Making Sense of Mental Health

The emotional wellbeing of children and young people with complex needs in schools

NASS

ncercc
national centre for excellence in residential child care

national children's bureau

Contents

Introduction and policy context	Page 2
Background to research	Page 4
Research Findings	Page 5
Discussion	Page 13
Ways Forwards	Page 14
Appendix 1 – Good practice checklists	Page 17
References	Page 19

Introduction

There has been a growing awareness over recent years about the mental health problems of children. The report ‘Bright Futures’ (1999) shocked the public with the statistics of up to 1 in 5 children experiencing a psychological problem at any one time.[i] Although estimates vary, recent research suggests that 20% of children experience mental health problems in a given year and about 10% at any one time.[ii] The 2004 ONS report on the mental health of children and young people between the ages of 5 and 16 found that 1 in10 had a diagnosable mental disorder; 4% had an emotional disorder, 6% a conduct disorder, 2% a hyperkinetic disorder and 1% less common disorders such as autism, eating disorders or selective mutism. 2% had more than one disorder.[iii] An analysis of calls to Childline indicated that 6000 children and young people called about issues relating to mental health, including depression, eating disorders, bullying, physical and sexual abuse and living with someone who has mental illness.[iv] UNICEF reported that growing up in the UK is a bleaker experience than in any other wealthy country.[v]

Children and young people with learning difficulties and/or disabilities are at greater risk of developing mental health problems. The “Count Us In Inquiry” estimated that at any one time 40% of young people with learning disabilities will be experiencing significant mental health problems.[vi] An analysis of the Office of National Statistics (ONS) surveys in 1999 and 2004 of the mental health of children and young people has suggested that 36% of children with a learning disability have a diagnosable mental health problem and they are up to six times more likely to have a psychiatric disorder than their non disabled peers. With respect to children with a learning disability and a mental health problem, 53% live in poverty compared with 30% of all children; 48% have been exposed to two or more adverse life events compared with 24% of all children; 44% are supported by a mother who is likely to have a mental health problem compared with 24% of all children; 38% live in families in which no adult is in paid employment compared with 7% of all children. Difficulties in problem solving and a predisposition to mental illness associated with some conditions are contributory factors. However, it has been estimated that 20-33% of the increased risk of psychopathology can be attributed to the impact of social disadvantage, along with several adverse life events experienced frequently by children with a learning disability.[vii]

An examination of risk factors underlines the vulnerability of many of these children.

At risk factors for mental health problems in the child are:

- genetic influences
- low IQ and learning disability
- specific developmental delay
- communication difficulty
- difficult temperament
- physical illness, especially if chronic and/or neurological
- academic failure
- low self esteem.

Risk factors within the family include family breakdown, lack of attachment, neglect, abuse and psychiatric illness. Within the wider community they include socio-economic disadvantage, homelessness, discrimination, harassment, abuse and other significant adverse life events. Many of these risk factors may apply to children with special educational needs.

The role of schools in promoting emotional wellbeing

Increasing focus on the promotion of mental health by schools has been apparent over the last eight years. Guidance on mental health promotion was issued by the Department for Education in 2001.[viii] 'Every Child Matters' and the NSF for Children together with the White Paper, 'Choosing Health' (2004)[ix] and the 'Healthy Living Blueprint' (2004)[x] aim to support all children and young people to have good physical and mental health. In addition the relaunch of the 1999 National Healthy School standard as the National Healthy Schools Programme in 2005 has given impetus to activities to promote emotional health and wellbeing in the school setting. By 2009, every school should be working towards the National Healthy Schools status.

According to the new Programme, a school that is promoting emotional wellbeing will:

- identify vulnerable children and have strategies to support them
- provide leadership to create a positive environment
- use the curriculum to help pupils to explore feelings using appropriate teaching styles
- have effective pastoral care, including support in bereavement
- uphold values which challenge stigma and discrimination
- provide training for staff involved in pastoral care
- have clear and effective anti-bullying policies
- have a range of school activities for pupils to participate in and show leadership
- have confidentiality policies.[xi]

The curriculum is a crucial vehicle for promoting emotional wellbeing, particularly through personal, social and health education (PSHE), although this is not a statutory requirement, and through citizenship, which is a statutory requirement from Key Stage Three. In primary schools, the Social and Emotional Aspects of Learning (SEAL) materials[xii] complement PSHE at Key Stages One and Two and other initiatives, such as circle time and buddy schemes, in promoting emotional wellbeing. Non-governmental initiatives, such as "Zippy's Friends"[xiii] have been influential in promoting emotional resilience in young children, while "Pyramid"[xiv] can support children up to year 6 if they are experiencing difficulties.

SEAL materials have now been introduced at secondary level.[xv] They aim to build on the work of PSHE, citizenship, drama and art in promoting the development of social and emotional skills. Ofsted reports that progress has been made in the delivery of PSHE between 2001 and 2006 and leadership and management are good in nine out of ten schools.[xvi] Suggestions for improvement include involving pupils in the content and outcomes of the curriculum, improved monitoring and evaluation, ensuring that work at Key Stage Three takes account of work at Key Stage Two and links to support services through drop-in centres. It also mentions that many teachers, governors and parents need to improve the teaching of sex education.

The main themes in Key Stage Four should lead to positive outcomes for the emotional well-being of young people if well implemented. They should enable young people to develop confidence and responsibility, make the most of their abilities, develop a healthy and safer lifestyle, develop good relationships, respect difference and enjoy a breadth of opportunities. However for vulnerable young people, there are significant barriers to enjoying a full life in adulthood. These can impact negatively on them and their families.

Making Sense of Mental Health – The Research Project

Background and Context

This publication draws on the findings from research undertaken for the National Association of Independent Schools and Non-Maintained Special Schools (NASS) through the Centre for Special Needs Education and Research (CeSNER) University of Northampton.

NASS member schools are a diverse group, catering for children and young people with a very wide range of disabilities. Often it is difficult to find areas of agreement about key issues but schools kept reporting that addressing mental health and emotional wellbeing was one of their most pressing challenges. NASS commissioned the research in response to the experiences of member schools in trying to identify and meet the emotional wellbeing of children and young people. We had a great deal of anecdotal evidence about an increase in the number of children with mental health problems and a change in the nature of problems experienced but no way of quantifying this. School staff reported concerns about feeling poorly equipped to support children with mental health problems but we also heard stories of the creative approaches schools were using to try to ensure that their emotional needs were met.

We used the project to identify the extent of mental health difficulties experienced by young people in NASS member schools and to examine the current approaches used to support these pupils in order to address their mental health needs. The research was conducted over a nine month period (in one academic year) and data was collected from 48 special schools who are members of NASS.

We hope that our experiences, as schools, will also be useful to those who work with children with disabilities and special educational needs within other residential settings.

Making sense of terminology

It was suggested that the incidence of mental health problems being experienced by pupils in NASS schools may be changing; there was no data of incidence rates across this SEN population. This in itself presented problems. The terminology used created difficulties when identifying these individual pupils. For example - what was meant by 'mental health problems'? What was a mental health problem and what was a symptom of a pupil's complex needs? How appropriate or rigorous were the identification measures? Clarification was needed within these issues and working definitions were required.

Subjectively, schools reported possible changes in their school populations. Pupils were presenting with more complex needs and creating more extreme challenges for staff. Schools were possibly experiencing a wider range of mental health issues in their pupils (e.g. eating disorders). In addition, diagnosis of mental health problems was thought to be haphazard. Some pupils had dual diagnoses (by external professionals) of an SEN and a mental health problem; other pupils who presented with more extreme problems had no diagnosis. These issues are important when considering both the need for the research undertaken and the focus adopted by the research team.

At the outset of the research we needed to clarify the terminology and definitions used in order to enable respondents to the survey to be able to consider issues with consistency of understanding. It is probably true to say that even now there are considerable discrepancies of understanding with regards to this complex topic. At the beginning of the research the team spent a day considering the nature of mental health difficulties and assembling a definition, which has guided the work of the project. This was achieved through a concept analysis using, amongst other approaches, a nominal group technique. The following definitions were agreed prior to the start of data collection.

1. Definition of mental health

"A positive sense of well-being which enables an individual to be able to function in society and meet the demands of everyday life. People in good mental health have the ability to recover effectively from illness, change or misfortune."

2. Definition of a mental health problem

"The term "mental health problems" is used to describe levels of emotional, psychological or psychiatric distress that present significant challenges for the young person, their families and those who support them. This may cover a range of problems from relatively mild emotional disorders such as anxiety (which can become very serious) and mild depression to serious psychiatric disorders (e.g. psychosis)."

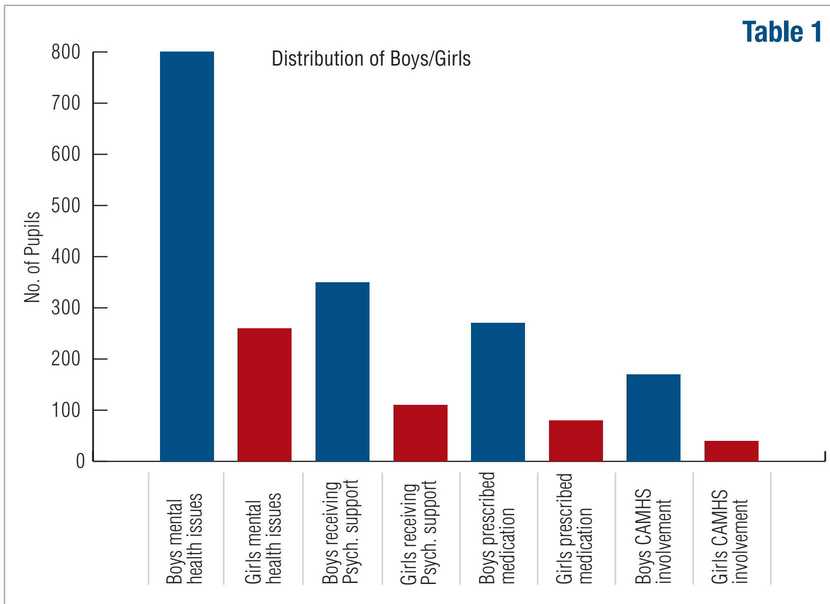
Findings

A number of key themes were identified through analysis of both the school questionnaire data and the data collected from follow up interviews with school personnel. These are presented here with supporting evidence from both the qualitative and quantitative data.

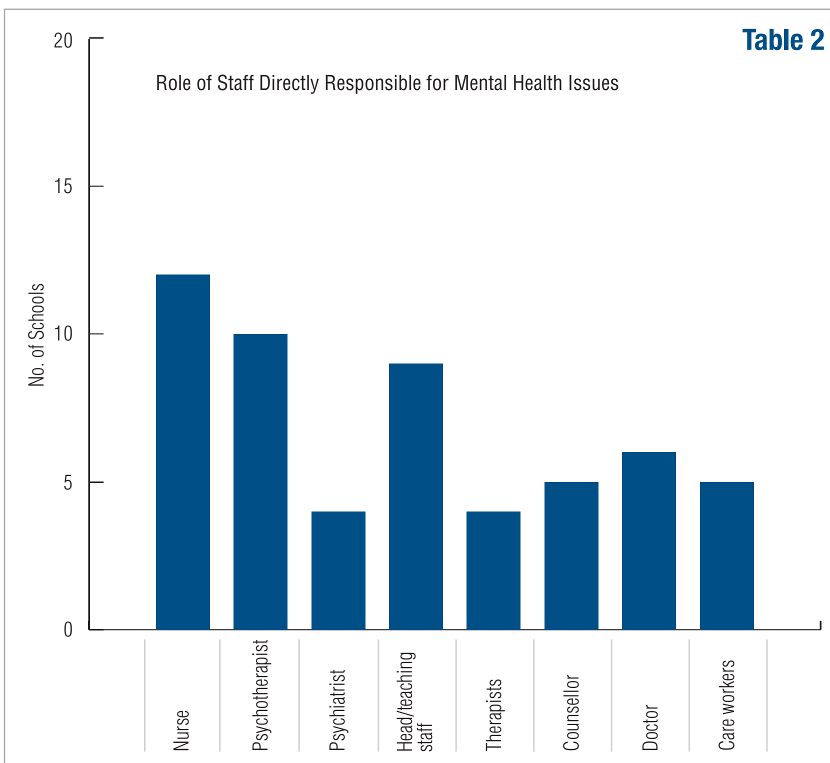
Mental health as an issue for schools

It is apparent from the data that the majority of the NASS schools within the sample perceive that a significant number of their students require support for mental health problems. Whilst students are placed within the schools ostensibly to address their special educational needs, many of the respondents interviewed saw mental health difficulties as being an important issue within their schools. It is clear that whilst this is not the primary reason for referral of students to the NASS schools, it is an issue which is of significant concern and which many professionals do not believe is being adequately addressed.

It was evident from the questionnaire responses that the NASS schools within the survey saw mental health issues as a matter of considerable concern. More than 1,000 pupils in the responding schools were identified as having mental health difficulties, the majority boys (table 1). This gender balance is not surprising as the majority of pupils attending the schools are boys. An issue which may be of concern is the small proportion of these pupils identified as having mental health difficulties who have received specialist support.



Schools within the research sample were generally aware of mental health problems and had established practices for ensuring the welfare of all pupils. Specific responsibility for the management of mental health issues was often allocated to a named member of staff, the role of person named varying considerably across schools (table 2). It is important here to recognise that NASS schools vary considerably in size and designation of staff and that this variability in responsibilities is what might be expected.



When should we worry? When is it a "Mental Health Problem"?

The evidence from this research suggests some confusion over definitions of mental health issues and a lack of confidence in identifying these in the specific populations within the special schools. In particular individuals interviewed were often unsure about the relationship between specific conditions such as Autistic Spectrum Disorder, Attention Deficit Hyperactivity Disorder or Social Emotional and Behavioural Disorders and mental health problems. If, for example, one compares the signs of a condition such as autism with the recognised symptoms of a mental health problem such as generalised anxiety disorder there are a number of common features such as avoidance of situations that give rise to anxiety and social withdrawal.

In some instances it was assumed that mental health difficulties were an accepted feature of these conditions. This level of acceptance was, at times perceived by some professionals as the cause of low expectations in respect of individual behaviour. It was also apparent that, at times, a mental health difficulty was being identified as a causal factor in pupil behaviour

for which schools were unable to provide an alternative explanation.

"They (teachers) want a diagnosis of something so they can say ' it wasn't me but it is the condition' and certainly a lot of behaviours don't, because they are not normal, fall within the normal range of behaviours. I think they can appear to be as a result of some sort of mental health issue."

(Psychologist)

This psychologist was not being critical of teachers but rather recognised the frustrations which some feel at their inability to account for difficult or unpredictable behaviours.

Difficulties of identifying mental health problems are not assisted by a lack of clarity over definitions and in some instances staff in schools feel confused by this issue.

"I have only been to two meetings and the first one was very much an argumentative meeting where we had exactly that discussion about what do you call mental health and who are we, us mere mortals to make that diagnosis, you know? Do you say, just because they have got an additional diagnosis, a dual diagnosis, does that necessarily mean they have got mental health issues like, if they have got Tourette's syndrome or autism does that mean that they've got a mental health issue? If they have got emotional difficulties, does that automatically mean they have got a mental health issue as well? We haven't finished that debate."

(Teaching assistant)

"You know, what is a mental health issue? What is a behavioural issue? What is an ASD issue?...Some people certainly would argue that if you can get the environment right and the approaches right around a young person then the perceived mental health problems seem to diminish."

(Care manager)

This confusion was apparent in staff at all levels and is a clear obstacle to the development of a cohesive policy or the delivery of well-structured support mechanisms. School personnel often raised their difficulties of identification of mental health issues within their pupil populations. In particular they highlighted difficulties where pupils have ASD/Tourettes/SEBD as behaviour presentations that could be open to interpretation as 'part of their condition' or symptoms of poor mental health.

School staff also highlighted specific challenges where pupils had communication difficulties – either restricted expression (e.g. pupils who were non-verbal) or whose understanding of social/interpersonal situations were limited (e.g. pupils with ASD). In some instances behaviours were seen as a means through which pupils expressed their own frustrations and thereby became a way of communicating personal distress.

"The majority of students have no spoken language, their main means of communication is through their behaviour."

(Head teacher)

Some schools provided examples of innovative approaches to enabling pupils to express their emotions or feelings and thereby relieve anxiety or stress.

"We can do that through exploring using visual mind maps and using other visual methods like "feelings thermometers" and the "feelings wheel" that we use sometimes. So, we can gauge how a person is feeling by them being able to indicate this through some method. As to underlying causes, which is always what we try to establish, so that we know how to address the matter, again it is about working with the child. It is

through using the correct communication to see if you can gain more insight; it is talking to people who know the child well, especially parents. It is communicating with staff and other people who work alongside the child and it is keeping records of behaviour so that we can see the patterns and so we know what strategies are working and what we need to discard or improve upon."

(Speech and language therapist)

Interviews with staff in the schools make it clear that they are regularly seeking ways of supporting pupils in expressing their feelings and emotions. The suggested use above, of feelings thermometers or visual mind maps is one example of how professionals are seeking the means to ensure that the feelings and emotions of young people are duly considered in respect of planning to meet their educational, health and social needs. The use of visual approaches was regularly cited as being important as schools developed strategies to support young people in expressing their feelings. This was particularly noted in those schools working with young people with autistic spectrum disorders.

Enabling young people to take some control of their own feelings and to express these to others was given a high priority by some schools. Here again, the use of a "thermometer" was cited as helpful.

"We have one student who has a mood thermometer that he does use to recognise and to let other people know when he is starting to feel anxious and stressed."

(Head teacher)

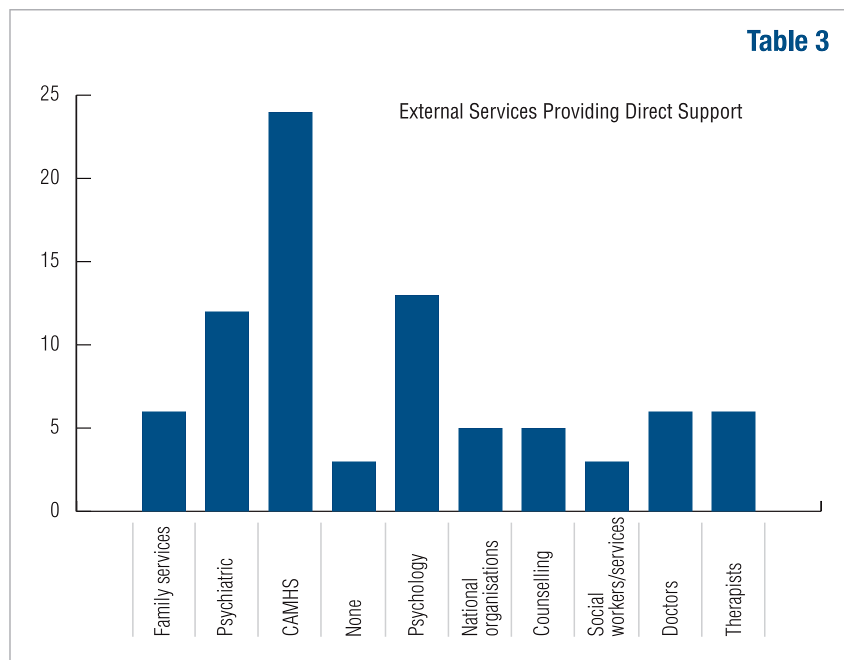
The challenge which schools face in defining and identifying mental health issues is clearly exacerbated by both difficulties of pupil communication and confusion with regards to those aspects of diagnosed conditions, such as autistic spectrum disorders or ADHD, which are reported to manifest behaviours which may be attributed to neurological difficulties. The data from this research indicates a clear willingness on the part of professionals both within schools and from supporting agencies to support pupils who show signs of distress but also indicates feelings of inadequacy with regards to identifying or defining some of the causal factors which impact negatively upon the lives of pupils.

Variability in sources and quality of support

Provision of support for staff in the management of mental health issues in students came from a variety of sources and there is no consistent pattern across schools (table 3).

Whilst many of the schools receive some support from Child and Adolescent Mental Health Services (CAMHS) the levels and quality of this support appears to vary from school to school. Both psychological and

Table 3



psychiatric services were cited by some schools as being important in the provision of support to schools and families. Many schools commission and buy-in their own psychology and psychiatry services.

However, services were not easily accessible to all and there appears to be a lack of understanding with regards to the roles that these professional colleagues may be able to play in respect of the mental health needs of students with special educational needs. With regards to CAMHS, interviewees often referred to the strain under which these services are operating and did not wish to apportion blame to the individual workers for an inability to deliver services. However, the research clearly indicates a high level of frustration caused by an inability to access appropriate CAMHS or other psychiatric services for pupils who were perceived to be in urgent need of help.

"Mental health services are in short supply within the NHS. I think when a child is showing anxiety, depression, or a drastic change in behaviour, behaviours we can't cope with, that is a problem. It does seem quite a battle for services sometimes."

(Healthcare manager, school for pupils with SLD/PMLD/ASD)

"They don't respond, we don't feel in contact with them, we don't know what has happened if they are seeing one of our pupils."

(Teacher, school for pupils with SEBD)

However, not all schools experienced this level of difficulties in accessing support from CAMHS and other agencies. When relationships with CAMHS are well established there is evidence that teachers and others feel well supported and see the service provided as playing a significant role in supporting schools, families and young people. An example of this was given in reference to a pupil who had been self-harming and required regular intervention.

"They (CAMHS workers) were fantastic with her, absolutely brilliant, and she would go and see them weekly…they did lots of work with her. I felt that was a really positive experience and I was impressed with them…I found working with them definitely helped."

(Head of Care, school for deaf pupils)

An issue raised in some schools centred on how they maintained relationships with services at a distance. Many young people are in residential schools some way from their home and placing authority. In some instances procedures require that help with mental health issues is sought from the placing authority, rather than the authority in which the school is located, and this can result in delays in providing a service.

Where professionals from outside agencies were able to provide support these colleagues were often seen as being knowledgeable both in respect of mental health issues and the needs of the specific students within the school (table 4).

"We have got a clinical psychologist who works with the more profoundly disabled, that is her specialism. This is a strategy being put in place for one young person who has huge behaviour problems at the moment. She has been brought in to try and find out what is causing it and how we can help her get through it. And she is really good because she can come at a whim almost, you just have to email and she can be there, so she has been very supportive."

(Teacher, school for pupils with SLD/PMLD)

A factor here may be that where professional colleagues are directly contracted to a school they have

greater opportunities to develop relationships with staff, to acquire greater insights into pupils and to gain a more in-depth understanding of how individual schools operate.

Examples were given through interviews of some direct interventions from professionals in respect of specific difficulties. These included support from therapeutic agencies for pupils who were experiencing difficulties with sleep. A few schools have made use of music therapists or play therapists but in the interviews conducted these were spoken of in general terms rather than with direct reference to mental health. There were examples of good interagency and multi-disciplinary responses to pupil needs which were effectively co-ordinated and clearly had major benefits for young people in distress. In response to a pupil who had shown increased levels of anxiety which resulted in heightened aggression towards both students and staff, one school was able to provide evidence of an effective co-ordinated response.

"The senior leadership team and the SENCo were involved, along with our sensory person. Through the SENCo, the local CAMHS team were approached and outside agencies were brought in. This was in the form of a clinical psychologist who liaised with the school and worked with the school and the senior management team and the teacher and the sensory adviser to develop a programme…

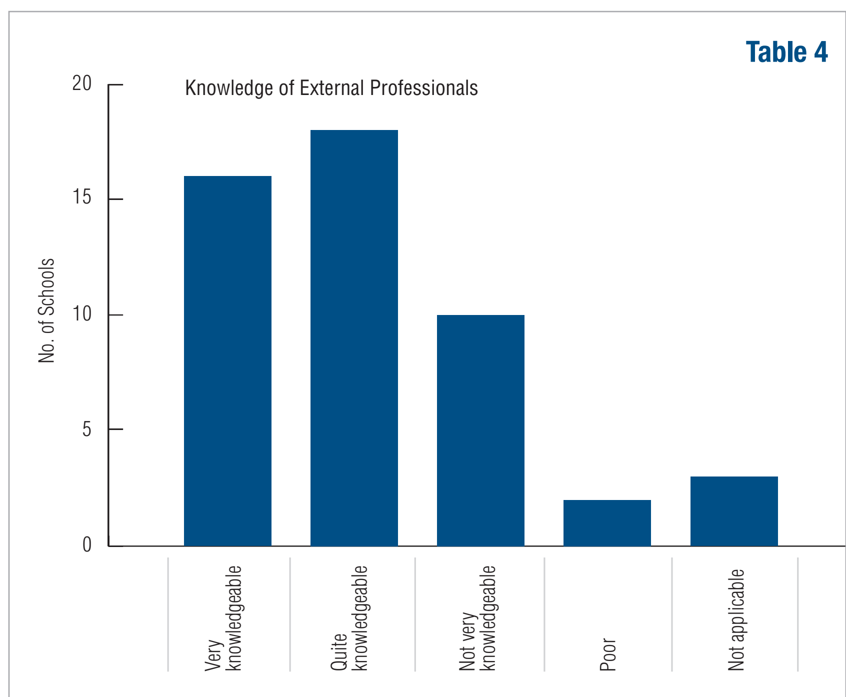
I think at the moment it is working well within the limitations that the staff have in dealing with mental health issues."

(Class teacher)

This teacher was typical of many interviewed in recognising that within schools there is limited experience or understanding of mental health issues, which emphasises the need for a co-ordinated response with other professional agencies. In the case of this school, that response was seen to have been effective and this resulted in an improved situation for both pupils and staff.

However, a co-ordinated response does depend upon professionals being able to agree upon definitions of mental health and establishing effective links across agencies. Such a co-ordination is not always forthcoming and this can at times lead to frustrations. In some instances finding the most appropriate individual or team to provide support is the key to gaining successful interventions.

"The psychiatrist who came out to interview him doesn't actually feel that he does have a problem. She feels that it is behavioural and she is going to give us some suggestions as to how we can challenge his behaviour. But we did feel that there was something that was missing, that we needed some



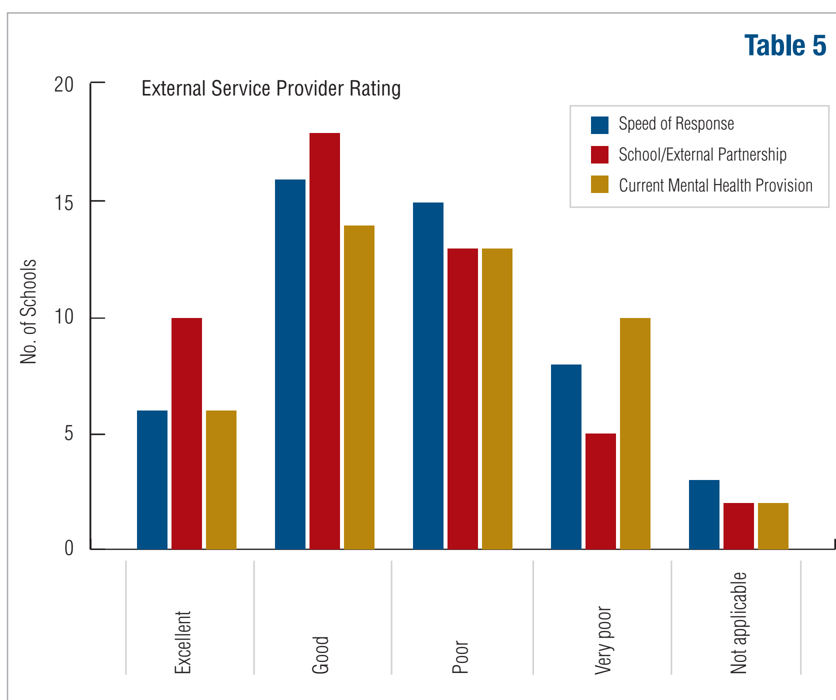
expert input. We went through to CAMHS initially and they weren't able to help us. It was then passed on to the county Learning Disability Mental Health Assessment Team and they helped us - they actually sent somebody out to meet with us. I have to say she, when we actually got to that point, she was very thorough." (Care team leader)

Whilst staff in schools often commented favourably on professional knowledge of mental health service providers, the speed of response to school need was regarded as variable. Whilst 43% of respondents were satisfied with the time required to gain action from professional service providers this was matched by 43% who felt that response times were either poor or very poor (table 5).

However, schools are aware of the pressures under which services operate and the constraints under which service providers often find themselves working and they seldom believe that the difficulties of provision are related to a lack of willingness to respond. Indeed the majority believe that they have a good working relationship with colleagues from a range of professional agencies.

Staff training

Data from the questionnaires indicated that few staff had received specific training in the area of promoting emotional well-being and positive mental health (table 6). Some of the non-teaching staff, and in particular those with nursing qualifications had received training as part of a more generic nursing or care course. A few had attended training specifically related to counselling and some had received training in the management of behaviour which gave reference to mental health problems. However, interview data suggests that there is a need for additional training in this area in order to overcome some of the confusions and apprehensions which currently surround the management of mental health issues.



Asked about professional development, a teacher working with pupils with SEBD who had identified a number of mental health issues in the pupils with whom she worked commented:-

"Well, from my experience over the last twenty years, unless somebody has done it as part of another course, in terms of us offering in-service training here, that is not something we have looked at."

(Teacher, school for pupils with SEBD)

Many interviewees felt that mental health issues had been "touched upon" in other courses related to health education or behaviour management but that this lacked the detail to promote staff confidence or assist adequately in terms of either identification of need or intervention.

"When I was doing my learning disability nurse training it briefly covered some mental health, but probably only about two days' worth and you have got to consider that that is going back twenty years."

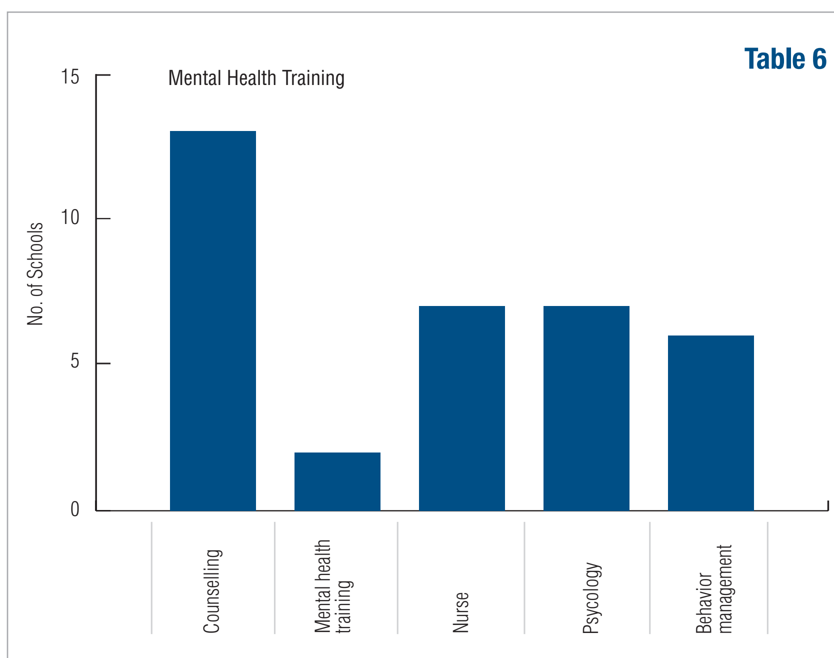
(Care manager, school for pupils with SLD/PMLD)

Other staff felt that they had some knowledge in respect of specific areas of mental health but that this was inadequate in relation to the breadth of issues with which they were regularly faced. They were often fairly clear in expressing both the areas of training and the format which it should take.

"I would like training on the wider issues because I am aware of the issues in terms of depression. I know that there are other mental health issues that we have with regards to children in other classes around the school…I would like more training on a much wider understanding of the different mental health issues where our children can suffer…I would like that on a formal basis, to know how to move thinking forwards and how to change, or hopefully try to adapt children's thinking to help them cope in a better way."

(Teacher in a school for pupils with ASD)

A particular concern with regards to the provision of training centred upon the availability of training providers who had both an understanding of mental health issues and the nature of the pupils served by a school.



Opinions were expressed which emphasised that whilst there were very skilled professionals working within mental health services, they sometimes lacked a detailed understanding of specific groups of pupils, such as those with ASD.

"There are people who have expertise in autism and there are people who have expertise in mental health, but to have both I think is probably quite rare. It might be that we work with somebody who hasn't got the expertise in autism but we add that in and we end up doing something with somebody that is a bit cutting edge."

(Head teacher, school for pupils with ASD)

Curriculum response

Direct teaching about mental health and emotional well being has become a feature of many mainstream schools. In special schools, where this is likely to be an issue of some concern, it might be expected that some attention would be devoted to mental health within the school curriculum. However, the picture emerging from the data is one of considerable inconsistency. 96% of respondents suggested that the emotional well-being of students in school was given a high priority in school and was addressed within the

school curriculum. The questionnaire survey reveals that 62% of schools have some level of focus upon mental health and emotional wellbeing issues within their personal, social and health education (PSHE) curriculum. The range of approaches to teaching about mental health issues or addressing student needs during the school day was considerable. Some schools have established tutorial systems whereby individual students can seek assistance or receive instruction from a member of staff that they know well. Other schools make considerable use of therapists or counsellors. Hardly any of the schools have developed curriculum materials specifically for dealing with mental health or for teaching students about emotional well being. There were some positive responses describing the use of concrete and visual resources to support pupils in their understanding and expression of personal emotions e.g. emotion thermometers and fans to indicate emotional state, the use of objects of reference to signify requests to 'help' deal with emotional states – e.g. aromatherapy oil to ask for relaxing massage - and social stories to help learn, for example, appropriate social responses. Whilst two schools specifically mentioned use of the Social and Emotional Aspects of Learning (SEAL) materials, these were not mentioned by the majority and may be inappropriate for use in some special schools without considerable modification.

Staff in some schools were aware of the need to incorporate mental health issues into their curriculum, often locating this within the remit of PSHE.

"I am not sure that we do at the moment…and I think that is something we need to do, we need to put in really, and you know we could have inset days for children on various issues to do with mental health without it sounding like mental health, we could have PSHE days and things like that."

(Teacher, school for pupils with SLD/PMLD)

Some schools were able to articulate specific approaches which they have used to support the emotional well being of pupils. Reference to commercially produced schemes such as 'Zippy's Friends' or 'Listen to Me' were cited by a few but these were a minority of schools and most appeared to have considered mental health issues within the curriculum only as a peripheral part of a more general approach to health education within PSHE. In some instances schools had examined available resources, generally designed for use in mainstream schools, but had found these inadequate in terms of a more needy population.

"In general you might find that in a resource pack for dealing with bereavement or anger you find one or two pieces of it which are actually quite useful but the rest you couldn't use."

(Teacher, school for pupils with SEBD)

Discussion

Whilst there are clearly issues of concern around the mental health of some young people in the NASS schools, it is clear from the research that staff in those schools are committed to addressing these issues within their existing resources. A lack of training in relation to this issue is an inhibiting factor in supporting a more cohesive approach to the management of mental health. This is at times further exacerbated by difficulties in providing a co-ordinated response across agencies to meet the needs of pupils and staff. However, there are examples of good practices in many of the schools who engaged in this research and a willingness on the part of all schools to move forward to establish a well co-ordinated response to mental health issues. Examples were seen of excellent collaboration between schools and outside agencies such as CAMHS. It is, however, clear that the availability of services varies across the country and that in some instances schools have major concerns about being able to access the necessary support for their pupils.

Ways forwards

The knowledge base of effective treatments for children and young people with complex needs and disabilities who experience mental health problems is slowly growing. However, it is still too often the case that the mental health needs of young people with disabilities go unnoticed until problems are severe and entrenched (e.g. Howlin 1997[xvii]).

A number of specialist organisations have compiled helpful information on mental health conditions in young people with particular special educational needs and disabilities. For example, the National Autistic Society has produced a very helpful fact sheet setting out how particular conditions such as depression and anxiety might manifest themselves in someone with autism or Asperger Syndrome [xviii]. Mind has also produced a useful resource on mental health and learning disabilities [ixx].

Although this study revealed that some school staff lack confidence in dealing with "mental health issues", when they are defined as such, it was also clear that the emotional wellbeing of pupils is a core concept in most schools. In 2009, all maintained schools will have a new duty to "promote the emotional wellbeing of pupils". This places schools in an excellent position to focus on the promotion of good mental health and the prevention and identification of mental health problems.

It was evident from the research that many schools undertake activities that might be seen as addressing emotional wellbeing without necessarily perceiving that this might also be a means of addressing mental health issues. In some schools there is still a perception that anything to do with "mental health" belongs in a professional arena beyond school. Mental health is still poorly defined as an issue for staff in many of the schools. This results in confusion with regards to policy development and the co-ordination of response and services. School staff can find themselves in a position where they both fail to understand how the work that they do within school supports mental health and fail to pick up on cues that a child or young person might be in need of further support from a mental health professional. There is a need to promote a discussion aimed at clarifying issues and for schools and agencies in the public and voluntary sectors to undertake further work to provide guidelines to staff in schools and other agencies with regards to the definition and identification of mental health difficulties.

Overall, there is a lack of curriculum and teaching materials related to mental health issues. Resources tend to be aimed at promoting emotional wellbeing in learners as opposed to addressing mental health needs and recognising mental health problems. Whilst some very good materials to develop the social and emotional aspects of learning have been designed for use in mainstream schools, these are often seen to be unsuitable/inappropriate for use with special school pupils. There is a need to both develop appropriate resources to enhance positive mental health and emotional wellbeing and to consider how these might be delivered within existing curriculum provision within the schools. Schools would also benefit from guidance and training focused upon the support of pupils experiencing mental health difficulties.

One of the key strengths of schools, and special schools in particular, is that staff know their pupils well. In the case of residential schools, school staff will be the people who spend most time with a child or young person. Literature on mental health issues and children with special education needs emphasises the need for staff to be alert to sudden changes in a child's mood or behaviour as a sign of possible mental health problems (e.g. Tantam and Prestwood 1999 [xx]). School staff are well-positioned to be able to note such changes.

The following example shows how one school has taken steps to think, in depth, about the emotional experience of being in a residential special school for a boy with Autistic Spectrum Disorder.

John has major issues with his family and why he is not living at home. He is trying to understand why he is at our school. This has been an on going issue for John. He has been attacking staff quite severely with major bites, punches to the face and throwing things at staff's faces - especially their eyes. He had also started picking up chairs and smashing them through the classroom windows (when he wasn't throwing them at staff!)

We quickly set up a separate classroom for John in a wooden chalet beside the house where he lives whilst he is at school. This was a quiet space where he could work and take time out without any distractions and noises from other children and school routines. He had his own individual timetable which he worked through and he was also able to access whole group activities with his class mates, e.g. religion lessons, movement lessons and snacks and break time, if he was in a good mood. We also used a minimum of verbal communication with John, as this helped keep his anxiety levels down.

To help address his family situation, we have designed a social story or life story for him in written word and Makaton to help him understand why he is no longer living at home and that he has not been rejected by his family. We have worked with social services with this through his social worker who has approved the story and will bring Mum in during the holidays so that she can read it to John.

We have now set up another quiet space away from his house and we have slowly introduced this special new space for him before the holidays so that he will know where to go after the holidays. This will help reduce John's anxiety levels. He is also taking medication for anxiety and he is having twice weekly massage sessions and lots of other sensory sessions with aromatherapy to also help. We are also working with John on how he can understand and express whether he is happy, sad, angry etc. before he explodes and attacks staff. He is working with various emotional cards and although we are in the early stages, this seems to be getting through to him and he seems to be understanding the various concepts. We also introduced a tent for this child to crawl into and put a duvet and a pillow in to allow him to completely shut the outside world out.

This example is replicated in other schools and exemplifies how schools can use a variety of methods to address pupil wellbeing. The student in this example is receiving input from mental health professionals for his anxiety and is taking medication for this. However, the school seeks to provide an environment where his anxiety levels can be reduced and to provide opportunities for him to learn more about healthy emotional responses. This combination of responses from school and outside agencies has been particularly effective for this pupil.

From this study, we have been able to draw together a number of recommendations for schools and other agencies.

Recommendations for Schools

There is a need to increase staff confidence with regards to the professional services being provided to schools by external agencies. This is likely to be achieved only at such time as there is a clarification of roles and responsibilities based upon a shared perception of the needs of students, staff and families.

Procedures for securing professional support from outside agencies are often ill-defined. Where the provision of support works effectively, roles and responsibilities are well defined and practices based upon well documented and familiar procedures are in place. However, in many schools the steps to be taken in

addressing complex student mental health needs are not clear.

Schools need to work with other service providers in order to ensure that lines of referral and intervention are clearly understood by all parties who are working for the education and support of pupils and families. The development of a service matrix, which outlined responsibilities, patterns of intervention and evaluation of impact upon pupils would have benefits for all parties.

There are examples of good practice in developing approaches and teaching resources related to mental health in many of the NASS schools. Similarly, there are a number of innovative approaches to assessment and pupil self management in place. The development of a means of disseminating these practices would be beneficial not only to colleagues working in NASS schools, but also to teachers and others working in special schools across the country.

Recommendations for other agencies

Schools at times feel that the responses they receive from other agencies are not fully meeting their needs in respect of pupil mental health issues. Whilst they perceive a willingness on the part of health professionals to give their full support, lines of communication are not always clear and at times a co-ordinated response across agencies and with schools is not forthcoming. There is a need for health agencies, including CAMHS to work more closely in partnership with schools in ensuring that paths of referral, intervention and evaluation of input are clarified for all parties, including families in order to develop a more cohesive approach to supporting young people's mental health needs.

Conclusion

Staff in the NASS schools are addressing the needs of a complex population of young people, many of whom have been allocated school placements for social and health reasons in addition to their educational needs. The research indicates that these colleagues are highly professional in their application of assessment and educational interventions to support the holistic needs of their pupils but that they are unable to fully address the mental health needs of those pupils who require specific interventions and monitoring by specialist staff. The interface between health professionals and teachers is critical in ensuring that pupils who exhibit difficulties associated with their mental health have their needs fully addressed. Where this support is forthcoming it is apparent that staff in the NASS schools are very successful in meeting the mental health needs of pupils. This level of success has not been consistently achieved and must be a matter of concern for all who are working for the support of young people with complex needs.

Appendix 1 – Good practice Checklists

Check lists for policy and practice –

with respect to children and young people with complex needs

For local authorities and independent and non-maintained schools

Do consultations within the school community find ways of listening to the voices of these pupils?

Are there good links with other institutions and bodies to ensure effective multi-agency working?

Do schools have strategies in place to involve and support families in meeting the needs of vulnerable children?

Are schools effectively implementing the healthy schools programme and supporting the emotional wellbeing of their pupils?

Are schools, as a matter of good practice, reporting to governors annually on the PSHE and Citizenship programmes even though this is not a statutory requirement?

Are young people in schools at the centre of planning for their current and future needs?

Is there continuity in personnel, particularly with respect to an advisor or a key worker, in planning with the student for their future?

Do staff know where to refer pupils who may experience mental health problems?

Do staff have in-service training in the promotion of emotional well being and the identification of emerging mental health problems?

For local authorities, primary care trusts, mental health trusts and strategic health authorities

Are there primary child and adolescent mental health workers who can act as a gateway and ensure that children are appropriately referred and do not fall through the net?

Are children where possible treated in mainstream services? Are specialist services available locally or regionally for those with the most complex needs?

Are there adequate staffing levels to meet the needs of these children and their families?

Is there a clear gateway into child and adolescent mental health services (CAMHS) and then a clear pathway through these services?

Are all staff trained to be confident to work with and treat these children?

Is there a clear pathway into adult mental health services for those who require them?

For Government

Are the programmes to combat poverty sufficiently sensitive to the needs of these children and their families with respect to employment, benefits, childcare and housing?

Is Ofsted able to blend the different cultures of education and social care into one inspection framework?

References

[i] The Mental Health Foundation (1999) Bright Futures: Promoting children and young people's mental health London: The Mental Health Foundation

[ii] Mental Health Foundation (2005) Lifetime Impacts: Childhood and Adolescent Mental Health : Understanding the lifetime impacts London: The Mental Health Foundation

[iii] Green,H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2004) The Mental Health of Children and Young People in Great Britain London: The Office of National Statistics

[iv] NSPCC (2007) Childline Case Notes: Calls to Childline about depression and mental health www.nspcc.org.uk

[v] Unicef (2007) Child Poverty in perspective: An overview of child well-being in rich countries www.unicef.org/irc

[vi] Foundation for People with Learning Disabilities (2002) Count Us In: Meeting the mental health needs of young people with learning disabilities London: The Mental Health Foundation

[vii] Emerson, E. and Hatton, C. (2007) The Mental Health of Children and Adolescents with Learning Disabilities in Britain The University of Lancaster and the Foundation for People with Learning Disabilities www.learningdisabilities.org.uk

[viii] The Department for Education and Employment (2001) Promoting Children's Mental Health in School Settings London: Department for Education and Employment

[ix] Department of Health (2004) Choosing Health: Making healthy choices easier London: The Department of Health

[x] The Department for Education and Skills (2004) Healthy Living Blueprint for Schools London: The Department for Education and Skills

[xi]The Department of Health and Department for Education and Skills (2005) National Healthy School Status: A Guide for Schools
www.wiredforhealth.gov.uk/PDF/NHSS_A_Guide for Schools 10 05.pdf

[xii] See www.standards.dfes.gov.uk/primary/publications/banda/seal

[xiii] See www.partnershipforchildren.org.uk/zippy-s-friends.html

[xiv] See www.nptrust.org.uk

[xv] DfES (2007) Social and Emotional Aspects of Learning For Secondary Schools : Guidance Booklet
http://bandapilot.org.uk/secondary/resources/welcome_page/sns_ssealguidance0004307.pdf

[xvi] Ofsted (2007) Time for Change :Personal, Social and Health Education
www.ofsted.gov.uk

[xvii] Howlin, P. (1997). *Autism: preparing for adulthood*. London: Routledge. Available from the NAS Publications Department.

[xviii] National Autistic Society – Asperger Syndrome and Mental Health
http://www.nas.org.uk/nas/jsp/polopoly.jsp?d=128&a=3346 accessed 23/10/08

[ixx] Mind – Learning Disabilities and Mental Health Problems
http://www.mind.org.uk/Information/Factsheets/Learning%2Bdisabilities/#Treatments_for_mental_health_problems_in_people_with_learning_disabilities accessed 23/10/08

[xx] Tantam, D. and Prestwood, S. (1999). *A mind of one's own: a guide to the special difficulties and needs of the more able person with autism or Asperger syndrome. 3rd ed*. London: National Autistic Society.
Available from the NAS Publications Department.

Acknowledgements

This publication was written with the support of the National Centre for Excellence in Residential Child Care.

The publication draws on work commissioned by NASS in 2006 from the Centre for Special Needs Education and Research (CeSNER) at the University of Northampton. This study was carried out in 2006-07 by a research team comprising:

Professor Richard Rose – CeSNER
Anne Fergusson – CeSNER
Marie Howley – CeSNER
Johnson Jament – CeSNER
Mary Feng Yang – CeSNER
Liz Bonnett – CeSNER
Kim Taylor – St Christopher's School
Emma Birkett – Prior's Court Foundation
Clive Fowler – West of England School and College
Caroline Bulmer – Wargrave House School

The project was supported by a steering group comprising:

Claire Dorer – NASS
Professor Barry Carpenter – Sunfield
Karen McLean – Contact a Family
Pauline Holbrook – Specialist Schools and Academies Trust
Lorraine Petersen – NASEN
Hazel Morgan – Independent Consultant
Jonathan Stanley – NCERCC
Robert Phillips – Seashell School

For further information about the National Association of Independent Schools and Non-maintained Special Schools contact:

Karen Rippon
Administrative Officer
NASS
PO Box 705
York
YO30 6WW

Telephone: 01904 624446
Email: klrippon@btinternet.com