OXFORDSHIRE GOVERNORS' ASSOCIATION (OGA)

Notes of the Spring Term Open Meeting held at The Beecroft Theatre, The Oxford Academy at 10.00am on 27th February 2016

Welcome

Carole Thomson (CT) Chair of OGA welcomed over 54 governors, LA officers, members of the Oxford Health NHS Foundation Trust and others to the meeting. The format for the morning was explained, opening with a presentation by Dr Mina Fazel DM MRCPPsych, which would end at around 11.15am. Attendees would then be asked to participate in Round Table Discussion Groups of Key Challenges for Schools – up to 4 groups with different topics.

CHILDREN'S MENTAL HEATH – WHAT NEEDS TO CHANGE?

A warm welcome was given to Dr Mina Fazel, who is a Research Fellow in the Department of Psychiatry at the University of Oxford. The focus of her current research is school-based mental health interventions. She is working with the Oxford Health NHS Trust. She is a mother of three children. The aim of the presentation was explained:

Aims

- School mental health : who and what
- UK development of school-based mental health services
- Oxfordshire examples
- Mental health toolbox taster
- Questions

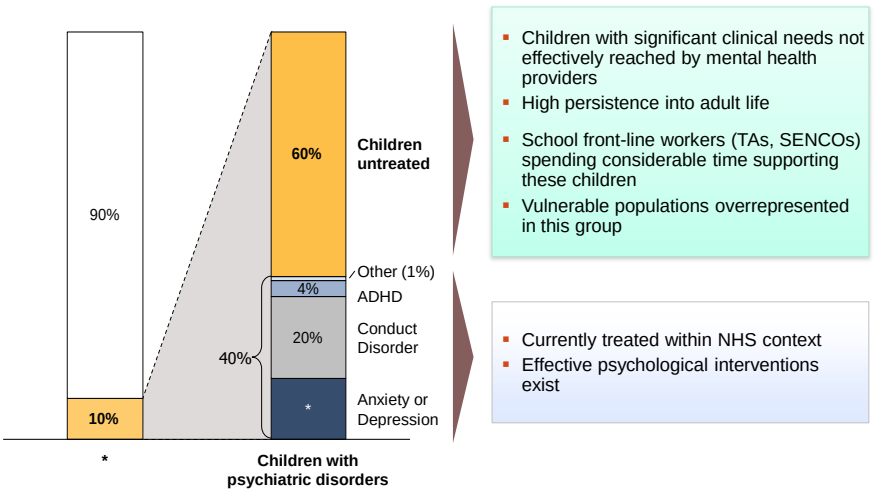
Chief Medical Officer

"There is a great need for earlier treatment for children and young people with mental health problems. Half of adult mental illness starts before the age of 15 and 75% by the age of 18. Unless young people get help, they risk a life of problems including unemployment, substance misuse, crime and antisocial behaviour. Under-investment in mental health services, particularly for young people, simply does not make sense economically"
CMO Annual Report, September 2014

Mina emphasised the '***great need for earlier treatment for children and young people. Half of adult mental illness starts before the age of 15 and 75% by 18.'*** The audience was asked what they thought prevented access to children needing mental health care. Suggestions were:

- Stigma – friends, family and society – will be labelled as a problem child
- Teachers in schools not knowing, not recognising it. Assume simply that children are naughty, misbehave. What is 'normal'?
- Think they will grow out of it
- Services and access to funding – referrals bounced back – waiting lists of 8 to 12 months
- Lack of preventive work – nothing can be done – wait until it is more severe before you can access the service
- How is 'mental health service' defined because services are defining themselves to get funding which dis-empowers schools, parents etc
- Lack language to explain the problem – a sore throat is easy but children do not know how to express how they are feeling/thinking and how to express emotions
- Issue of blame - parents perceiving that the school blames them – very complicated
- Difficult to provide the skills and time for teachers to deal with this

Children's mental health needs in the UK



School Years

- Prevalence of mental health difficulties
- Relationship between academic achievement and mental health
- Persistence
- School specific factors:
  - Bullying
  - Relationship with teachers
  - Burnout of teachers
- Considerable time spent in school

10% of children will need access to mental health support. Of this 10%, data shows that 40% are accessing services (behaviour, anxiety, depression etc.); and 60% are untreated with a risk of high persistence into adult life. Schools spend a lot of time supporting this group, which includes vulnerable children. There was an important relationship between academic attainment and mental health. Issues such as depression, loss of energy and interest make it hard to study.
Evidence shows that bullying has an increasing impact on the remainder of the victim's life with increased risks of self-harm, suicide and mental health issues.
Relationships with teachers and the roles they play are significant – one person outside the family can have a huge impact on a child suffering mental illness. Conversely, studies show the large impact of a teacher perceiving mental illness in a negative way. Mina would love to see trainee mental health practitioners link with teachers and vice versa to improve knowledge and understanding. 50% of teachers in USA leave the profession shortly after training and many give the reason that they cannot manage the emotional and behavioural needs of children.

14 year study of 2000 adolescents

- Assessed 8 times over 14 years
- High symptoms scores at least once in adolescence: 29%M: 54%F
- 60% had a further episode as a young adult
- Less likely to have a recurrence if first episode lasted less than 6 months
- Longer duration most clear cut predictor of young adult disorders (3x)
- Parental separation and divorce strong risk factor

UK School-based mental health

- Targeted Mental Health in Schools (TaMHS) (2008-2011)
  - £60 million programme
  - Early intervention for 5 – 13 year olds at risk
  - Included 3000 schools in 151 Local Authorities who determined budget allocations
- Longitudinal study and RCT
  - 137 primary and 37 secondary schools

TaMHS evaluation

<u>Findings</u>

- More positive links with mental health services associated with greater reductions in behavioural problems in secondary schools
- Parents reported schools as key point of first contact for mental health advice for child

<u>Implications</u>

- Prioritise improved relationships and referral routes between secondary schools and mental health services
- Ensure schools retain a role in referral

Support is available from a range of sources: peers, pastoral support staff, teachers, school counsellors, school nurses, school psychologists, charities, mental health services. Treatment can include: CBT, behaviour interventions, art therapy, counselling, medication, family therapy.

American Experience

- Established school mental health over 30 years ago
- Over 2000 school-based mental health services
- Growing evidence base
- Visits for mental health second highest after accidental injury
- 75% of children receiving mental health care receive it in the school system
- Fewer drop-outs
- 12% of American child psychiatrists spending time in schools

Types of interventions: promotion

Mental health promotion *(Australia is the world leader on interventions)*

- Mindmatters
  - Student supports: Social and emotional learning programmes
  - Teacher: professional development
- I can problem solve
- Good Behaviour Game
  - Divide class into groups
  - Define behaviours that are wanted and not wanted
  - Reward

Health Promoting Schools

- Curriculum teaching and learning
  - Recognising discrimination
  - Acknowledging individual differences
  - Having conflict resolution skills
  - Working co-operatively
  - Gaining knowledge of and skills to counter cyber and text bullying
- School organisation and ethos
  - Staff professional development
  - Staff role modelling of positive behaviours
  - School anti-bullying policies
    - Anonymous "bullying boxes"
    - Consequences for bullies
    - School telephone line for students to report incidents by text
- Community links and partnerships (*requires respect to students, parents and other community members)*
  - Open-door policies
  - High profile anti-bullying policy
  - Professional development for parents on enhancing resilience, managing relationships and addressing bullying
  - Coffee mornings for parents and other interested members of wider community

Global context

- 80% world population children in Low and middle income countries
  - Largest proportion of their population
  - Resources to education insufficient
- Schools everywhere
  - Great variation
  - Needs of children somewhat similar
  - 9% out of school: 58 million worldwide
  - Challenges at school: resources and abuse potential
- Mental health services
  - mhGAP pronounce for children

School Health Promotion and Empowerment: SHAPE

- India
- Training lay counsellors
- Physical and mental health promotion
  - Screen for hearing and visual problems
  - Individual mental health interventions
- Supervision with skilled counsellors
- Whole school violence and bullying prevention strategies

Globally

- School opportunity to integrate mental health care within a system of care that already exists
- Sustainable intervention
- Research gaps
- Implementation prioritisation
- Scaling up of services

Mina had worked with refugee children and spoke briefly of her experiences and results of research into their special concerns. In Syria 700k children were out of school. Of refugee children in Oxfordshire who were surveyed, in answer to the question was life worse before coming to UK or after there was a 50% split. Of those receiving care from mental health services 71% preferred to be seen at school – because “hospital is scary”, “most welcoming people were at school”, “safer at school”.

Oxfordshire Services

Mental health services

- Overwhelmed health services
  - 30% increase in referrals
  - Long waiting lists

Education

- 34 state funded secondary schools
  - 7,000 children per school year
  - School health nurses
- Over 20 independent schools

Mental health provision in schools

- School dependent
- School counsellors
- Pastoral care system
- Limited links with local mental health services
- After a pilot study CAMHS staff will now spend half a day each week in secondary schools. Pilot study planned for primary education.

What might be the effect of this for Oxfordshire Services?

- See young people earlier in services
- See more young people as many have difficulty accessing services
- Engagement might improve with fewer non-attendances
- Help schools mange difficult and concerning problems on:
  - Individual cases
  - Classroom problems
  - Whole school difficulties
- Provide additional support to school staff

Challenges

- Ethical
  - Consent from whom?
  - Notes & Confidentiality: who should know?
- Screening
  - Should we do this?
  - When and how?
  - Teacher nomination system?
- Pastoral care systems within schools
  - How best to work in collaboration? *
- Space
- Private schools

Mina emphasised that with budgetary pressures and CAMHS coming in schools may be tempted to cut the support they offer through Counsellors etc. but it is important that schools must not get rid of their pastoral support. She advised that Oxfordshire is the only County in the UK that will be bringing CAMHS directly in to schools.

Questions for Schools (in discussion it was agreed there was no difference between primary and secondary)

- If a child wants to see the school CAMHS worker, should the parents give consent beforehand?

  This was discussed and the conclusion was 'Yes' and if child does not want parents to know we should get them to that point unless there is a safeguarding issue

- What do teachers need to know from CAHMS?
  How they can support the child, what follow-up, what parents should be doing to help

Children's mental health

Current 'crisis'

- More exposure to risks
  - Austerity
  - Family breakdown
  - Parental mental illness
  - Complexities of social needs
- Less stigma associated with seeking treatment
- Vulnerable groups

Schools and Mental Health

- Services in schools democratises access to services
- Integration challenges:
  - Governance issues
  - Education and health
  - Political, administrative
- Mutual contributions to training
- Need more evidence of what mental health interventions to deliver and need to learn
  - CAHMS working in schools?
  - Family links?
  - Mindfulness
  - FRIENDS for life?

Other Questions

- What if everyone likes the "intervention" but it doesn't actually improve mental health outcomes? Should it still be offered? *
- Whose responsibility?

* Answer offered from the floor, no it shouldn't, expensive interventions must be evidence based.

Conclusions

- Exciting times
- Opportunities
- We all need to invest
- Patience
- Intellectual Curiosity

On behalf of all present Carole Thomson thanked Mina for an informative and most interesting presentation. It was pleasing to learn that Oxfordshire was at the forefront of raising the profile of mental care and the implementation of initiatives to improve the working together of mental health services and schools had started.

Carole announced that there would be a short break after which attendees were requested to join a Group for a Round Table Discussion, a copy of all the suggested questions for discussion were available for all attendees. Lunch would be available from 12.15pm. Suggested topics for discussion were:

Group 1 Mental Health Mina had very kindly agreed to stay for this discussion.

Group 2 Other issues – Life without levels, Recruitment and Retention of staff etc.

Group 3 Implications of the Education and Adoption Bill: Academisation and other forms of Collaboration.

Group 4 Finance and Premises

The majority of those present continued to discuss mental health issues in groups, inspired by the presentation they had heard.