs of a small but significant group whose difficulties are complex, chronic and severe. These are children and families who may be best served by a Tier 3 multi-disciplinary service, but who are unlikely to access such a service in a CAMHS clinic. In these families there is often a history of non-engagement or truncated engagement with services. These are often the children about whom a primary school is most worried. They are children who may cause considerable disruption in the classroom and playground or who may become excessively withdrawn and unreachable.</p> <p>In our experience, to have a sustained impact in these cases, something more thorough-going than mentoring, after-school clubs or brief counselling is needed. The Tavistock has developed a psychotherapy outreach in primary schools project (TOPS), which bases specialist Tier 3 Child and Adolescent Psychotherapists in 5 primary schools in L.B. Camden. The project is currently funded by the Camden Children's Fund and staffed by the Tavistock clinic. Working in close partnership with the schools, adapting services to local needs and linking up with local services, the project offers:</p> <ul style="list-style-type: none"> • Assessment of individual children • Individual psychotherapy 	Thank you for your comments. This will assist us during the development of the guidance.

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				<ul style="list-style-type: none"> • Group psychotherapy • Family work • Whole class group work • Parent consultation and support • Staff support • Staff training • Consultation to staff • Staff discussion group <p>A report and evaluation of the project, including children's, parents' and teachers' views and setting out financial costs, will be published at the end of April 2007. There will also be a Tavistock conference on 4th May 2007: Promoting emotional health in Camden primary schools: how can psychotherapeutic work help?</p> <p>This is planned to disseminate best practice and to explore a range of primary school-based projects.</p>	
			Section 4	<p><u>The impact of specialist targeted interventions on school culture</u></p> <p>A specialist CAMHS service working within a school can help to support and develop the educational staff's understanding of ordinary emotional development, which must form the basis of any understanding of emotional risk and resilience. A key aim of the Tavistock outreach in primary schools project, shared by the educational staff and the mental health clinicians, is to enable a good enough grasp of child mental health to become integral to school culture. Learning of this fundamental kind is achieved primarily through collaborative work between specialist clinicians and education staff in relation to individual complex cases. It is through the opportunity to think together rigorously and creatively</p>	Thank you for your comment. Depending upon the evidence, specific elements of guidance may be produced that are applicable to other groups.

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				<p>about the actual children in their care that real learning takes place. This is a very different kind of learning than that achieved through most in-school training courses.</p> <p>For example: a Year 6 boy from a refugee background was referred to the specialist CAMHS service in his LB Camden primary school because of concern about his escalating aggressive outbursts in the classroom and playground, his inability to manage ordinary communication with peers and adults and his difficulties with learning. He was on the verge of being excluded and there was worry about how he would manage the impending transition to secondary school. The specialist CAMHS service undertook an assessment, which involved working closely with his class teacher, a teaching assistant, the SENCO and Inclusion Manager. An interpreter was also involved as mother was not confident in English; mother was a single parent and there was a history of non-engagement with the school and other services. As well as sessions with the mother and son, a key part of the assessment process, within confidentiality boundaries, was thinking together with the school to try and understand the family's complex circumstances and the possible impact of this, among other factors, on the boy's emotional development and subsequently on his capacity to make use of learning opportunities in school. School staff are well placed to notice when something might be the matter with a child; their observations, together with a specialised child mental health approach to making sense of what has been observed, affords a unique opportunity to pick up</p>	

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				and address children's difficulties. In addition to offering ongoing psychotherapy for the child in the school, supported by regular sessions for his mother, this case provided a learning opportunity for staff in the school at all levels. This kind of learning is based on developing the school staff's own emotional understanding from their own experience, with the support of specialised child mental health clinicians.	
				The specialist CAMHS clinicians also offer consultation and training in primary schools, which can provide a valuable broad introduction and serve to build multi-disciplinary collaboration. The development of specialised child mental health consultation and training for educational staff is detailed in comments submitted by Emil Jackson for the Association of Child Psychotherapists in relation to the whole school approach.	
			Section 4	<u>The impact of specialist targeted interventions on community culture</u> The presence of a specialist CAMHS service within a school not only increases access to services for local families but also impacts on the perception of child mental health services in the wider local community. It helps to reduce anxieties about stigma and blame and promotes the idea that help with complex emotional difficulties can be an ordinary part of school and community life.	Thank you for your comment. Where the evidence allows this may be pursued.
			Section 4	<u>The impact of specialist targeted interventions on health inequalities</u> The five schools in which the Tavistock outreach project is based are in areas of long-term deprivation and disadvantage. A significant proportion of the	Those children with learning difficulties who are in school and between the ages of 4 and 11 are included in this guidance.

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				school populations are from refugee backgrounds or families where English is the second language. Having specialist CAMHS clinicians working within the schools is an effective way of addressing some of the health inequalities linked to access to services and distribution of resources.	
Young Minds – Carly Raby			4	It was good to hear of such a strong commitment from Jane Cowl to including children and young people in the shaping of this guidance. If we can be of specific assistance in this area please let me know so we can work in partnership.	Thank you.