

Mental Wellbeing of Children Public Health Intervention Guidance

Report

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MANAGEMENT SUMMARY

1. Background and objectives

The Department of Health (DH) asked The Centre for Public Health Excellence (CPHE) at NICE to develop guidance on school-based interventions aimed at promoting good mental health among children aged 11 years and under. The aim of the guidance is to provide recommendations for good practice, based on the best available evidence of effectiveness, including cost-effectiveness. It is aimed at teachers, schools support staff and school governors. It is also aimed at others working with and responsible for children and young people. This includes professionals within the NHS, local authorities and the wider public, private, voluntary, and community sectors.

Fieldwork was commissioned to examine relevance, utility and practicality of draft statements (before publication, as recommendations in the draft guidance for consultation). The main research questions were as follows:

- What are the views of those working in the field on the relevance and usefulness of these statements to their current work or practice?
- What impact might the statements have on current policy, service provision, or practice?
- What factors (eg, time available, training) could have an impact – positively or negatively – on the implementation and delivery of the guidance?
- Do practitioners know of any evidence – from their own experience and practice or elsewhere – not currently taken into account by the statements?

2. Our approach

We adopted a qualitative approach to the fieldwork. The findings below are based on fieldwork with 91 professionals and parents across 35 fieldwork units. The sample achieved is detailed in the table below.

Type of participants	London	Newcastle	Liverpool	Total
Primary school head teachers	5 x depth interviews	1 x group of 4 2 x depth interviews		n=11
Primary school teachers with responsibility for pastoral care, PSHE, SEAL, or Healthy Schools	1 x group of 4	1 x group of 4 1 x depth interview		n=9
Support and clinical staff (including educational and clinical psychologists, nurses, social workers, and speech therapists)	1 x trio, 1 x depth interview (clinical psychologists) 2 x depth interviews (educational psychologists) 1 x group of 5 (school nurses) 1 x paired depth social workers	1 x paired depth (speech therapists)		n=15
PCT and LEA staff (including local authority directors of children's services, policy staff from local authorities, PCTs, and CAMHS.	2 x depth interviews (Healthy Schools coordinators) 2 x depth interviews (Heads of Psychology Services) 1 x depth interview (Head of Behaviour Support Services) 1 x depth interview (Director of Children's Services)	1 x group of 6 (a mix of PCT, local authority, and CAMHS policy lead) 1 x depth interview (policy staff) 1 x depth interview (Healthy Schools coordinator) 1 x group of 6 (school nurses)		n=20
School governors	2 x depth interviews 1 x group of 6	1 x group of 4		n=12
Parents of children with emotional and behaviour issues	1 x group of 9 (all attending parenting classes)	1 x group of 7 parents (none had attended parenting classes)	1 x group of 8 (2 x attended parenting classes)	n=24
Total	n=45	n=38	n=8	n=91

3. Summary of main findings

3.1 Overall perceptions of the draft statements

- All participants think the mental wellbeing of primary school children is important, and all want the children for whom they are responsible to enjoy good mental wellbeing; they recognise that mental wellbeing affects how well a child does in life.
- Professionals, governors, and parents acknowledge that the performance of a school and the mental wellbeing of its pupils are inextricably linked.
- All recognise that a variety of factors can influence mental wellbeing, including peer relations, home environment, relationships with and between family members, other life experiences (eg, bereavement), abuse (eg, mental, physical or sexual), and transition to secondary school.

- Primary school professionals acknowledge that they can directly influence a range of these factors at school (eg, improving peer relations) and can help to tackle issues that take place outside of school (eg, within the home environment) by notifying the relevant authorities, for example.
- Primary school professionals say they have better systems in place for tackling bullying and disruptive behaviour in the classroom than identifying and supporting pupils who are anxious or depressed.
- Primary school professionals would like to act proactively to prevent their pupils from experiencing poor mental wellbeing, but admit they tend to intervene reactively after a problem has occurred.
- Some primary schools have good access to specialist support, including clinical psychologists, educational psychologists, school nurses, social workers, counsellors, and therapists working in either the NHS, local authority teams, Child and Adolescent Mental Health Services (CAMHS), and the voluntary sector; others express concerns about how long their pupils have to wait to gain access to such specialist support once an issue has been identified (eg, up to six months).
- Some schools have achieved the Healthy Schools Standard, are well on the way to implementing the SEAL programme, and have appointed pastoral care leads, while others say they are only just starting to look at such measures
- Primary school professionals and parents admit that they can be reluctant to acknowledge when a child has problems with its mental wellbeing, because they fear the reactions of the pupil's parents or carers; primary school professionals might also have concerns about labelling a child inappropriately.
- Parents and professionals from black and minority ethnic backgrounds are concerned about cultural difference being interpreted as a mental wellbeing issue.
- Having read the statements, many parents and professionals suggested that promoting mental wellbeing should be a regulatory requirement and part of any OFSTED inspection to make sure schools comply.

3.2 Overall perceptions of NICE involvement in this area

- The draft statements are positively received and are thought to have the potential to add value to primary school policy and process; all welcome evidence-based guidance to help them do their best.
- All participants think NICE is well qualified to make recommendations on health issues (including mental wellbeing); they know NICE publishes guidance on a range of issues, in particular, pharmaceutical products.
- Many primary school professionals think promoting mental wellbeing should be included in a school's development plan and would like to see it become part of the OFSTED regulatory assessment.

- Many primary school professionals want the final guidance to be co-branded with an educational institution (eg, Department for Children, Schools and Families; OFSTED, etc) to make sure primary school professionals take notice of the recommendations.

3.3 Response to Statement 1

- All consider Statement 1 relevant, appropriately targeted, and easy to understand.
- Those involved in developing the local Children and Young People's Plan say that their plan acknowledges the importance of mental wellbeing, but do not think it complies with the proposed NICE CPHE statements; as such, they think the statement provides outlines of what they need to include in future versions of the plan.
- All professionals understand that primary schools will be expected to have a comprehensive programme; several professionals thought the statement could be more prescriptive about precisely what NICE wants schools to do (eg, schools who had achieved the Healthy Schools Standard and were working to wards the implementation of SEAL wanted to know if they would comply with the statements once these programmes were in place.
- Primary school staff and PCT Healthy Schools/PSHE coordinators recognise the importance of school ethos to ensuring any such initiative is implemented.
- Parents and professionals alike welcome the acknowledgement of the need to provide support for pupils, parents, and teachers; however, when asked, we found large variations in the ability of each school to engage parents (especially the parents of children at risk of poor mental wellbeing).
- Parents and professionals welcome the emphasis on early intervention.
- All welcome the emphasis on training for staff, but head teachers whose schools have not yet implemented Healthy Schools or SEAL in full often say that they would need extra resources to deliver this; consequently, they are not always confident that the statements here are feasible.

3.4 Response to Statement 2

- All think Statement 2 is relevant, appropriately targeted, and easy to understand.
- All welcome the clarification about what a comprehensive programme to promote mental wellbeing should include.
- All welcome explicit references to both emotional and social wellbeing; parents and professionals are generally clear on what both of these terms mean.
- All are surprised that the topic should only be covered for *at least two years*, and suggested it should be integrated all the way through primary school life.

- Parents currently attending parenting courses to help them tackle their child's behaviour problems welcome the emphasis on managing behaviour and improving pupil-teacher relationships, because they think the teachers' lack of such skills had resulted in their child being labelled "a problem".
- Most professionals, governors, and parents welcome the emphasis on training and development; teachers say they would welcome access to formal "supervision" to help them build skills to tackle difficult and challenging behaviour in the classroom, and several professionals and parents believe that promoting the mental wellbeing of staff is essential to making sure the mental wellbeing of pupils is assured.
- However, head teachers from schools who have not implemented programmes like Healthy Schools or SEAL are often unsure whether they would have sufficient resources to provide such training and support; consequently, they question the feasibility and usefulness of this statement.
- Many primary school professionals think that government policy should change and place greater emphasis on promoting emotional wellbeing.
- All participants think parenting and carer skill courses should be readily available, but acknowledges that it could be difficult to get parents to attend such courses; head teachers whose schools have not implemented programmes like Healthy Schools or SEAL question whether they have the resources to provide such support.
- All agreed that activities should be integrated throughout primary school life (both curriculum and non-curriculum activities).
- Professionals involved in implementing SEAL and the Healthy Schools Standard wanted to know if their school would comply with these statements if it implemented these programmes in part or fully.
- Parents think schools should do more to tell parents:
 - What systems and processes they have in place for promoting mental wellbeing, preventing poor mental wellbeing, and identifying, assessing, and intervening to protect children at risk of poor mental wellbeing.
 - How to gain access to further information, advice, and support to help them to promote the mental wellbeing of their child/children.

3.5 Response to Statement 3

- All think Statement 3 is relevant, appropriately targeted, and easy to understand
- Several professionals from various backgrounds suggested that the target population should place greater emphasis on preventive measures, eg, to focus on those *at risk* of anxiety and depression, rather than those *experiencing anxiety or the early signs of depression*.
- All agree that staff should be appropriately trained to identify anxiety and depression; governors and head teachers wanted specific references to accredited training courses to which they should refer staff.
- Primary school professionals agree they should identify children about whom they had concerns, but are less confident about assessing them and diagnosing the problem; they think this was the role of specialist support services.
- Professionals think the Common Assessment Framework (CAF) provides a useful framework for intervening appropriately once a problem is identified, but want to know if there is a specific framework for identifying children at risk of poor mental wellbeing.
- Primary school professionals want more guidance on how to engage parents.
- Many professional from various backgrounds questioned why only cognitive behaviour therapy was referenced here, and not other interventions.
- Many professionals from various backgrounds queried why only group sessions were referenced for both children and parents, and not one-to-one support and family therapy.
- Many professionals from various backgrounds queried the timescales outlined (ie, *an hour a week for at least 8 weeks and up to 6 months*, rather than as long as is needed).
- Several primary school professionals and other professional groups want to see a longer list of risk factors or early indicators identified.
- Several parents from disadvantaged backgrounds, and the professionals who work with them, expressed concerns about singling out parents from disadvantaged backgrounds in this way, because they consider this judgmental.
- Several parents and professionals from black and minority ethnic groups also stressed the need for systems and processes to be culturally sensitive, and that they should not be prejudiced towards children from black and minority ethnic backgrounds.
- Many professionals thought maximum waiting times should be specified to assure effective access to specialist support services.
- Many professionals from various backgrounds want explicit references to the evidence base here to substantiate the details raised in relation to how to intervene.

- Head teachers and governors were concerned about the resource implications of ensuring effective delivery of the services outlined in the statement, within their school and within available funds.

3.6 Response to Statement 4

- All welcome Statement 4, considered it relevant, appropriately targeted, clear and easy to understand.
- All welcome the emphasis on children at risk of developing aggressive or other disruptive behaviour.
- Several primary school professionals questioned why the target population is children aged four to seven, rather than children of any primary school age.
- Primary school professionals are confident about identifying pupils at risk, but they think specialist support services should assess and diagnose the problem.
- Parents from disadvantaged backgrounds, and the professionals who work with them, think it is judgemental to say *children at risk are likely to be living in disadvantaged circumstances*.
- Several professionals from each of the professional groups included in the sample suggested that a longer list of risk factors could be included.
- Professionals thought the Common Assessment Framework (CAF) provides a useful way of structuring interventions, but asked whether there was a specific way of assessing children at risk of violent and aggressive behaviour.
- All want more guidance on how to engage the parents of children at risk.
- All recognise the need to use proven techniques like cognitive behavioural therapy, but queried why only this method was cited here.
- Many professionals from various backgrounds queried:
 - Why only group sessions are referenced for both children and parents, and not one-to-one support and family therapy.
 - The timescales outlined (ie, why *an hour a week for at least 6 months and up to 2 years*, rather than as long as is needed).
 - Why booster sessions were only suggested for children aged ten and eleven, neglecting the possibility of violent and aggressive behaviour reoccurring before then (eg, at age eight or nine).
- Several parents and professionals from black and minority ethnic backgrounds also stressed the need for systems and processes to be culturally sensitive and that they should not be prejudiced towards children from black and minority ethnic backgrounds.
- Many wanted explicit references to the evidence base here to substantiate the details raised in relation to how to intervene.

- Head teachers and governors from schools who had not yet fully implemented the Healthy Schools programme or SEAL were concerned about the resource implications of ensuring effective delivery of the services outlined in the statement within their school.

A. INTRODUCTION

This report presents the findings of fieldwork commissioned by Centre for Public Health Excellence (CPHE) at the National Institute for Clinical Excellence (NICE) to test draft statements in advance of the publication of draft guidance and recommendations on promoting the mental wellbeing of children (of primary school age).

The Department of Health has asked the Centre for Public Health Excellence (CPHE) at the National Institute for Clinical Excellence (NICE) to: *Prepare guidance for schools on the promotion of good mental health in children.*

Mental wellbeing has important consequences for social and educational attainment both at primary school age and beyond. There is limited national data on how to promote mental wellbeing among children of primary school age. However, evidence suggests that around one in 10 children under 11 years of age have been diagnosed with a mental disorder. Boys are more likely than girls to be diagnosed with a mental disorder. Children from disadvantaged households, looked after children, and children from some black and minority ethnic backgrounds (eg, Pakistani and Bangladeshi) are more likely to be diagnosed with a mental disorder¹.

Against this backdrop, two scopes were prepared for the guidance on different, yet associated, aspects of the subject area:

- **Targeted activities:** that focus on particular types of behaviour, particular groups of pupils (eg, children at particular risk), and factors likely to lead to poor mental health or mental disorders; they can include:
 - Programmes to help children make the transition from primary to secondary school
 - Lessons taught as part of the curriculum
 - Changes in school ethos and the environment
 - Activities involving the family and/or community
 - Specialist in-house services
 - Health, social, or specialist community services
- **Whole school approaches:** which can encompass how to use school policies, systems, and structures to create an ethos and an environment that promotes mental wellbeing, for example:
 - Physical environment

¹ The summary of evidence is drawn from the final scope for the draft guidance and is based on the findings of *The Health of Children and Young People*, ONS, 2004.

- Links with parents and the community
- The management, development and support of teachers
- Curriculum-based programmes and other activities aimed at developing the social and emotional competence of all students (eg, helping them to develop conflict management and problem solving skills).

The final guidance will focus on children of primary school age (four to eleven) and will include pupils both attending and excluded from school:

- State sector maintained schools and independent schools
- Special education environments

The final guidance will be primarily for public health commissioners, policy makers, professionals, and practitioners who work with, or are responsible for, children and young people in the primary school setting.

The final guidance will cover interventions that seek to promote:

- Emotional wellbeing (including happiness and confidence)
- Psychological wellbeing (including autonomy, problem solving, resilience, attentiveness/involvement)
- Social wellbeing (good relationships with others, not delinquency, interpersonal violence and bullying).

B. OBJECTIVES

NICE CPHE commissioned Dr Foster Intelligence to conduct fieldwork to test the draft statements in advance of the publication of draft guidance and recommendations to obtain robust feedback from diverse professionals who work with children of primary school age, primary school governors, and parents of children with emotional and behavioural issues (including parents who have attended parenting courses).

The stated objectives were as follows:

- To examine the relevance, utility, and practicality of the statements with:
 - Teachers
 - School support staff
 - School governors
 - Professionals with a public health remit working within the NHS
 - Local authorities
 - School and children's advisory services
 - The wider public
 - Private, voluntary, and community sectors and others working with, or responsible for, children and young people, with particular reference to children and young people in primary school
- The main research questions were as follows:
 - What are the views of those working in the field on the relevance and usefulness of these statements to their current work or practice?
 - What impact might the statements have on current policy, service provision, or practice?
 - What factors (eg, time available, training) could have an impact – positively or negatively – on the implementation and delivery of the guidance?
 - Do practitioners know of any evidence – from their own experience and practice or elsewhere – not currently taken into account by the statements?

C. OUR APPROACH

1. A qualitative approach

A qualitative methodology was adopted for the study. The nature of qualitative enquiry enabled us to scope out in depth and detail the responses across audiences to the main research questions. This helped us to understand what people thought of the guidance, and why they held particular views. It enabled us to ensure that participants were clear about the role of the CPHE and the status of the guidance and its recommendations. It also enabled us to check comprehension of the statements themselves (in consultation with CPHE team observers), and consider their detail, complexity, and implications thoroughly.

2. Groups and depth interviews

The findings reported below are based on a series of group discussions and depth interviews. Group interaction enables participants to trade views and experience, and to formulate more informed viewpoints in the process. It enables us to explore current policy and practice, and responses to the draft statements and their proposed implementation. It also enables participants to work more creatively, and to develop solutions to any issues identified.

Group discussions involved between 3–9 participants and lasted for up to 90 minutes. Groups were made up of homogenous participants (eg, in the professional grouping terms of role and responsibilities) to ensure that a group dynamic developed effectively. This also allowed us to segment the sample (eg, by professional group) to ensure sufficient coverage.

Some busy professionals can find it difficult to attend a group discussion at a fixed venue and time. Therefore, we also conducted a number of depth interviews. Depth interviews can be arranged at a time and location convenient to the individual participant. They also give participants an absolute guarantee of confidentiality. Consequently, they can encourage professionals to be more candid about current practice, issues, and challenges within their organisation (ie, to say things they may be reluctant to express in a group of their peers).

Fieldwork was conducted in advance of the consultation period on the draft NICE CPHE guidance and recommendation. Because the draft statements were not in the public domain at the time of the fieldwork, all participants were asked to sign a confidentiality agreement.

Where possible, CPHE team members observed fieldwork sessions to hear participants' views first hand. Fieldwork was conducted using agreed discussion guides (see appendix 3).

3. Recruitment

Participants were recruited using an agreed recruitment questionnaire (see appendix 2). All recruitment was managed in-house to ensure quality standards. We identified a list of potential participants, wrote to them (see appendix 1), then followed up by

telephone to see if each person was available for the group, fitted our criteria, and was willing to attend. Group discussions were conducted at a fixed venue and time. Depth interviews were usually held at participants' place of work at a time convenient to them.

4. Sample achieved

The findings below are based on fieldwork with 91 professionals and parents across 35 fieldwork units. Fieldwork included staff from state and independent schools. The table below gives a breakdown of the fieldwork conducted.

Type of participants	London	Newcastle	Liverpool	Total
Primary school head teachers	5 x depth interviews	1 x group of 4 2 x depth interviews		n=11
Primary school teachers with responsibility for pastoral care, PSHE, SEAL, or Healthy Schools	1 x group of 4	1 x group of 4 1 x depth interview		n=9
Support and clinical staff (including educational and clinical psychologists, nurses, social workers, and speech therapists)	1 x trio, 1 x depth interview (clinical psychologists) 2 x depth interviews (educational psychologists) 1 x group of 5 (school nurses) 1 x paired depth social workers	1 x paired depth (speech therapists)		n=15
PCT and LEA staff (including local authority directors of children's services, policy staff from local authorities, PCTs, and CAMHS.	2 x depth interviews (Healthy Schools coordinators) 2 x depth interviews (Heads of Psychology Services) 1 x depth interview (Head of Behaviour Support Services) 1 x depth interview (Director of Children's Services)	1 x group of 6 (a mix of PCT, local authority and CAMHS policy lead) 1 x depth interview (policy staff) 1 x depth interview (Healthy Schools coordinator) 1 x group of 6 (school nurses)		n=20
School governors	2 x depth interviews 1 x group of 6	1 x group of 4		n=12
Parents of children with emotional and behaviour issues	1 x group of 9 (all attending parenting classes)	1 x group of 7 parents (none had attended parenting classes)	1 x group of 8 (2 x attended parenting classes)	n=24
Total	n=45	n=38	n=8	n=91

5. Analysing the response

All fieldwork was tape-recorded and transcribed verbatim. Researchers also took notes in case of any difficulties with recordings. We used grid analysis to analyse the response (a technique developed by the National Centre for Social Research). Grid analysis allows the research team to assemble a large amount of qualitative data in an easily digestible way, without compromising the overall structure of the original transcript.

Each respondent is allotted a row within the grid. Each column is used to explore a specific theme. Themes are usually grouped by the overall study objectives to enable us to make sure we deliver against the original scope. Respondents are usually grouped by type to enable us to identify convergent and divergent views both within and between sample groupings. Data from each transcript (or respondent) is entered into the grid cell according to the overarching theme. We summarise the range of views at the bottom of each column and the frequency with which each is expressed to give a feel for the weight of a specific opinion.

We would only generalise about the response when we have 12 or more participants per sample cell. Below this, we consider findings to be indicative.

Two researchers analyse the grids once they are assembled. Where any different interpretation of the response emerges, a third researcher adjudicates. This helps to ensure valid interpretation of the data.

Throughout the report we refer to staff from different sectors collectively. For example, we refer to head teachers, teachers, and governors as primary school professionals.

Verbatim quotes are selected from the transcripts to illustrate the findings. They are anonymised to ensure confidentiality.

D. MAIN FINDINGS

1. Overall perceptions of the draft statements

- All participants think the mental wellbeing of primary school children is important.
 - All primary school professionals have direct experience of children with poor mental wellbeing.
 - Parents acknowledge that their children have mental wellbeing issues and need appropriate support.
 - Many parents and professionals from different backgrounds acknowledge recent media coverage of mental wellbeing issues among primary school children.

“If we don’t get the mental health of our children and young adults right, what kind of society are we going to be living in?”

Depth interview, Head Teacher, state primary school, Newcastle

- All want the children for whom they are responsible to enjoy good mental wellbeing (in terms of emotional, psychological, and social wellbeing) and say they want to do everything they can to promote mental wellbeing and prevent any harm to social and emotional wellbeing.
- All participants recognise that mental wellbeing affects how well a child does in life (in terms of academic achievements, future employment, personal relationships, health, etc).
- Professionals, governors, and parents acknowledge that the performance of a school and the mental wellbeing of its pupils are inextricably linked; consequently, they think schools have a clear incentive to promote and protect the mental wellbeing of their pupils.

“...if there were an emotional literacy thermometer that you could measure emotional wellbeing, then [academic] results and all that would rise anyway...”

Group discussion, Head Teachers, London

“Well, if they’re not emotionally stable, their work will deteriorate, so they’ll not perform well enough in class if they’re upset about things”

Group discussion, Parents, Liverpool

- All recognise that a variety of factors can influence mental wellbeing, including:
 - Peer relations (eg, feeling bullied by other pupils or staff is cited as causing anxiety and depression at school, including experiences of racism among black and minority ethnic pupils).
 - Home environment (eg, in terms of overcrowding, access to social goods, mental health of parents, substance abuse within the home).

- Relationships with and between family members (including experience of separation, divorce, domestic violence, caring for siblings and parents, etc).
- Other life experiences (eg, bereavement can cause anxiety and depression, experience of war or genocide among refugee children, etc).
- Different types of abuse (mental, physical or sexual).
- Transition to secondary school as a potential risk factor.
- Primary school professionals acknowledge that they can directly influence a range of these factors at school (eg, improving peer relations, managing the transition to secondary schools, support children in difficult circumstances); they acknowledge that they should identify and tackle issues that take place outside of school (eg, within the home environment), including notifying the relevant authorities about any concerns they have about a child's welfare.

"...there's a lot of issues there [affecting children's mental wellbeing], and I think a lot of it's background and where they're coming from and disadvantages at home; society...it's much wider [than what goes on in school] because it's third generation unemployment on this estate in some areas...I think there's a massive need out in the community and it isn't about school"

Depth interview, Head Teacher, state primary school, Newcastle

"I welcome this paper, and I think we should be looking at these things in school. But I think we should also be looking at root causes into these problems, busy parents, dysfunctional families, hardship or whatever...because school cannot be the place always where children and young people are sorted out"

Group discussion, Head Teachers, Newcastle

- Primary school professionals say they have systems in place for identifying and intervening, to promote and protect the mental wellbeing of their pupils.
 - All say they have clear policies for tackling bullying and disruptive behaviour in the classroom; primary school professionals are clear about what is expected of them and what they have to do if they have concerns about a child's behaviour.
 - When asked, many admit they do not have an agreed policy or process for identifying and supporting pupils who are anxious or depressed; primary school professionals are notably less confident about how best to respond if a pupil is having emotional difficulties.
- Primary schools operate in different contexts; some have good access to specialist support services, including clinical psychologists, educational psychologists, school nurses, social workers, counsellors, and therapists working in either the NHS, local authority teams, Child and Adolescent Mental Health Services (CAMHS), and the voluntary sector. Others express concerns about how long their pupils have to wait to gain access to such specialist support once an issue has been identified (eg, up to six months in some instances).

- Primary schools have different starting points in relation to the mental wellbeing of their pupils, for example:
 - Some schools have achieved the Healthy Schools Standard, are well on the way to implementing the SEAL programme, and have appointed pastoral care leads.
 - A member of the management team has usually led the implementation process, with the support of a nominated coordinator.
 - They use a range of techniques to build emotional and social skills across the school curriculum and throughout school life (eg, playground buddy schemes, and circle time techniques).
 - Professionals responsible for implementing SEAL and/or Health Schools Programmes stress how complex these programmes are and how much time and effort it takes to implement them, including training staff across the school to implement the programmes effectively; however, they acknowledge the positive impact these measures have on the school and its pupils.
 - Others say they are only just starting to look at the Healthy Schools Standard and/or SEAL:
 - Staff from these schools are more likely to have concerns about building emotional and social skills development into the curriculum due to the pressure to teach academic subjects.
 - Professionals from these schools looking into Health Schools Standards and/or SEAL often express concerns about the resource implications associated with implementing such complex programmes.
- Although primary school professionals say they would like to act proactively to prevent their pupils from experiencing poor mental wellbeing, many say they do not know how to do this and admit they tend to intervene reactively after a problem has occurred.
 - Governors and head teachers often think that very clear directives need to be given to make sure preventive action is taken.

“I think it’s...very difficult for schools because schools are principally... educational institutions and I think often teachers are a bit unsure and a bit unwilling to make judgements about children’s emotional wellbeing. So I think they need quite a lot of support and reassurance and training to give them the confidence to be identifying needs”

Depth interview, Child Psychologist, London
- Primary school professionals and parents admit that they can be reluctant to acknowledge that a child has problems with their mental wellbeing.
 - Primary school professionals can have concerns about intervening until they are sure a pupil has a problem, because they fear the reaction of the pupil’s parents or carers:

- Several teachers say they have encountered conflict with a pupil's parents when they have raised concerns about their behaviour or emotional wellbeing.
- Several of the parents who were attending parent courses reported being angry with teaching staff who raised concerns about their child, because they felt the school was judging both them and their child; however, they were generally grateful for the help and support they received subsequently from the parenting class.
- Primary school professionals can have concerns about labelling a child inappropriately.
- Parents and professionals from black and minority ethnic backgrounds were concerned about cultural differences being interpreted as a mental wellbeing issue.
- Primary school professionals can have concerns about the impact on the their organisation's reputation if lots of children within their care are reported as having poor mental wellbeing, but recognise that it is likely to reflect favourably on the school if they actively seek to promote good mental wellbeing and prevent poor emotional and social wellbeing.

2. Overall perceptions of NICE involvement in this area

- Against this backdrop, the draft statements are positively received and are thought to have the potential to add value to primary school policy and processes by clarifying what is expected of them in terms of promoting mental wellbeing.
- All participants want to make sure what they do works; consequently, all welcome evidence-based guidance to help them do their best.
- All participants think NICE is well qualified to make recommendations on health issues (including mental wellbeing).
 - They know NICE publishes guidance on a range of issues, particularly pharmaceutical products.
 - They know it considers available evidence in reaching its decisions.
- Many primary school professionals think promoting mental wellbeing should be included in a school's development plan and would like to see it become part of the OFSTED regulatory assessment.
- However, several professionals have concerns that primary school professionals may miss the final guidance because they come from an organisation that is generally associated with healthcare issues; in response, they suggest that the final guidance should be:
 - Co-branded with an educational institution (eg, Department for Children, Schools and Families, OFSTED, etc).

- Linked to other guidance and policies in this area so that it is used in conjunction, not instead of other programmes and policies.

"I think they'll have heard in the news, NICE with drugs and all that type of thing. I think most informed people would have but I don't think they know on the ground level, I don't think they have knowledge of NICE....It would have to come out through somebody else [as well]...Usually it's the Department for Children, Schools and Families. When they produce things they recognise it as their body."

Depth interview, PCT Healthy Schools Coordinator, Newcastle

3. Response to Statement 1

Statement 1

Who is the target population?

Professionals working with children in primary schools.

Who should take action?

Commissioners and providers of services to children in primary schools including: those working in children's trusts, local authority education services, schools, primary care trusts (PCTs), and child and adolescent mental health services.

What action should they take?

- Develop and agree arrangements, as part of the "Children and Young People's Plan" and as part of joint commissioning activities, to ensure primary schools promote the emotional and social wellbeing of children. All primary schools should provide a comprehensive programme which:
 - Is based on a "whole school" approach that promotes an ethos of positive behaviour and effective relationships. It should include support for all pupils and parents. It should also include specific help for those children most at risk (or already showing signs) of emotional and behavioural problems and their parents.
 - Is offered as part of the school's policies for attaining the National Healthy Schools Standard and reaching the Outcome Framework targets.¹
 - Includes training and support for teachers and non-teaching staff. Training should be provided by qualified professionals. They may be working in Healthy Schools teams, community nursing or specialist educational, family support and mental health services (levels 1 and 2), and in the voluntary or private sectors.
- Put in place the necessary coordinating mechanisms and resources to ensure primary schools have access to the skills, advice, and support they need to deliver a comprehensive programme (see statements 2–4).

- All welcome Statement 1; they think the language used is easy to read and understand; they think it is appropriately targeted.
- All think the target population is clear.
- All think the statement is relevant because they think the mental wellbeing of primary school children is important and that everyone has a responsibility to promote and protect the mental wellbeing of children and young people.

"I think it's very relevant because I think particularly within our team, community psychologists, we're interested in addressing [issues of mental wellbeing] at an early stage and more preventative work and I think there are... moves towards the kind of model which is having clinical psychologists going into children's centres and schools more than formerly, so I can see a...fit between the aspiration of this and...what this service is beginning to do"

Depth interview, Child Psychologist, London

"I think it's quite good in that teachers in teaching training, it's important to get them to recognise the emotional side and not solely be driven by SATS and everything else. I think teachers sometimes lose sight of other needs that children have"

Group discussion, School Health Adviser, Newcastle

- Those involved in developing the local Children and Young People's Plan say that their plan acknowledges the importance of mental wellbeing, but do not think it complies with the proposed NICE CPHE statements:
 - As such, they think it provides a useful checklist outlining what they need to include in future versions of the plan.
 - Levels of awareness of the plan among other professionals varies.

"The Children & Young People's Plan...that's the overriding and then there are priorities that come through for primary schools and we're part of those priorities and they make priorities that are specific to our localities. We've just been brought into localities and then obviously we'll have training feeding into that"

Depth interview, Head Teacher, state primary school, Newcastle

"Never heard of [the Children & Young People's Plan]. I think because we're an independent school we don't tend to get caught up with the net of that"

Depth interview, Head Teacher, independent primary school, London

"[Mental wellbeing is] not directly in the Children & Young People's plan, so our Children & Young People's plan has been really streamlined. So in there in terms of schools, there is work around attendance, enabling the children to attend school and...when you pull that down to 'so how do we do that?' then it's aspects around emotional wellbeing, to make sure you're happy and healthy in school..."

Depth interview, PCT Healthy Schools & PSHE Coordinator, London

- All professionals say they are clear that primary schools will be expected to have a comprehensive programme and cannot be selective about which aspects of the guidance they adopt.
 - However, several professionals also thought the statement could be more prescriptive about precisely what NICE wants schools to do to make sure schools are not selective about the elements they include (eg, including more detail on the Healthy Schools Standard and Outcomes Framework).
 - They thought schools were selective in their approach at present.
 - Many parents and professionals suggest that this should be a regulatory requirement and part of any OFSTED inspection to make sure schools comply.

- Many schools say they have a “whole school” approach, but we found some variations in how schools interpreted the meaning of “whole school”.
 - Some perceived this as meaning it should be integrated into the curriculum only.
 - Others thought it meant that it should be engrained throughout the fabric of the school (including both the core curriculum and other school-based activities, like assemblies, break times, etc).
- Primary school staff and PCT Healthy Schools/PSHE coordinators recognise the importance of school ethos to ensuring any such initiative is taken seriously and acted upon.

“You see, it’s not just about a programme, it’s about creating policy and creating an ethos and environment”

Depth interview, PCT Healthy Schools Coordinator, London

- Parents and professionals alike welcome the acknowledgement of the need to provide support for pupils, parents, and teachers; however, when asked, we found large variations in the ability of each school to engage parents (especially the parents of children at risk of poor mental wellbeing).
- Parents and professionals welcome the emphasis on early intervention (ie, help for those most *at risk*).
- Many professionals think this information is covered in other policy documents (Healthy Schools Programme, SEAL, etc), but that it is useful to be included here as part of a comprehensive summary of what is expected in relation to promoting the mental wellbeing of primary school children.
- Several primary school professionals would like clearer direction here about exactly what NICE CPHE is asking them to do (eg, including specific details about what schools have to do to achieve the National Healthy Schools Standard and Outcome Framework targets).
 - Schools that had achieved the Healthy Schools Standard and were working towards the implementation of SEAL wanted to know if they would comply with the statements once these programmes were in place.
- All welcome the emphasis on training for staff:
 - Many pastoral care coordinators say they have received no training for their role; they would like formal training to make sure they do the right things.
 - Head teachers often say they would need extra resources to deliver this (eg, to pay for training, to cover staff while attending training, to hold inset days on the topic, etc)
 - They are not clear where extra resources would come from to enable them to deliver such extensive support.
 - Consequently, they are not always confident that the statements here are feasible.

"I do actually think that this is a major problem: I think that the way the whole thing about schools now, the league tables, the curriculum, OFSTED, all of that is I think one of the major things that goes against us. I really do, because schools are judged against their results. OFSTED come in and assess you as a school and they're not assessing this [promoting mental wellbeing of children]"

Group discussion, Head Teachers, London

"It's like utopia, isn't it, really?"

Group discussion, School Health Advisers, Newcastle

4. Response to Statement 2

Statement 2

Who is the target population?

Children in primary schools (aged 4–11 years), their parents/carers, and teachers.

Who should take action?

Teachers and non-teaching staff working with children in primary schools. Those working in, and with, local authority education services (including Healthy Schools teams), primary care (such as school nurses), and child and adolescent mental health services (levels 1 and 2).

What action should they take?

Provide a comprehensive programme to promote children's emotional and social wellbeing. This should include:

- A curriculum on emotional and social development (covering the development of “emotional literacy”, problem solving, coping, conflict management, and other skills). This should be provided over a period of at least 2 years by appropriately trained teachers and non-teaching staff.
- Training and development for teachers and non-teaching staff to deliver the curriculum, including how to manage behaviour and improve child-teacher relationships. Ongoing supervision and support should be provided to develop these skills.
- Help to develop parents'/carers' parenting skills (this may involve providing information or small, group-based training sessions run by community nurses (such as school nurses and health visitors) or other appropriately trained practitioners.
- Integrated activities to promote emotional and social wellbeing within all areas of school life. For example, classroom-based teaching should be reinforced in assemblies, homework, and play periods (in class as well as in the playground).

- All welcome Statement 2:
 - They think it is easy to read and understand, and think it is appropriately targeted.
 - They also think it is clear who should take action.
 - Many professionals agree the statements are relevant to them, though the findings suggest that those working in independent schools think the statements target state schools and not them.

“[The statements are]...probably not that relevant really. I think we’re probably too small. We don’t have enough problems that would warrant any wider issues, really...In some schools I’m sure it would be very useful. But it’s horses for courses really. One size doesn’t fit all”

Depth interview, Head Teacher, independent school, London

- All welcome the clarification about what a comprehensive programme to promote mental wellbeing should include.
- All welcome explicit references to both emotional and social wellbeing; parents and professionals are generally clear what both of these term mean.
- However, professionals and governors voiced some concern about the detail of these statements:
 - All are surprised that the topic should only be covered for *at least two years*, and suggested it should be integrated all the way through primary school life (all thought their schools already did this, though probing suggests that the levels of activity within each school can vary considerably).

“I’m not sure why it’s just [two years]... Yeah I think [a curriculum on emotional and social development] should be throughout a child’s school career. It should be going on all the way through to when they leave school, basically, because you do it in different ways at different stages”

Depth interview, PSHCE Lead, state primary school, Newcastle

- Parents currently attending parenting courses to help them tackle their child’s behavioural problems, in particular, welcome the emphasis on managing behaviour and improving pupil-teacher relationships; they think teachers’ lack of such skills had resulted in their child being labelled ‘a problem’.
- Most professionals, governors, and parents welcome the emphasis on training and development, but:
 - Teachers say they would welcome access to formal “supervision” to help them build skills to tackle difficult and challenging behaviour in the classroom.
 - Several professionals and parents believe that promoting the mental well-being of staff is essential to making sure the mental wellbeing of pupils is assured.
 - Teachers also stress the importance of integrating such training in to general teacher training courses, including PGCE.
- However, head teachers from schools who have not implemented programmes like Healthy Schools or SEAL are often unsure whether they would have sufficient resources to provide such training and support.
 - They think they could have inset days on such topics, but already had considerable pressure to cover other issues via such training.
 - They think that government policy would have to change current educational priorities and place greater emphasis on promoting emotional wellbeing (eg, as being essential to academic success).

- They think government policy currently focuses tightly on academic achievement, which made it difficult to find time and funds to cover training and support for other things.
- Consequently, they question the feasibility and usefulness of this statement.

"I think league tables put pressure on schools to divert them away from the important things of emotional wellbeing to places like academic standards and tick boxes and stuff"

Group discussion, Head Teachers, London

- Head teachers and governors would also welcome more specific information on the level and type of training suggested: what training/who should deliver the training/how much training should there be/how long should it go on for?
- All participants think parenting and carer skill courses should be readily available, but acknowledge that it could be difficult to get parents to attend such courses (especially those whose children are most at risk of poor mental wellbeing).
- Again, a few head teachers whose schools have not fully implemented programmes like Healthy Schools or SEAL questioned where the resources to provide such support would come from; consequently, they question the feasibility and usefulness of this statement.

"The issue is, it's the parents schools would like to engage more than anything that don't come. They get the fertile ground interested parents. I think the skill is getting parents who never come up to school or who aren't interested"

Depth interview, PCT Healthy Schools Coordinator, Newcastle

"The parenting one, as well, there again, because we have a parents link worker at the school, we can help parents develop their skills. But if we didn't, as teaching staff, we would find it hard to help parents develop their skills"

Depth Interview, Head Teacher, state primary school, Newcastle

- Psychologists wonder whether school nurses are suitably qualified to provide parenting skills courses; they thought such provision required specialist expertise.
- School nurses were interested in getting involved, but thought they would need training to do so.
- However, school nurses were also concerned about the impact such involvement might have on their workload (they did not think this was currently part of their remit).

"We're generic workers and each of us have our own skills. Some are better at other things. So, you're almost talking, I feel, of the school nurses that have a specific interest in this area to have the training and the skills. You develop a team that works around this so you know where to go. If you're not careful, you become Jack of all trades and master of none"

Group discussion, School Health Advisors, Newcastle

- All agreed that activities should be integrated throughout school life (both curriculum and non-curriculum activities)

- Professionals involved in implementing SEAL and the Healthy Schools Standard wanted to know if their school would comply with these statements if it implemented these programmes in part or fully.
- Similarly, professionals involved in delivering behaviour change courses (eg, the Webster-Stratton model) wanted more explicit references to their model here.
- Parents think schools should do more to tell parents:
 - What systems and processes they have in place for promoting mental wellbeing, preventing poor mental wellbeing, and identifying, assessing, and intervening to protect children at risk of poor mental wellbeing.
 - How to gain access to further information, advice, and support to help them to promote the mental wellbeing of their child/children.

5. Response to Statement 3

Statement 3

Who is the target population?

Children in primary schools (aged 4–11 years) who are experiencing anxiety or early signs of depression, together with their parents/carers.

Who should take action?

Teachers and non-teaching staff working with children in primary schools. Those working in, and with, local authority education services (including Healthy Schools teams), primary care (such as school nurses), and child and adolescent mental health services (levels 1 and 2).

What action should they take?

- Ensure teachers and non-teaching staff are appropriately trained to identify and assess the early signs of anxiety and depression among primary school children. Early signs of anxiety and depression may include poor peer relations, low self-esteem, and behavioural problems. Children at risk are likely to be living in disadvantaged circumstances. They may include those who persistently refuse to go to school, from families where there is marital conflict or little stability, who have experienced particular adverse life events (such as parental divorce) or have been exposed to violence. Looked after children are particularly likely to develop anxiety or depression.
- Identify and assess children who are experiencing the early signs of anxiety or depression using existing methods such as the common assessment framework (CAF). Discuss the options for reducing these problems in conjunction with the child and their parents/carers.
- Where appropriate, offer tailored group sessions lasting up to an hour on a weekly basis. These should be delivered by specialists (such as counsellors or clinical psychologists) using cognitive-behavioural techniques (these should include a problem-solving component). Groups should include no more than eight children. The sessions should help children with their emotional and social development by giving them practical skills such as problem-solving techniques, and coping and conflict management strategies. Sessions should take place for at least eight weeks and could be offered for up to six months, according to the child's needs.
- Offer group sessions to the children's parents/carers to improve their parenting skills (including how to manage the child's behaviour and their anxiety and/or depression). These sessions should be organised to run in parallel with the children's sessions. Ensure parents/carers living in disadvantaged circumstances are given the support they need to participate fully in these sessions. This may include the provision of childcare or transport costs.

- All welcome Statement 3 in principle.
 - Most think the language is easy to read and understand.
 - Several professionals from various backgrounds suggest that the target population should focus on those *at risk* of anxiety and depression, rather than those *experiencing anxiety or the early signs of depression*.
 - Most professionals think it is clear who should take action.
 - Educational and clinical psychologists working in schools and/or voluntary organisations providing services for schools suggested they should be referenced explicitly here.
 - All participants think that it is important to raise awareness in schools of anxiety and depression in children.

“It’s something I don’t think primary schools tend to talk about. I don’t think we expect smaller children to suffer from, certainly depression, and I don’t think we’d use the term anxiety as a society”

Depth interview, PCT Healthy Schools & PSHE coordinator, London

- All agree that staff should be appropriately trained to identify anxiety and depression and acknowledge that this was not always currently the case in relation to these two conditions (they think processes were clearer for bullying and aggressive and violent behaviour).
 - Governors and head teachers wanted specific references to accredited training courses to which they should refer staff.
- Parents and professionals alike think school staff should refer pupils on to appropriate professionals if they had concerns, but should not diagnose children themselves (to avoid labelling children, etc).
- Professionals think the Common Assessment Framework (CAF) provides a useful framework for intervening appropriately once a problem was identified, but wanted to know if a specific framework exists for identifying children at risk of poor mental wellbeing.
- Engaging both the child and their parents was welcomed, but many primary school professionals said they found it difficult to get parents to acknowledge a problem and to attend training sessions.
- All welcomed the emphasis on engaging relevant professionals and using proven techniques like cognitive behavioural therapy.
- Psychologists think the statement would ensure that appropriate levels of resources were identified to ensure effective support was delivered by services like their own.
- However, in practice, the statement raised a number of concerns.

- Parents whose children had emotional or behaviour problems had a range of concerns:
 - Parents did not want teaching staff talking to their child about their emotional wellbeing without them being present. They were concerned that the child might be too young to understand the implications of what they were saying both for themselves (in terms of labelling themselves unwittingly) and for their parents (in terms of labelling their parents as a problem).
 - Parents did not always feel confident that teaching staff were suitably qualified to decide whether or not a child was showing signs of being at risk of anxiety and/or depression.
 - Parents were also sometimes concerned about schools prying into a child's home life unnecessarily.
 - Overall, parents wanted to be actively involved in decisions about their child.
 - Several parents whose children had emotional and social wellbeing issues reported conflict with teachers and head teachers at their child's school.
 - They said they had initially felt like they were being judged negatively by staff at their child's school when it was suggested that they might attend a parenting course.
 - However, they were keen to ensure the best outcomes for their child, were often at their wits end in terms of their child's behaviour, and had attended the course to see if it could help.
 - All were very positive about the help and support they had received from both the professionals who led the course and the encouragement from other parents on the course.
- Professionals involved in assessing and working with children with anxiety and depression expressed concerns about the details outlined in the statements.
 - Although teaching staff often said spontaneously that their schools had systems in place for tackling anxious and depressed children (albeit informal processes), few thought their school would comply with the standards outlined in the statements.
 - Several teaching staff expressed concerns about the implications and potential repercussions (eg, from parents, from head teachers, from governors) if they identified a child as at risk of anxiety or depression wrongly; several had experienced conflict with parents whose children were at risk of anxiety or depression when they had attempted to intervene.

"You've just got to be careful about giving people those labels quite early on because you don't want to be creating people that are depressed or creating patients early on"

Group discussion, Parents, Newcastle

“What I might consider anxiety and depression may be different to what somebody else might and the way I would think that should be dealt with. We haven’t had training for that. We’re not experts at that and we haven’t had training for that and actually that could be a can of worms, make it worse”

Depth interview, Head Teacher, state primary school, Newcastle

- Several professionals wanted to know if specific methods existed for assessing children at risk of poor mental wellbeing; they did not feel that the Common Assessment Framework (CAF) provided such a system.

“The actual CAF process didn’t really help us identify and assess children. You come to that [the CAF] after you’ve made the decision. It’s not really a very good method for identifying and assessing the child’s problems in terms of their clinical needs, or whatever. It’s just a tool for trying to...ensure that there’s not double working, really and that everybody’s working together and all the agencies are involved – anybody who might be involved gets around the same table and so information is shared”

Depth interview, Head Teacher, state primary school, Newcastle

“There should be a clear structure...structural things that you would expect a school to have in place. Pastoral support, mentoring and things like that. And then, once a child has actually moved a number of steps up the pyramid, we get involved...”

Depth interview, Child Psychologist, Behaviour Support Service, London

- Educational and clinical psychologists saw such assessment and diagnosis as their role and did not think other professionals were qualified to judge (but should refer children about whom they had concerns for an assessment).
- Educational psychologists thought they should be explicitly mentioned in relation to delivering specialist interventions.
- However, Webster-Stratton practitioners stressed that a much wider range of professionals could potentially be involved in delivering a programme and should be acknowledged (eg, school nurses, social workers, etc); they also wanted an explicit reference to their programme here as clinically-proven to be effective.
- Many professionals questioned why only cognitive behavioural therapy was referenced here, and not other interventions (although no other specific interventions were mentioned).
- Many professionals from various backgrounds queried:
 - Why only group sessions were referenced for both children and parents, and not one-to-one support and family therapy; parents and professionals alike questioned whether an anxious or depressed child would thrive in a group setting with up to eight other children.
 - The timescales outlined (ie, why *an hour a week for at least 8 weeks and up to 6 months*, rather than as long as is needed)

- Several primary school professionals and other professional groups wanted to see a longer list of risk factors or early indicators identified (eg, they were surprised that bullying, different types of abuse, bereavement, separation, etc were not explicitly mentioned).
- Several parents from disadvantaged backgrounds, and the professionals who work with them, expressed concerns about singling out parents from disadvantaged backgrounds in this way, because they considered this judgmental; however, they welcomed the statement to support parents from disadvantaged backgrounds to attend such programmes.
- Several parents and professionals from black and minority ethnic groups also stressed the need for systems and processes to be culturally sensitive and not prejudiced towards children from black and minority ethnic backgrounds.
- Many primary school professionals were concerned that children may face long waiting times to gain access to appropriate support once identified; this appeared to diminish their willingness to intervene; they thought maximum waiting times should be specified/assured.
- Several primary school professionals wanted more explicit guidance on how to engage parents whose children were at risk with such programmes.
- Many professionals from various backgrounds wanted explicit references to the evidence base here to substantiate the details raised in relation to how to intervene.

“...I’m not sure there is much evidence for group work addressing depression and anxiety in children. I mean I don’t know but it would be useful, if there is, for that to be identified in this document because my sense is that there’s a limited understanding about what is the best approach”

Depth interview, Child Psychologist, Community Psychology Service, London

- Senior professionals from various backgrounds (eg, directors/heads of services) wanted more explicit references to the need for coordinated activities, joint commissioning, joint assessment, etc.
- Head teachers and governors from schools who had not implemented Healthy Schools and SEAL were concerned about the resource implications of ensuring effective delivery of the services outlined in the statement in their school and within available funds.

“It says’ offer tailored group sessions for a child lasting up to an hour on a weekly basis provided by a specialist’. It says child psychologists. Get real!”

Group discussion, School Health Advisers, Newcastle

6. Response to Statement 4

Statement 4

Who is the target population?

Children in primary schools (aged 4–7 years) who are at risk of developing (or who already display) aggressive or other disruptive behaviours, and their parents/carers.

Who should take action?

Teachers and non-teaching staff working with children in primary schools. Those working in, and with, local authority education services (including Healthy Schools teams) and primary care (such as school nurses), child and adolescent mental health services (levels 1 and 2).

What action should they take?

- Ensure teachers and non-teaching staff are trained to identify and assess children at risk of developing (or who already display) aggressive or disruptive behavioural problems. Children at risk are likely to be living in disadvantaged circumstances. They may include those who persistently refuse to go to school, from families where there is marital conflict or little stability, who have experienced particular adverse life events (such as parental divorce), or have been exposed to violence. Looked after children are particularly likely to develop aggressive or disruptive behaviours.
- Identify and assess children who are at risk of developing (or who display) aggressive or other disruptive behavioural problems, using existing methods such as CAF.
- Discuss the options for tackling these problems with the child and their parents/carers.
- Provide tailored support to prevent or reduce aggressive or other disruptive behavioural problems. This additional support should include:
 - Where appropriate, offering and organising group sessions lasting up to an hour a weekly basis. They should be delivered by specialists (such as counsellors or clinical psychologists) using cognitive-behavioural techniques. Groups should include no more than eight children. The sessions should help develop the children's social skills (including problem solving, conflict resolution, anger management, and communication skills). Sessions should take place for at least months and could be offered for up to 2 years, according to the child's needs. Booster sessions may be provided for pupils in their final year before secondary school (at age 10–11 years) and beyond, where appropriate.
 - Offering group sessions to the children's parents/carers to improve their parenting skills. These sessions should be organised to run in parallel with the children's sessions. Consider providing support to encourage parents/carers who are particularly disadvantaged to participate. This may include the provision of childcare or transport costs.

- Like Statement 3, all welcomed Statement 4 in principle.
 - Most think the language is easy to read and understand.
 - Many parents and professionals from various backgrounds were please to see that statement four targeted children *at risk* of developing aggressive or other disruptive behaviour.
 - However, several primary school and other professionals questioned why the target population was children aged 4–7 and not any primary school aged child (albeit they accepted the need to intervene early, but thought that such behaviour could manifest at any stage in a child's development for a variety of reasons and risk factors).
 - Most professionals thought it was clear who should take action.
 - Educational and clinical psychologists working in schools and/or voluntary organisations providing services for schools suggested they should be referenced explicitly here.
- Many head teachers and teaching staff said that their school had a policy and process for tackling disruptive behaviour (including aggressive and violent behaviour towards staff and pupils, such as bullying).
 - Staff had had inset days on the policy and process and were confident about what was expected of them in terms of identification.
 - They were less confident about assessing children, and would generally prefer to refer children on to relevant professionals to be assessed.
 - Several teaching staff were worried about wrongly labelling a child as violent or aggressive.
 - Several primary school professionals had experienced conflict with the parents of children who were violent or aggressive toward staff or pupils, and found it difficult to tackle such issues; further guidance on handling such situations would be welcomed.

“We have systems in schools, reward systems and sort of spotlight systems, where we sometimes put children whose behaviour is beginning to be disruptive under...spotlight and they have a chart where the teacher writes a comment...But then we will go to another level of having children who have more one-to-one support and others will have a small...nurture group. We give them times of exercise so they...use the energy that is otherwise pent up and simple tasks that the educational psychologist would have suggested for different types of behaviour”

Depth interview, Head Teacher, state primary school, Newcastle

- Parents from disadvantaged backgrounds, and the professionals who work with them, think it is judgemental to say *children at risk are likely to be living in disadvantaged circumstances*; they thought all children were potentially at risk.

“The families don’t have to come from poor backgrounds or be divorced or in care or whatever to have needs...I think generally, unfortunately, the majority do come perhaps from that background, but I don’t think it’s right to phrase it that way. It’s got to be there for everybody because you could miss the very well-off people from Dallas Hall and they could be having the worst home life in the world...”

Group discussion, Parents, Newcastle

- Several professionals from each of the professional groups included in the sample suggest a longer list of risk factors could be included here (eg, they were surprised that bullying, different types of abuse, bereavement, separation, etc were not explicitly mentioned).
- A foster parent who was attended parenting courses similarly did not like the explicit reference to *looked after children* being particularly likely to develop aggressive or disruptive behaviours; she felt this blamed her parenting skills.
- Professionals thought the Common Assessment Framework (CAF) provided a useful way of structuring the process once a problem was identified, but did not provide a way of identifying and assessing a child itself; they queried whether an approved assessment framework was available for violent and aggressive behaviour among primary school children.
- Discussing options with both the child and their parents was welcomed, but several primary school professionals suggested that it could be difficult to get parents to acknowledge the problem and to attend training sessions; parents were, however, concerned about teaching staff discussing issues with their children without them present (for fear of labelling themselves or their parents).

“I think one of the tasks is bringing the parents and the children together because I think a lot of the difficulties that children experience are family-based difficulties and I think one thing that schools might have is that of course they can, to some extent, address family-based difficulties but some of these things are...I suppose it might feel that schools are being asked to do more than they can do, as it were”

Depth interview, Child Psychologist, Community Psychology Service, London

- All welcomed the emphasis on engaging relevant professionals, and using proven techniques like cognitive behavioural therapy; however, several professionals questioned why a wider range of interventions was not referenced (eg, no specific methods were subsequently cited).
- Professionals involved in assessing and working with children who were violent and aggressive raised a number of issues in relation to the detail of the statement:
 - Educational and clinical psychologists saw such assessment and diagnosis as their role and did not think other professionals were qualified to judge (but should refer children about whom they had concerns for an assessment).
 - Educational psychologists thought they should be explicitly mentioned in relation to delivering specialist interventions.

- However, Webster-Stratton practitioners stressed that a much wider range of professionals could potentially be involved in delivering a programme and should be acknowledged (eg, school nurses, social workers, etc); they also wanted an explicit reference to their programme here as clinically-proven to be effective.
- Many professionals questioned why only cognitive behavioural therapy was referenced here, and not other interventions (although no other specific interventions were mentioned).
- Many parents and professionals from different backgrounds queried why only group sessions were referenced for both children and parents, and not one-to-one support and family therapy as appropriate for the child and their family.
- Many parents and professionals from different backgrounds queried the timescales outlined (ie, why *an hour a week for at least 6 months and up to 2 years*, rather than as long as is needed)
- Many parents and professionals from different backgrounds queried why booster sessions were only suggested at age 10 and 11. What if violent and aggressive behaviour reoccurred before this (eg, at 8 and 9)?
- Several parents and professionals from black and minority ethnic backgrounds also stressed the need for systems and processes to be culturally sensitive and should not prejudice children from black and minority ethnic backgrounds.
- Many professionals wanted maximum waiting times for access to specialist support services to be specified.
- Several primary school professionals wanted more explicit guidance about how to engage parents whose children were at risk with such programmes.
- All welcomed the statement to support parents from disadvantaged backgrounds to attend such programmes.
- Many professionals from different backgrounds wanted explicit references to the evidence base here to substantiate the details raised in relation to how to intervene.
- Senior professionals from various backgrounds (eg, directors, heads of service) wanted more explicit references to the need for coordinated activities, joint commissioning, joint assessment, etc.
- Psychologists thought the statement would ensure that appropriate levels of resource were identified to ensure effective support was delivered by services like their own.
- Head teachers and governors from schools that had not implemented the Healthy Schools or SEAL programme were concerned about the resource implications of ensuring effective delivery of the services outlined in the statement in their school and within available funds.

“Reducing these problems in conjunction with the child, parents, and carers, that takes an awful lot of time to organise and manage, and then you offer a targeted group session. Who? I haven’t got an hour. I’d love to be able to give an hour on a weekly basis but it does say ‘provided by specialists’, but I’d like to know who the specialists are and where they would be, who they are and where they would work”

Depth interview, Head Teacher, state primary school, Newcastle

“Take for example educational psychology. You say to a teacher they have to be seen by the ed psych and they’ll say – oh no, because we’ve used our ed psych time up this term, so we can’t get this child seen”

Group discussion, School Health Advisers, Newcastle

“...there’s a funding issue there because if we were to be supporting schools in doing this, it would mean we’re not doing something else, you know, it might mean that we weren’t...able to run our clinics or other aspects of our work”

Depth interview, Child Psychologist, Community Psychology Service, London

E. CONCLUSIONS

E1. General response to the statements

1. The mental wellbeing of primary school children is considered important; no one wants a child for whom they are responsible to experience poor mental wellbeing.
2. Primary schools tend to have better policies and processes for tackling bullying and disruptive behaviour than anxiety and depression among their pupils.
3. Primary school professionals admit they tend to intervene reactively once a problem has occurred rather than act preventively to stop problems occurring in the first place.
4. Consequently, the statements are widely thought to add value to primary school policy and practice.
5. In principle, primary schools have numerous incentives to promote the mental wellbeing of their pupils; for example, their pupils are more likely to achieve academically if they have good mental wellbeing, parents are more likely to send their pupils to a school that seeks to promote mental wellbeing; however, in practice, some primary schools have more developed policies and processes than others.
6. Primary school professionals recognise that they should identify children at risk of poor mental wellbeing as early as possible and intervene to promote mental wellbeing; however, a number of factors can deter them from doing so:
 - Fear of intervening inappropriately, and labelling a child unnecessarily.
 - Fear of conflict with the child's parents or carers.
 - Fear of not being able to assure rapid access to appropriate specialist support (some schools have better access to specialist support than others).
 - Not knowing what to do.
7. It is hoped that these statements will encourage professionals to identify potential issues and intervene earlier than they do at present.
8. Whether or not a school is working towards the Health Schools Standard and/or SEAL greatly influences the response to the statements; head teachers and governors working in schools that have not started to implement these programmes are more likely to be concerned about the feasibility of implementing the statements within current resources than others.
9. NICE is considered a credible source of such guidance, but it may be worth co-branding the final output with an educational organisation to make sure professionals working in or with primary schools engage with the recommendations.

10. Against this backdrop, the statements are positively received, considered appropriately targeted and relevant.
- There is consensus that promoting mental health should become a regulatory requirement for primary schools.
 - Parents think schools should be required to tell parents what systems and processes they have in place for promoting mental wellbeing, preventing poor mental wellbeing, and protect children at risk of poor mental wellbeing.

E2. Response to Statement 1

1. Statement 1 receives a particularly positive response and is thought to have the potential to help those involved in developing Children and Young People's Plans to develop effective strategies for promoting mental wellbeing.
2. The statement makes it clear that primary schools will be expected to have a comprehensive programme to promote mental wellbeing; however, more detail on precisely what primary schools have to do to comply would be welcomed, especially whether those who have achieved the Healthy Schools Standard, implemented SEAL, and the Outcomes Framework in full are considered compliant.
3. It is widely recognised that school ethos can influence the mental wellbeing of pupils.
4. Parents and professionals welcome the emphasis on early intervention.
5. All welcome the emphasis on training for staff, but head teachers whose schools have not yet implemented Healthy Schools or SEAL in full often say they would need extra resources to deliver this; consequently, they are not always confident that the statements here are feasible.

E3. Response to Statement 2

1. Statement 2 also receives a positive response; however, clarification about what a comprehensive programme to promote mental wellbeing should include is widely welcomed.
2. Explicit references to both emotional and social wellbeing are welcomed and understood by parents and professionals alike.
3. Parents of children with behavioural problems welcome the emphasis on managing behaviour and improving pupil-teacher relationships; they think a teacher's lack of such skills can result in a child being labelled "a problem".
4. The emphasis on training and formal supervision for staff is also widely welcomed, albeit some head teachers can have concerns about the resource implications of providing such support.

5. Promoting the mental wellbeing of staff is also considered essential to making sure the mental wellbeing of pupils is assured.
6. Access to specialist support can vary greatly between schools; specification of maximum waiting times could help to ensure rapid access to specialist support.
7. Ideally, government policy would place greater emphasis on assuring the mental wellbeing of pupils (as fundamental to academic attainment) to make sure primary schools implement the required action.
8. There is consensus that activities to promote mental wellbeing should be integrated throughout primary school life (including non-curriculum activities), rather than the suggested two years.

E4. Response to Statement 3

1. If possible, professionals would like to see Statement 3 place more emphasis on preventing anxiety and depression among pupils, rather than intervening after a child has anxiety or depression.
2. There is consensus that staff need to be trained to identify anxiety and depression (eg, via inset days); any references to accredited training that meets the required standards would be welcomed.
3. The assessment and diagnosis of any problems with mental wellbeing is generally considered the role of specialist support services; the Common Assessment Framework (CAF) is thought to provide a useful framework for intervening, but references to any approved method for assessing children at risk of anxiety and depression would be welcomed.
4. Primary school professionals wanted more guidance about how to engage the parents of children at risk of poor mental wellbeing (eg, how to avoid conflict, and how to encourage them to attend parenting courses without causing offence).
5. A number of queries are raised about the detail of Statement 3:
 - Why is only cognitive behavioural therapy mentioned? Are any other interventions approved?
 - Why are only group sessions for both children and parents references? Is one-to-one support and family therapy recommended?
 - Why should interventions with pupil last for an hour a week for at least 8 weeks and up to 6 months? Why not for as long as a child needs?
 - Why single out children from disadvantaged backgrounds as at risk? Is this not judgemental? Aren't all children potentially at risk?
6. We assume some of the queries about the detail of the recommendations could be tackled by including explicit references to the evidence base.

7. Greater emphasis could be placed on making sure policies and processes take account of cultural difference (eg, to make sure the children from black and minority ethnic backgrounds are not labelled unnecessarily as having poor mental wellbeing).
8. The specification of maximum waiting times to assure effective access to specialist support services would be welcomed.
9. Schools who have not implemented the Healthy Schools Standard or SEAL are more likely to have concerns about the resource implications of the statements than those who are working towards the full implementation of these programmes.

E5. Response to Statement 4

1. Emphasis on tackling pupils *at risk* of developing aggressive or other disruptive behaviour preventively is widely welcomed.
2. Primary school professionals acknowledge that it is their responsibility to identify pupils at risk, but think specialist support services should assess and diagnose any problems.
3. Professionals think the Common Assessment Framework (CAF) will provide a useful way of structuring interventions, but any guidance on appropriate ways of assessing children at risk of violent and aggressive behaviour would be appreciated.
4. More guidance on how to engage the parents of children at risk effectively would also be welcomed.
5. A number of queries about the detail of Statement 4 were raised:
 - Why is the target population children aged 4 to 7 and not any primary school aged child?
 - Isn't it judgmental to say *children at risk are likely to be living in disadvantaged circumstances*?
 - Why is only cognitive behavioural therapy mentioned and not other interventions?
 - Why are only group sessions referenced for both children and parents, and not one-to-one support and family therapy?
 - Why should pupils attend groups for an hour a week for at least 6 months and up to 2 years, rather than as long as is needed?
 - Why should booster sessions be given at age 10 and 11? What should professionals do if violent and aggressive behaviour reoccurred before this (eg, at 8 and 9)?

6. We assume explicit references to the evidence base may address some of these queries directly.
7. It may be worth considering in more detail how primary schools can make sure any policy or process is appropriately culturally sensitive to avoid black and minority ethnic pupils being misdiagnosed as violent or aggressive.
8. Schools who have not implemented the Healthy Schools Standard or SEAL are more likely to have concerns about the resource implications of the statements than those who are working towards the full implementation of these programmes.

Appendices

1. Approach letter
2. Recruitment questionnaire
3. Discussion guide
4. Statements

1. Approach Letters

1.1. Letter of Bona Fides



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NICE CHILDREN'S MENTAL WELLBEING AND INTERVENTION GUIDANCE

NICE is an independent organisation, created by central government, to be responsible for providing national guidance on promoting good health and preventing and treating ill health. The objective of NICE's public health guidance is to bring about social, economic, organisational, community and individual change to improve health and reduce inequalities in health.

I am writing to ask for your help with a very important stage in the development of our Children's Mental Wellbeing and Intervention Guidance. We want to involve those working with children to evaluate our recommendations and have asked Dr Foster Intelligence to manage this process.

We need your input to help us make sure our recommendations are relevant, useful, feasible, and implementable. Therefore, your feedback is extremely important to us. We are especially keen to involve professionals working with children to make sure our recommendations work for you. Anything you tell us will be treated in the strictest confidence. No individuals or organisations will be identified when we report the findings.

I do hope you will be able to take part in this important project. If you have any queries about the research, please contact Amanda Killoran (Project Technical Lead) or James Jagroo (Public Health Analyst) at NICE on 020 7067 5800 or Russell Pask (Research Manager) at Dr Foster Intelligence on 020 7332 8885.

Yours faithfully

A handwritten signature in blue ink that reads "Antony Morgan".

Antony Morgan

Associate Director, Centre for Public Health Excellence

National Institute for Health and Clinical Excellence

1.2. Attendee Letter

16 July 2007

Dear XXXXX

NICE GUIDANCE MEETINGS FOR CHILDREN'S MENTAL WELLBEING

I am writing to invite you to take part in a Group discussion on NICE's children's mental wellbeing and intervention guidance. This research will help to promote good mental wellbeing amongst children through examining NICE guidance which focuses both on targeted activities and interventions within schools as well as general school policies and ethos.

Your input will be invaluable to making the guidance recommendations appropriate to primary schools and your comments and feedback will not be identified to yourself or your organisations within the research report. Dr Foster Intelligence will also provide you with a copy of the full research report. Dr Foster Intelligence will provide you with a copy of the draft NICE guidance closer to the meeting.

We would like you to attend a Group discussion of head teachers in Newcastle/ London:

6pm on xxth September at xxxx venue. Refreshments will be provided.

Please could you confirm your attendance at this event.

We are also organising Group discussions with:

- lead teachers responsible for children's mental wellbeing through programmes like SEAL and Healthy Schools, and;
- governors with lead responsibility for children's mental wellbeing.

We would very much appreciate it if you could put us in contact with these people within your school to be involved with the study.

If you have any questions about this research or would like us to contact the governor and lead teacher with these responsibilities, please contact Russell Pask (Research Manager) at Dr Foster Intelligence on 0207 332 8885.

Yours faithfully

Nigel Jackson, Head of Research Services, Dr Foster Intelligence

2. Recruitment Questionnaire

Letter of bona fides: NICE

NICE CHILDREN'S MENTAL WELLBEING AND INTERVENTION GUIDANCE

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I do hope you will be able to take part in this important project. If you have any queries about the research, please contact James Jagroo (Public Health Analyst) or Amanda Killoran (Project Technical Lead) at NICE on 020 7067 5800 or Russell Pask (Research Manager) at Dr Foster Intelligence on 020 7332 8885.

Yours faithfully



Antony Morgan

Associate Director,

Centre for Public Health Excellence

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intelligence
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RECRUITMENT QUESTIONNAIRE – CHILDREN’S MENTAL WELLBEING

Hello, my name is and I am conducting research for Dr Foster Intelligence on behalf of NICE.

NICE is developing children’s mental well-being and intervention guidance. They have asked us to consult professionals to get their views on the draft recommendations in the guidance. NICE want to make sure their recommendations are relevant, appropriate, feasible and implementable.

The session will be held at.....

.....

on.....

the start time will be.....

I have just a few short questions...

Q1. Can we check that you belong to one of the following groups...:

A head teacher of a primary school	1
A teacher providing pastoral care/ healthy schools policies, PSHE, SEAL for children of primary school age	2
A member of primary school support staff providing for the health and mental well-being of children in primary school	3
A school governor at a primary school	4
PCT, paediatric mental health services and LEA staff with responsibility for mental wellbeing of primary school age children	5
The parent of primary school age children	6
A voluntary sector or private sector professional involved in the mental wellbeing of children of primary school age	7
None of the above (THANK AND CLOSE)	8

ALL PARTICIPANTS TO BE INVOLVED IN SUPPORTING CHILDREN'S MENTAL WELLBEING

Q2a. Which type of primary school are you working for (or involved with)?

State-sector maintained school	1
Independent schools	2
Special education environments	3
All of the above	4
Other (specify)_____	

CHECK QUOTAS AND RECRUIT AS PER SPECIFICATION.

Q2b. To what extent does the school you work with (or are involved with) (your child goes to) have children from the following groups?

	A great amount	A fair amount	Not very many	None at all	D/K
Children from disadvantaged households	1	2	3	4	5
Looked after children	1	2	3	4	5
Children with special education needs	1	2	3	4	5
Children from Black and Minority Ethnic backgrounds	1	2	3	4	5
Children with mental health issues	1	2	3	4	5

Two-thirds must code at least one of the above (1 OR 2). Please ensure that there is a spread.

CHECK QUOTAS AND RECRUIT AS APPROPRIATE:

Name:

Address:

Telephone number:

Mobile number:

Email address

NICE CHILDREN'S WELLBEING GUIDANCE

Pre-task

Please read through the draft recommendations attached. You will be expected to take account of them when they are published, so please a note either on the document or in the boxes below:

- Which you consider relevant to you
- Which you consider useful
- Which you think are feasible and implementable and which you think are not
- Which will change what you currently do and how they will change things

Relevant

Useful

Feasible and implementable

Not feasible and implementable

Change things and how

PLEASE REMEMBER TO BRING THIS NOTE WITH YOU

3. Discussion Guide

NICE CPHE MENTAL WELLBEING OF PRIMARY SCHOOLCHILDREN

DISCUSSION GUIDE

1. Context

- Current role and responsibilities?
- What, if anything, do you currently do to promote the mental wellbeing of the children you work with / are responsible for?
- What do you currently do to assess the mental wellbeing of the children you work with / are responsible for and why? How well do you think you and your organisation do this and why? What needs to happen to improve what you do and why?
- What projects, programmes and policies are in place to promote mental wellbeing among the children you work with / are responsible for?
- How do you think your current activities and policies could be improved to promote mental wellbeing among the children you work with / are responsible for?
- To what extent have existing national guidance and recommendations influenced current policy and practice within your organisation on promotion of children's mental wellbeing? (eg NSF /education guidance)

2. Assessing spontaneous compliance with the statements

Re statement one

- Is there a Children and Young People's Plan for your area ? Does it cover the promotion of children's mental wellbeing? How does this influence your organisation/ your practice?
- Do you know what your school / the schools you work with currently does to attain the National Health Schools Standard and *Every Child Matters* Outcome Framework in relation to mental wellbeing?
- What training and support do you have access to / do you provide to make sure staff know how to promote the mental wellbeing of children? Who provides this training?

(Researchers note and explore if the plan meets requirements. Try and get hold of copies of the documents if possible.)

Re statement two

- Does your school / the schools you work with have a comprehensive programme for promoting emotional and social development? What is it? How good is it? How could it be improved?
- More specifically, do you know how skills relating to emotional literacy (eg, problem solving, coping) are developed within your school / the schools you work skills)? Do you know where and how it is delivered within the curriculum and elsewhere (eg, taught sessions, play sessions, assemblies, homework, etc) and why? How long it is taught for? Who is involved in teaching these skills. How well do you think it is taught? How could its delivery be improved and why?
- What training and support is available to help you develop and deliver the programme? Who provides this? How frequently do you get support and why? How good is it? How could it be improved and why?
- What access to training and support is there for parents/carers (parenting / carer skills development), eg, information, group based work, etc? Who delivers it? How is it delivered? How good is it and why?

(Researchers note and explore whether or not the programme complies with NICE recommendations. Try and get hold of any docs if possible)

Re statement three

- How well can you / the staff who work with children identify the early signs of anxiety or depression among primary school children and why?
- Do staff have access to training and support to help them identify anxiety and depression among primary school children (eg, poor peer relations, low self-esteem, behavioural problems) and why? Does training cover the common assessment framework (CAF)?
- Do you / your staff know how to identify risk factors (eg, truanting, marital conflict or instability, divorce, exposure to violence) and why?
- Do you have processes and structures for identifying children and risk and assessing their mental wellbeing (eg, using the CAF)? How well do these work? Who is involved? How and why? How often is the process reviewed and why? How do you think the process and structures could be improved?
- What support do you offer to children at risk / with poor mental wellbeing and why (eg, group support)? Who delivers the support (eg, specialist staff like counsellors and clinical psychologists)? What is involved (eg, emotional literacy skills building, cognitive behavioural therapy / cognitive behavioural therapy, problem solving)? How frequently is support given? How long does the support last? How many children are involved in the sessions? How often is the quality of the support reviewed? Who by and why?

(Researchers note and explore whether or not the support and training complies with NICE recommendations. Try and get hold of any docs if possible.)

Re statement four

- How / how well do you / your staff currently identify and assess children at risk of developing aggressive or disruptive behaviour problems, using existing methods such as the CAF? How could processes and structures be improved and why?
- How / how well do you / your staff do in terms of discussing issues and options with children / their parents/carers? What are the processes and structures for doing this? How well do they do it and how could they do better?
- What training and support is available to help staff (including support staff) identify and assess children at risk of developing aggressive or disruptive behavioural problems, using existing methods such as CAF? How could training and support be improved and why?
- What interventions do you have to support children at risk of developing aggressive and violent behaviour and their parents and why? What's involved? Who is involved? How good are they and how could they be improved? Do they include:
 - Group sessions lasting an hour (with no more than 8 children and delivered by a specialist)?
 - Parenting skills courses run in parallel with children's sessions?
 - Do you reimburse transport costs?

(Researchers note and explore whether or not they comply with NICE recommendations. Try and get hold of any docs if possible.)

3. Exploring the response to the NICE statements –all aspects to be covered

Overall response

Using the questionnaire provided as an aide memoire:

- What were their initial reactions to the guidance and statements ?
- What did they like / dislike? Why?
- In general, how useful / relevant/ feasible did they think they were? Why?
- How easy or hard did they think they would be to implement? Why?
- How much of an impact did they think they would have on the design and delivery of their service? How and why?
- To what extent do they think the recommendations overall would improve the quality of service provided? How and why?

Working through the recommendations individually, researchers check:

Relevance

- Is the recommendation relevant to them and their work (use self-completion exercise to identify diversity of opinion)? Why?
- To what extent does it affect the services they provide? How and why?
- To what extent is it relevant to the populations they work with? How and why?
- How could it be made more relevant to their work? Why?

Usefulness

- To what extent would they adopt the recommendation (use self-completion exercise to identify diversity of opinion)? Why?
- What factors would encourage them to adopt it and why?
- What would get in the way and why?
- How useful is the recommendation to them and their professional group? Why?

Feasibility/implementability

- How practical is it to implement the recommendations overall (use self-completion exercise to identify diversity of opinion)? Why?
- How much impact will it have on their delivery? Why?
- How confident are they that it will improve practice? Why? How could such positive impacts be ensured / built on? Why?
- What negative impacts, if any, do they think it might have? How can these be ameliorated? Why?
- What other factor would help / hinder the implementation of the recommendation (eg, service configuration, setting, population served, delivery, etc)? Why?
- What should be done about each of these impacts (positive and negative)? Why?

Credibility

- To what extent do they have trust and confidence in the recommendation (do they believe what it has to say)? (use self-completion exercise to identify diversity of opinion)
- How confident are they that it is the right recommendation based on the best available evidence? Why? To what extent would this influence their willingness to adopt the recommendation?

- To what extent does NICE provenance influence their views (positively or negatively)? Why?

Importance and improvements

Having worked through the recommendations individually, consider:

- Which of the recommendations are most important? Which are least important? Why?
- How can the recommendations be improved? Why?
- What impact would these improvements have on their willingness to adopt the recommendation? Why?
- What else could NICE do to encourage uptake of the recommendations / communicate them to their profession? Why?
- In summary, what three things would they most want the Institute to do next in relation to the proposed recommendations and why?

NICE CPHE MENTAL WELLBEING OF PRIMARY SCHOOLCHILDREN

PARENTS' DISCUSSION GUIDE

- Introduce self, Dr Foster Intelligence, National Institute of Clinical Excellence (NICE) Centre for Public Health Excellence (CPHE) and any observers
- Outline aims: to test relevance, perceived usefulness and feasibility, and public interest in forthcoming guidance
- Stress confidentiality and anonymity
- Stress importance of getting constructive feedback

1. Warm up

- Introduce self, household composition, how their kids are doing at primary school

2. Perceived importance of mental wellbeing

- What does the term mental wellbeing mean to you and why?
 - Prompt if necessary: emotional, social, and psychological wellbeing (i.e. how happy a child is, how they feel about themselves, how they interact with others, etc)?
- What things do they think affect a child's mental wellbeing positively and negatively and why? In what situations do you think a child's mental wellbeing is particularly at risk?
 - Prompt if necessary: divorce, bullying, caring for others, domestic violence, substance misuse at home?
- Have you noticed any things that have positively or negatively affected your child's mental wellbeing?
 - Prompt if necessary: what makes them happy / sad / anxious?
 - What would you do if your child seemed unhappy, withdrawn, or if they started getting more violent and aggressive and why?
- What do you think the role of primary school is or should be in terms of promoting the mental wellbeing of pupils and why?
 - Do you know what your child(ren)'s primary school does to promote mental wellbeing?
 - Do they know what help and support is available to parents and children? If yes, how do you know this and why?

2. Exploring the response to the NICE statements

Work through each of the recommendations, explain that the primary target audience

- What were their initial reactions to each specific statement and why?
 - Likes and dislikes and why?
 - What do they understand / not understand and why?
 - Do they think it is relevant to them, their children, and / or their child's primary school? If so, how and why?
 - Do they think their school could / should do this and why?
 - Do they know what their child's school currently does in relation to the activities listed and why?
 - What else would they like to see primary schools doing to promote the wellbeing of the children they teach?
 - Which bits do you think are most important for your child's primary school to tell parents about and why?
 - Which bits do they think other parents would be most interested to read about in the national press and why?
 - Would they be more or less likely to choose a school that did these sorts of things to promote mental wellbeing and why?

3. Specific questions

Statement 1

- How important do they think it is for the school to adopt a comprehensive 'whole school' approach (i.e. the school has to do all of this – it cannot pick and choose the bits it likes) and why?
- What relative priority do they think mental wellbeing should take in relation to other health issues that a Healthy School has to address (eg, tackling obesity, nutrition and exercise; preventing smoking; sex and relationships education; alcohol and drugs; preventing accidents, etc)?
- What relative importance do you think organisations like OFSTED (who assess school performance) should give to the quality of a school's programme to promote mental wellbeing compared to academic teaching and why?

Statement 2

- Do you know whether and how your child teaches and develops emotional and social skills (eg, problem solving, coping, conflict management, etc)?
- What do you think the relative importance of developing emotional and social skills should take compared to academic subjects (eg, reading, writing, maths, foreign languages, sciences, etc) and why?

- What do they think about schools providing support to develop parents'/carers' skills and why?
 - Which parents should such support be offered to and why?
 - Would they be interested in attending and why? What might put them off attending and why?
- How happy are they for mental wellbeing to be promoted across school life (eg, including assemblies, homework, play periods) and why?

Statement 3

- If their child was displaying early signs of anxiety or depression, how happy would they be for the school to respond in this way and why?
- Does the statement involve parents in an appropriate way and why?
- If it was their child, would they be willing to get involved in group sessions organised by the school? What could the school do to encourage parents to attend such course?
- What kinds of support would they hope to get to help them manage their child's anxiety and depression and why?
- How would knowing that such help and support was available at their school affect perceptions of the school (positively and negatively) and why?
 - Probe: would they think the school had a problem if it publicised its policies on this and why?

Statement 4

- If their another child in their child's class was displaying early signs of disruptive or aggressive, how happy would they be for the school to respond in this way and why?
 - What if it was their child displaying such behaviour and why?
- Does the statement involve parents in an appropriate way and why?
- If it was their child, would they be willing to get involved in group sessions organised by the school? What could the school do to encourage parents to attend such course?
- What kinds of support would they hope to get to help them manage their child's anxiety and depression and why?
- How would knowing that such help and support was available at their school affect perceptions of the school (positively and negatively) and why?
 - Probe: would they think the school had a problem if it publicised its policies on this and why?

(Time permitting – go through considerations to get some context – likes / dislikes?)
Agree / disagree with what it is saying and why?)

4. Overview

- How important do they think it is for primary schools to do all of this and why?
- How feasible do they think it is for their child's primary school to do all of this?
- How important do they think it is for primary schools to communicate its whole policy to parents and why?
- What messages do they think NICE CPHE should be trying to get across to parents in relation to this guidance when it launches its recommendations and why?
- Any other changes or improvements and why?

4. Statements

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

**PUBLIC HEALTH INTERVENTION DRAFT STATEMENTS:
to inform the development of guidance**

Confidential

Promoting the mental wellbeing of children in primary education

Introduction

The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE or the Institute) to produce public health guidance on promoting the mental wellbeing of children in primary schools.

For the purposes of developing this guidance, mental wellbeing is defined as good emotional, psychological and social health.

The guidance is for teachers, school governors and professionals with public health as part of their remit working in education, local authorities, the NHS and the wider public, voluntary and community sectors.

The Public Health Interventions Advisory Committee (PHIAC) has considered the reviews of the evidence and the economic appraisal.

This document sets out the preliminary statements that will inform the development of the guidance by the Committee.

DRAFT STATEMENTS

Statement 1

Who is the target population?

Professionals working with children in primary schools.

Who should take action?

Commissioners and providers of services to children in primary schools including: those working in children's trusts, local authority education services, schools, primary care trusts (PCTs) and child and adolescent mental health services.

What action should they take?

- Develop and agree arrangements, as part of the 'Children and Young People's Plan' and as part of joint commissioning activities, to ensure primary schools promote the emotional and social wellbeing of children. All primary schools should provide a comprehensive programme which:
 - is based on a 'whole school' approach that promotes an ethos of positive behaviour and effective relationships. It should include support for all pupils and parents. It should also include specific help for those children most at risk (or already showing signs) of emotional and behavioural problems and their parents.
 - is offered as part of the school's policies for attaining the National Healthy Schools Standard and reaching the Outcome Framework targets²
 - includes training and support for teachers and non-teaching staff. Training should be provided by qualified professionals. They may be working in healthy schools teams, community nursing or specialist educational, family support and mental health services (levels 1 and 2) and in the voluntary or private sectors.
- Put in place the necessary coordinating mechanisms and resources to ensure primary schools have access to the skills, advice and support they need to deliver a comprehensive programme (see statements 2–4).

² HM Government (2004) Every child matters: change for children. London: Department for Education and Skills.

UNIVERSAL APPROACHES

Statement 2

Who is the target population?

Children in primary schools (aged 4–11 years), their parents/carers and teachers.

Who should take action?

Teachers and non-teaching staff working with children in primary schools. Those working in (and with) local authority education services (including healthy schools teams), primary care (such as school nurses) and child and adolescent mental health services (levels 1 and 2).

What action should they take?

Provide a comprehensive programme to promote children's emotional and social wellbeing. This should include:

- a curriculum on emotional and social development (covering the development of 'emotional literacy', problem solving, coping, conflict management and other skills). This should be provided over a period of at least 2 years by appropriately trained teachers and non-teaching staff
- training and development for teachers and non-teaching staff to deliver the curriculum, including how to manage behaviour and improve child-teacher relationships. Ongoing supervision and support should be provided to develop these skills
- help to develop parents'/carers' parenting skills (this may involve providing information or small, group-based training sessions run by community nurses (such as school nurses and health visitors) or other appropriately trained practitioners
- integrated activities to promote emotional and social wellbeing within all areas of school life. For example, classroom-based teaching should be reinforced in assemblies, homework and play periods (in class as well as in the playground).

TARGETED APPROACHES

Statement 3

Who is the target population?

Children in primary schools (aged 4–11 years) who are experiencing anxiety or early signs of depression together with their parents/carers.

Who should take action?

Teachers and non-teaching staff working with children in primary schools. Those working in (and with) local authority education services (including healthy schools teams), primary care (such as school nurses) and child and adolescent mental health services (levels 1 and 2).

What action should they take?

- Ensure teachers and non-teaching staff are appropriately trained to identify and assess the early signs of anxiety and depression among primary schoolchildren. Early signs of anxiety and depression may include poor peer relations, low self-esteem and behavioural problems. Children at risk are likely to be living in disadvantaged circumstances. They may include those: who persistently refuse to go to school, in families where there is marital conflict or little stability, who have experienced particular adverse life events (such as parental divorce) or have been exposed to violence. Looked after children are particularly likely to develop anxiety or depression.
- Identify and assess children who are experiencing the early signs of anxiety or depression using existing methods such as the common assessment framework (CAF). Discuss the options for reducing these problems in conjunction with the child and their parents/carers.
- Where appropriate, offer tailored group sessions lasting up to an hour on a weekly basis. They should be delivered by specialists (such as counsellors or clinical psychologists) using cognitive-behavioural techniques (these should include a problem-solving component). Groups should include no more than eight children. The sessions should help children with their emotional and social development by giving them practical skills such as problem-solving techniques, and coping and conflict management strategies. Sessions should take place for at least 8 weeks and could be offered for up to 6 months, according to the child's needs.
- Offer group sessions to the children's parents/carers to improve their parenting skills (including how to manage the child's behaviour and their anxiety and/or depression). These sessions should be organised to run in parallel with the children's sessions. Ensure parents/carers living in disadvantaged circumstances are given the support they need to participate fully in these sessions. This may include the provision of childcare or transport costs.

Statement 4

Who is the target population?

Children in primary schools (aged 4–7 years) who are at risk of developing (or who already display) aggressive or other disruptive behaviours and their parents/carers.

Who should take action?

Teachers and non-teaching staff working with children in primary schools. Those working in (and with) local authority education services (including healthy schools teams) and primary care (such as school nurses) child and adolescent mental health services (levels 1 and 2).

What action should they take?

- Ensure teachers and non-teaching staff are trained to identify and assess children at risk of developing (or who already display) aggressive or disruptive behavioural problems. Children at risk are likely to be living in disadvantaged circumstances. They may include those: who persistently refuse to go to school, in families where there is marital conflict or little stability, who have experienced particular adverse life events (such as parental divorce) or have been exposed to violence. Looked after children are particularly likely to develop aggressive or disruptive behaviours.
- Identify and assess children who are at risk of developing (or who display) aggressive or other disruptive behavioural problems, using existing methods such as CAF.
- Discuss the options for tackling these problems with the child and their parents/carers.
- Provide tailored support to prevent or reduce aggressive or other disruptive behavioural problems. This additional support should include:
 - where appropriate, offering and then organising group sessions lasting up to an hour on a weekly basis. They should be delivered by specialists (such as counsellors or clinical psychologists) using cognitive-behavioural techniques. Groups should include no more than eight children. The sessions should help develop the children's social skills (including problem solving, conflict resolution, anger management and communication skills). Sessions should take place for at least 6 months and could be offered for up to 2 years, according to the child's needs. Booster sessions may be provided for pupils in their final year before secondary school (at age 10–11 years) and beyond, where appropriate
 - offering group sessions to the children's parents/carers to improve their parenting skills. These sessions should be organised to run in parallel with the children's sessions. Consider providing support to encourage parents/carers who are particularly disadvantaged to participate. This may include the provision of childcare or transport costs.

PUBLIC HEALTH NEED

The guidance will support the following national service frameworks (NSFs) and other government policies:

- 'National service framework for children, young people and maternity services' (DH 2004a)
- 'Every child matters' green paper (HM Government 2003), and 'Every child matters: change for children' programme (HM Government 2004)
- 'Promoting children's mental health within early years and school settings' (Department for Education and Employment 2001)
- 'Healthy minds: promoting emotional health and wellbeing in schools' (Ofsted 2005)
- 'Bullying – a charter for action' (DfES 2003a)
- 'The respect action plan' (Home Office 2006)
- 'Healthy living blueprint for schools' (DfES 2004)
- 'Choosing health: making healthier choices easier' (DH 2004b)
- 'National healthy school status – a guide for schools' (DfES 2005c)

CONSIDERATIONS

PHIAC took account of a number of factors and issues in drafting these statements.

- 1.1 PHIAC adopted an holistic approach to mental wellbeing within primary schools. This emphasises the importance of a supportive environment and ethos, including support for pupils with special needs.
- 1.2 Children's mental wellbeing is influenced by a range of factors, from their individual make-up and family background to the community within which they live and society at large. As a result, school-based activities to develop and protect their mental wellbeing can only form one element of a broader, multi-agency strategy. Other elements will include the development of policies to improve the social and economic circumstances of children living in disadvantaged circumstances.
- 1.3 Lack of investment in mental health promotion in primary schools is likely to lead to significant costs for society. Research shows that a child's emotional, social and psychological wellbeing influences their future health, education and social prospects. Children who experience emotional and social problems are more likely, at some point, to: misuse drugs and alcohol, have lower educational qualifications, be untrained, unemployed or involved in crime.
- 1.4 Targeted and intensive school-based interventions may prove cost effective in the longer term. This could be achieved by preventing behaviours which could lead to costly consequences for the NHS, social services and the criminal justice system.

- 1.5 It is important to recognise and respond to the needs of children from different socioeconomic, cultural and ethnic backgrounds.
- 1.6 When using group-based approaches, care is needed with groups that include both aggressive and non-aggressive children, as the intervention may have adverse consequences on the latter. It is also important to respond to individual needs.
- 1.7 PHIAC acknowledged that implementation of the recommendations will need to take into account the capacity and configuration of local children's services. Children's trusts will determine the most appropriate way of ensuring integrated delivery of the recommended programmes.
- 1.8 Teachers and non-teaching staff in primary schools need training to promote young children's mental wellbeing if they are to be successful. PHIAC hopes that the relevant training and education organisations will acknowledge this need and seek to equip schools staff with the necessary competencies. Schools can use their evaluation processes to identify any ongoing professional development needs in this area.
- 1.9 This guidance will not consider:
- interventions that address the relationship between mental wellbeing and factors such as school based programmes physical activity levels and nutrition
 - clinical interventions for established mental illness.