HOUSE OF COMMONS

Education Committee

Oral evidence: Mental health and well-being of looked after children, HC 481

Wednesday 16 December 2015

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Written evidence from witnesses:

- Sarah Brennan (MHW0067)
- David Graham (MHW0055)
- Lisa Harker (MHW0043)
- Kevin Williams (MHW0019)
- Carol Jones (MHW0034)

Watch the meeting

Members present: Neil Carmichael (Chair); Michelle Donelan; Marion Fellows; Suella Fernandes; Lucy Frazer; Ian Mearns; Caroline Nokes

Questions 1 - 67

Witnesses: **Sarah Brennan**, Chief Executive, Young Minds, **David Graham**, National Director, the Care Leavers' Association, **Lisa Harker**, Director of Strategy, Policy and Evidence, NSPCC, and **Kevin Williams**, Chief Executive, the Fostering Network, gave evidence.

Q1 Chair: Good morning and welcome. Apologies for the slight delay. Will you say who you are and what you represent, for the purpose of those watching?

Kevin Williams: Kevin Williams, Chief Executive of The Fostering Network.

Lisa Harker: Lisa Harker, Director Of Strategy, Policy and Evidence at the NSPCC.

David Graham: David Graham, National Director of the Care Leavers' Association.

Sarah Brennan: Sarah Brennan, Chief Executive of Young Minds.

Q2 Chair: Thank you very much, and welcome to you all. Looked-after children and young people are far more likely to suffer from mental health problems than their non-looked-after peers. Is the current provision of mental health services meeting the needs of this vulnerable group?

Lisa Harker: No, they are clearly not. We have been tracking the concerns raised to us through ChildLine by children and young people themselves. We counsel around 11,000 looked-after children every year and we are seeing a rising proportion of those counselling sessions concerning mental health issues. In the year to April, a quarter of sessions involved mental health issues and that has risen to a third since April.

We are also seeing a very sharp rise in the number of children and young people telling us that they are having difficulty accessing services: a 124% increase in concerns to April this year. On that evidence, we are concerned that children and young people are not getting access to the support they need. Levels of mental health issues and worries are very high.

Chair: Would anyone else like to comment?

Kevin Williams: We agree that the answer is no. We agree with lots of what Lisa said in terms of access to services being particularly poor. Access to CAMHS is a real issue for a number of young people who are looked after, particularly those young people who may move from different areas. So often for access to CAMHS there can be up to a six-month waiting list and, if young people move placement, they have to start that whole process again. We would certainly like to see a more personalised budget approach to being able to access mental health services for looked-after children.

On a positive note, I think there are two areas that the Government has made huge strides in that will have an impact on young people's wellbeing. One is the legislation that means that long-term foster care is now a permanent option and recognised as such, because we think that placement stability will be one of the key factors that helps to improve emotional wellbeing for looked-after young people.

The second area is Staying Put. We think the level of change for young people—that transition into adulthood—is a key point in terms of their wellbeing for early adulthood and going on, so being able to remain with foster carers longer is absolutely the right thing to do and will reduce involvement in mental health services in the future. However, while there is good intention, we think that implementation of Staying Put is particularly poor and sporadic across the country at the moment, so we would like to see improvements there.

Sarah Brennan: I will kick off with some stats: looked-after children are about four times more likely to have a mental health disorder than children who live with birth families. Three in five looked-after children have some level of emotional and mental health problems. Two in five looked-after children have a diagnosed behavioural disorder, and as adults they are between and four and five times more likely to attempt suicide.

So the statistics are absolutely clear. We have a group of young people who have multiple vulnerabilities and are much more likely to have a mental health problem. But in terms of accessing mental health care, we have got a sort of perfect storm about the medical services approach and the social care approach. The children and young people's mental health and well-being taskforce really highlighted this: we have young people presenting to

CAMHS who are then turned away because they do not fit the medical criteria of having a diagnosed mental health problem, yet these are the young people who have the highest likelihood of long-term, enduring and severe mental health disorders.

We wanted to look at what is going on there and how we can change this—what is happening on the understanding of those in mental health services and why aren't these young people, the ones who need it most, accessing the help and care they need? What has come through very clearly is that not just looked-after young people but, as a shorthand, young people with multiple vulnerabilities have a common experience of trauma that has an impact on their development emotionally and psychologically and mental health services could really help around that.

So what can we do to increase that access? We came up with a number of recommendations. Some of them are about how clinical services respond, but others are just about the human experience of children and young people going into mental health services. When young people who already feel disempowered in life turn up in an NHS

setting they are least likely to engage; they are most likely to have a DNA, a "Did not attend", so even when they do get a service they are very likely not to make use of it. These are young people for whom services need to be in places where they feel comfortable; they need to be made welcome and to feel comfortable so that it is not stigmatising, formal or imposing. Clinicians are changing their approach, so young people can access care and looked-after children can access mental-health services. Because of professional concerns, it is not just about a medical model of diagnosis—as well as the type of care.

David Graham: I would agree with everything that has been said so far. I want to pick up on Sarah's point about it not being a medical model. It is this definition of "wellbeing" and looking how that affects a young person day to day with issues around identity, self-esteem, confidence and relationship-building. Particularly where there has been a lack of stability, this has a real effect on who you are as a person and how you are with other people, which can affect your wider life.

We find it is not just mental health services, but the whole range of services that a young care leaver might be engaging with who do not have an understanding of what that care experience was like or how that care experience can affect the person's psychology and therefore be influencing their behaviour choices or decision making. They are not seeing that person in the whole. Therefore, people do not get the right help, they do not get the right support and they often seem—perhaps, if it is a behaviour issue—to be typical teenagers, who are troublesome and not engaging. Professionals might use that phrase "hard to reach", when actually there is a whole sense of issues and a whole psychology of stuff behind the decisions that the young people are making, but they are not getting that support day to day.

Q3 Chair: Thank you. We have talked to young people who have been through this experience in care with mental health issues. One of the striking things that came out of those conversations is that right at the very start assessments were not thoroughly, properly or appropriately done. What recommendations can you give us to improve that?

Lisa Harker: First, it is really important that children and young people are properly assessed at the beginning. As you know, young people who enter care are supposed to receive a strengths and difficulties questionnaire, which is a screening tool that will help to identify those children most at risk. It is only a screening tool, so the important thing to note is that the completion rates are not yet 100%—the latest data show, I think, that 72% of looked-after

children receive the SDQ. Fewer than half of children in the east midlands, though, are currently assessed by the SDQ, so there is a lot of regional variability. That is the starting point, to get that screening tool right, but it is only a screening tool, and a fuller mental health assessment by a mental health professional is required for those children who receive high scores on the SDQ. On the basis of that assessment, proper planning is also required, which would lead to access to support and possibly to support for the foster carer of a looked-after child.

There are some examples of good practice, such as the one in Haringey, the first stop service. It provides SDQ screening for all looked-after children entering care, a fuller, extended screening process, and further follow-up support for young people and their carers on the basis of those scores. So it is being done well in some places, but this ought to be the norm and not the exception, and putting that right is the starting point, because looked-after children are an exceptional group—the state is the corporate parent and a huge amount of assessment and paperwork is done around taking a child into care.

Q4 Chair: So you would say we would be wise to look at best practice. If you could point us in that direction, that would be good, because we might find out how to proceed and make our recommendation on how to improve that matter.

Lisa Harker: I would be very happy to advise about some case studies of good practice.

Q5 Chair: What would each of you recommend to improve CAMHS?

Kevin Williams: We think that part of the problem is how to access CAMHS. We would like to see a shift towards more personalised budgets. We think that a shift towards personalised budgets on a regional basis—so not with money linked to the child—might be a way for individual foster carers and social workers to be able to access services for that particular child. That is part of the issue.

David Graham: All the engagement we have with CAMHS is around level of need. The level of assessment to get into CAMHS is too high—the level of your diagnosed issue has to be really very high. That misses out the whole swathe of issues around wellbeing and, perhaps, particular issues that a young person is being affected by at the time. That needs to change.

Sarah Brennan: There needs to be a liaison model so that clinicians are available for advice and support and can fast-track admissions into CAMHS. That is already happening so we can give you examples of best practice. Care staff need to understand mental health better and be able to have informed conversations with their linked person in mental health services, so that you have a relationship.

Q6 Chair: In short, it is about personalised budgets, lowering the bar and involving clinicians more efficiently.

Sarah Brennan: Yes.

Lisa Harker: I would not want to lose the point that Sarah made earlier about the need for more understanding of attachment disorders and trauma—specifically that related to abuse and neglect—in CAMHS services. Rather than a medical model, there should be an

understanding of the kinds of emotional and social issues that arise from abusive relationships.

Q7 Chair: So we should take into account the factors around the individual.

Lisa Harker: Yes.

Sarah Brennan: Another point is that transformation plans are a real opportunity here and should be really paid attention to. I can give recommendations on that too, but that is the headline.

Chair: Thank you very much indeed. Your answers were very helpful for the Committee. Marion is now going to discuss existing statutory practice.

Q8 Marion Fellows: I want to ask a few questions about the current statutory guidance on promoting the health and wellbeing of looked-after children. How effective do you believe the guidance is? How could it be implemented more consistently?

Sarah Brennan: There is considerable statutory guidance and requirements, but they do not seem to be adhered to or to be informing practice. Coming back to transformation plans, we have an opportunity to guide activities, certainly around joint commissioning and integrated care, because there is an expectation of that within the transformation plans, and people will not get their money if they don't do it. Another point is that we need young people's engagement in the whole process to further the guidance and the statutory requirements that are there. So I think we have a lever.

Lisa Harker: I would want to see the guidance around the use of SDQ screening for looked-after children strengthened. At the moment, in some parts of the country the guidance is interpreted as a sort of administrative exercise to collect the data and return it to the Department. It is a screening tool that ought to lead to a planning process for the support that a child needs. Even the scores returned to the Department flag up considerable concerns in terms of the number of children who are a cause for concern as a result of the screening, yet there is very little follow-up or pressure to understand what is being put in place to address that. The guidance is encouraging an administrative exercise, rather than a transformation in support.

Kevin Williams: I agree with lots of what has been said. Increasingly, recent evidence shows that care works; care does make a difference. Care is a protective factor that helps young people develop and grow, but as a state we are not really clear about what the purpose of the care system is. We would like to see a statement in law that the principal aim of the care system is for children and young people who spend significant time in care to achieve recovery and healing from past harm and to promote resilience—a strong statement from the state about what the purpose of care is.

Q9 Chair: That is a very good suggestion. Can I couple it with the other ongoing issue about agency co-operation? Would you see a statement setting out how agencies should work together?

Kevin Williams: Certainly inter-agency working is going to be crucial if we are going to resolve those issues. If we take the role of a young person, what they do not want to see is fragmented services between health, education and the looked-after system; what they want is systems that work for them as individuals. Much more integrated working would be a start.

The SDQ is a tool that should be used much more at the beginning and for identifying the needs of young people. It can be used to help in terms of what type of placement is best matched for the young person and how it is going to meet their needs.

Q10 Marion Fellows: Sarah, you have already talked about local transformation plans. Are there any other points you would like to make on that important subject?

Sarah Brennan: There is an expectation of having a joint plan locally and of having joined-up money. We are in a time of restricted resources. CAMHS, for all the additional funds coming in, has been cut year on year on year, so we have to be realistic about what we are expecting from CAMHS. The only way we are going to make change for looked-after children is through a joint plan locally, and that is what is expected to be delivered through the transformation plan.

The NICE guidance is excellent. Something around raising the profile, around the guidance that is available and out there already and using the inspection frameworks to make some of that stick would all be ways of making local areas take this seriously—I think they do take it seriously—and understand that there is a future gain and funds attached to it. People tend to work together if they can see that they are all going to gain from it, because it is hard.

Q11 Marion Fellows: There has already been an issue with people moving from area to area. Will that also affect local transition planning? If a child moves from one area to another, do they start again at the beginning or will it continue?

Sarah Brennan: There is a really good point around continuity of care. When we talk about looked-after children, we are talking about children in children's homes, children in foster care and adopted children. Certainly for adopted children, the care sometimes just ends. We know the linkage—the continuity of care—is absolutely critical for all parts, but certainly around mental health and wellbeing it is often the relationship and the consistency of care that is the most therapeutic thing. How those local arrangements can enable continuity of care is certainly challenging, but it is also essential.

Lisa Harker: Can I come in on the local transformation plans? They are not yet published—they are due at the end of the month—but we have seen some early plans that have been made, and they are very variable in terms of their understanding of and focus on looked-after children. Some are excellent and have some really innovative ideas in them, but some of them barely mention looked-after children at all. The question to the Department is this: how do we learn from the very best and ensure some consistency around the country?

Kevin Williams: I absolutely agree with Sarah's point about relationships. The Fostering Network was part of a collection of charities that did some work called the Care Inquiry a number of years ago. One of the findings was about the importance of relationships, and one of the areas that we are working on is seeing the relationship between foster carers and young people as the young people move to new placements. At the moment, most of the practice is that relationships are cut off. We would like to see a transition of relationships, so that that continuity of relationships can help build bridges with the new placement. At the moment, the sort of practice doctrine is that continuing relationships with foster carers is a bad thing. We think that continuity of relationships is a good thing.

Q12 Chair: Thank you for making that point. That is something else we picked up very strongly when we spoke to young people.

David Graham: May I make a point on the practice guidance, because it is statutory guidance, not practice guidance? It is a high-level, strategic document that does not give detailed insight into the practice that we would expect to be delivered on the ground. That is one of the reasons why its interpretation is so variable. So many of the sentences and statements in it are wide. They are legally written that way, to a point where you cannot really assess or monitor because the interpretation is so wide. Perhaps some sense of a more detailed practice guidance about what health and wellbeing for looked-after children and care leavers looks like, with good examples of good practice, would be more helpful.

Chair: Thank you, David. Lucy, you are going to be asking about training and support for foster carers.

Q13 Lucy Frazer: We have heard and read in submissions from many of you and others that children in care have mental health issues. Sarah, you mentioned that. It affects their life chances going forward. Many of you said that people were being turned away from CAMHS. Sarah, you said that people need to feel comfortable in the environment they are in to be able to share. I felt that very much when we met the children in care—trust was very important. The people who they can and should be able to trust are those who are looking after them day in, day out: the foster carers. Do you think that their training is adequate?

Kevin Williams: No. We would like to see a national framework of training for foster carers for two years post approval, linked to a nationally recognised qualification. Once we have that type of training, we will be able to think about developing a registration for foster carers. Part of that training needs to include an understanding of attachment, as has been mentioned, and a clear understanding of mental health issues. That should not be isolated, however, but linked into an understanding around education, because what we hear from young people is that they need to be seen as a whole person, taking into account the whole part. It is about developing and building their self-esteem and resilience.

Q14 Lucy Frazer: Should they have to do that training before becoming a foster carer?

Kevin Williams: No. We think that approval should continue as is, with the Skills to Foster training, which is the initial training prior to the approval to be a foster carer. We think that the additional training should be for two years post approval. While you are a practising foster carer, there should be ongoing training linked to a formal qualification, with some mental health training included in that. It should be a holistic approach to training, rather than compartmentalised.

David Graham: We would certainly agree with that. We believe in good quality residential care, too, but the training for residential workers needs to be vastly improved. Within good residential, there is an ideal opportunity to work on building those relationships for young people and building that trust and communication. Too often it is workers with the lowest qualifications who are put in those day-to-day situations. They are responding to behaviour and not seeing what is going on around it—they are not able to get underneath it.

As Kevin was saying, there needs to be more detailed attachment-based and trauma-based training, with a real understanding of what can happen to a young person in the care experience. Particularly for us, that needs to consider care leavers and adolescent entrants. There is so much going on as an adolescent. If you are going into care at 12, 13 or 14, the

carers need a good understanding and good levels of support, particularly in foster care, where there is behaviour or challenging issues that tend to lead to placement breakdown. Instead of the breakdown, they need to be given the skills to support that young person, so that they are supported to work through it and so that we see less placement breakdown and more stability

Sarah Brennan: We need to be specific when we talk about mental health, because we are actually talking about child development, what happens to a child in their development and what can impact on it negatively and positively, to give foster parents and staff an understanding of who they have in front of them and what they can do, as Kevin was saying, to build their emotional resilience. We also need to understand that what happens to a child might only pop up in terms of behaviour 10 years later. We are not talking about, "I've had the training; I'm okay now", because they might not experience the child's behaviour or troubles until some time later, and they will be completely floored.

I would like to support what has been said about being able to return to support and training, and being able to learn. For all parents, having teenagers is challenging. If you are looking after a teenager who has had some really extreme experiences, you do not know how that is going to impact. Clinicians might not know, either, but support is really essential.

Q15 Lucy Frazer: Who should provide that support?

Sarah Brennan: We have found, from working with parents and young people with mental health problems in general, not necessarily looked-after, that from each other is huge, so that they experience not being alone. Having facilitated training—whatever is possible—with input from specialists can also be helpful, as it is about being able to share experiences. It is not necessarily a training course; it might be a phone line. It could be a range of things. We just need to think about the long term, not a short injection.

Q16 Lucy Frazer: You raise a much wider issue. Many of us are parents and it is not only, as you say, children in care who have mental health issues. Should there be a wider provision or facility?

Sarah Brennan: We have a helpline for parents.

Q17 Lucy Frazer: This is not just about a crisis. As you say, if you catch issues early on, they do not develop, so should there be training for all parents? What would that look like?

Lisa Harker: It is important to recognise the distinct issues that will arise early on in a child's life and the level of loss that they have experienced if they have gone into care. Parenting a child in such circumstances is a different task from parenting. Parenting sometimes requires counterintuitive parenting, a form of therapeutic parenting that none of us claims to be an expert in. As an adoptive parent, I know that no training could have prepared me for that role; I learn as I go with the support of the professionals around me. I think foster carers should have exactly the same access to that level of support, particularly for the 50% of children for whom the SDQ is undertaken who are either a cause for concern or borderline cause for concern. We are already flagging that these are children who have deep problems that will at some point come out through their behaviour or their emotional wellbeing and mental health. So being ready to provide support around a foster care family will be

absolutely essential. Unless that action is taken, those problems will lead to further life problems.

Q18 Lucy Frazer: Who currently provides that support?

Sarah Brennan: It is not provided consistently. Who should provide it? I think there has to be a clinical need in an area for foster care families to seek advice either from CAMHS or embedded in looked-after children teams. As an adoptive parent, through the adoption support fund, you can get access to a range of therapies that support parents in their parenting of a child. That is not available to foster carers currently; I think it's a case of looking at whether it should be extended to foster carers. It will be a mixture of psychologists, social workers and psychotherapists, depending on the nature of the concern, who would be in a good position to provide help.

Kevin Williams: One of the pilots that the Fostering Network has run is about social pedagogy—a use of the head, heart and hands. It is about training that enables people to have an intellectual understanding of what causes behaviour that is linked to attachment. It is about using the heart; it's about how you understand the child and have that emotional attachment—the relationship building. And it's about the hands, because what we know about working with looked-after children is that often they want things to be very practically based. It is a social pedagogic approach, and areas like Rotherham and Derby, where a whole-system approach has been taken, have shown tremendous improvement for looked-after children. So linked to our framework we would definitely like to see a model linked to social pedagogy.

Q19 Lucy Frazer: Again, if there is a model that works, it would be helpful for us to know about it. My last question—sorry, David, you wanted to say something.

David Graham: I was just going to say that you talk about participation and you have a whole cohort—population—of care leavers in their 20s and 30s who were in those situations as 10, 11, 12 and 13-year-olds. It's really good to involve them in training, because they can go back and talk to those foster parents and give them a real sense of what it was like. That is a really valuable experience for them.

Q20 Lucy Frazer: We have mentioned foster carers, adoptive parents and professionals in residential care. Are there any other professionals—

Kevin Williams: Foster carers are professionals. We mustn't separate them out; they are part of the workforce. Sorry to interrupt.

Q21 Lucy Frazer: No, that's a good point. Are there any other professionals who would need additional training?

David Graham: We would say wider support agencies. We do a lot of work in the criminal justice sector. We have probably spent three to four years raising awareness of the care experience and how that affects young people, and for a lot of them it was a completely new area of work. I'm thinking of those areas and maybe housing and other local authority support services. To give them that basic understanding of the care experience and some of the issues that may be presented by young people in care and leaving care would be beneficial.

Lisa Harker: Teachers are the other professionals who are most likely to see the consequences of poor emotional wellbeing and mental health problems. Their lack of understanding of attachment disorders and trauma is also a concern, so having a look at initial teacher training and building in a base level of understanding would be beneficial.

Q22 Chair: Can I just reinforce Lucy's point? If there are models that work, we want to know about them. Okay, Ian is going to talk about transitioning out of the care system.

Q23 Ian Mearns: Well, I was going to, but Lisa's last answer has just given me a supplementary question. You talked about initial teacher training, and I am wondering whether these issues would be better dealt with as part of a proper programme of continuing professional development for teachers, rather than at the initial teacher training stage.

Lisa Harker: The two are not—

Ian Mearns: Mutually exclusive.

Lisa Harker: Our understanding of child development and the way the brain develops has changed enormously in the last decade. I don't think that has influenced initial teacher training in the way it should have done. Getting that baseline right would be a good start, but you are absolutely right that there is a need to upskill on a regular basis.

Q24 Ian Mearns: What I am concerned about is that we already have a huge teaching profession out there who have not had that as part of their initial teacher training, so the two things would have to be in tandem, but we would have to make sure that guidance was properly given in terms of making sure that it was being done.

Lisa Harker: There is an opportunity with the pilot the Department has recently announced of having a liaison person in schools to CAMHS—as well as a liaison person, somebody who can help to advise the teachers in the school and increase the level of knowledge and understanding.

Kevin Williams: We have a scheme called London Fostering Achievement, a peer support model, which has absolutely shown, through the virtual heads, huge improvement in understanding among teachers where they are working with looked-after children.

Q25 Ian Mearns: Part of the problem that we were worried about at the outset, and one of the reasons why we were getting involved in this inquiry, is that there was a real feeling out there that CAMHS provision was patchy at best, in terms of the way in which it was dealing with all young people, not just care leavers.

Waiting times, and access to appointments and services vary greatly around the country. This is a very broad question, but I wonder if there are any specifics you can think of as to how care leavers could be better supported to ensure that they can continue to access mental health services once they have left the care system.

David Graham: We were discussing a similar issue before we came in. One of the things is having a marker, so they have priority access to services. There are pros and cons to that marker in terms of labelling somebody and the stigma around that that possibly can exist, or that blinkered approach to expecting a care leaver to be presenting with a range of issues

when they might not necessarily do that. Those are the downsides. But the upsides are that you are not struggling to get that support when you need it.

In relation to care leavers with us working around mental health, the biggest issue is getting that access to services. It takes us, as an advocacy service, to really be banging on that door to support that young person to attend, and to talk to professionals. It is us on the end of the phone making those calls and bringing those people together in order to get what is often, in the first place, a simple referral to get somebody through the door. Either markers or specific services that are targeting care leavers.

Q26 Ian Mearns: It seems to me that quite often we get situations where youngsters fall of the edge of the CAMHS service and then cannot access an adult mental health service. I am wondering: would you agree with some sort of transitional CAMHS service—up to the age of 25, say—for young people who are care leavers?

David Graham: Yes, I would certainly see the benefit in that. It gives a single service so that that person can be in and out and getting that support over a continued period of time as they are developing and changing. That is only going to be incredibly supportive.

Kevin Williams: The language is really interesting. We talk about leaving care, and yet for our birth children, we would not at all talk about ending parenting. I think the Committee might want to consider some of the language that is used around the care system. If we are unhelpful in transitioning to adulthood, one of the roles of parenting is to help with that transition. If, from an early age, we start talking about leaving, or preparing to leave, that is a very strong message to a young person.

Q27 Ian Mearns: The Committee in the last Parliament produced a report called “Into independence, not out of care”.

Kevin Williams: Absolutely, and I recognise some of the shift. But we still continue to use the language of leaving care. The other thing I would say is, as I have already mentioned, the Staying Put pilot absolutely makes a huge difference. We think that young people leaving care at such a young age as 17, when they are often the least well educated and least well supported, will lead to an increase in mental health issues in adulthood and early adulthood. So we would like to see the implementation of Staying Put really considered and looked at.

We think that it absolutely could be a game changer if more young people were able to remain with their foster carers. While the Government’s intention, we think, is absolutely right, implementation at the moment is very patchy. At the moment, it often relies on the good will of foster carers who financially lose out in terms of keeping young people they have cared for over a number of years.

I certainly agree with David’s point: there are tensions about having a flagging system, but actually if you present with a minor mental health issue without your GP having a full understanding of your care history, how can they do that proper assessment work? We need to discuss that in more detail to think about the pros and cons of having a flagging system, so that we do not stigmatise young people who have care experience but are able to make sure that through early adulthood and into middle adulthood, they can receive the support that they need.

Q28 Ian Mearns: I am conscious of time, but one thing I am concerned about is this. I spent 27 years as a member of a local authority, and I am wondering: is the wellbeing and the progress of young people who have been in the care system effectively monitored by local authorities and other agencies to make sure that they continue to thrive and are not floundering in any way?

Lisa Harker: No.

Ian Mearns: I knew the answer, but I just wanted it for the record.

Lisa Harker: I think there are two issues: the continuity of care issue that you have raised—and I would support the access to CAMHS beyond the leaving care age; but also there is a gap in terms of young people who have left care who do not meet the threshold for CAMHS but whose emotional wellbeing is a concern. For those in care there is a carer who is advocating for them and trying to find the right support, but at that age there is nobody there to do that, and I think that is a worrying gap. Thinking about the support that might be available to that age group pre-threshold for CAMHS is an issue.

Sarah Brennan: I am just a bit concerned about what we are suggesting here, because adult services have even higher barriers and very different approaches to mental health from those of CAMHS; you do not necessarily want a 20-year-old going into a children's service either. I also think that there are many children or young people who have serious vulnerabilities but have not come through the care system, and we are very good at fragmenting children and young people all the time. Creating another separate service—I am not sure that it is either going to happen or would work.

What is happening across the system increasingly is a service that goes from nought to 25. It would be potentially much more constructive to push and put emphasis on that happening across the board, so that this would help looked-after children but also other young people who have got serious issues that they have emerged from previously, rather than trying to create another separate system or another separate thing, because people are overwhelmed.

I think, to be realistic and go in the direction of travel—and this is beginning to happen and is getting momentum—how this Committee could add to that momentum and pressure to increase that happening might be a more positive and constructive way, and also enable the services that are there to be appropriate. Because adult services actually, again, are even more of a medical model than CAMHS.

Q29 Ian Mearns: I think this is where the difficulty is: young people who have been through the care system can quite often have a range of different complex needs including a huge amount of emotional baggage, and I think what we are asking is should some special consideration be given to youngsters who have come through the care system?

Kevin Williams: Yes.

Lisa Harker: Yes.

Sarah Brennan: Yes—children experiencing trauma.

Q30 Chair: You mentioned the care plan before, and that would be a useful instrument, wouldn't it? If they were more commonly deployed and made the key instrument in terms of providing support and care, that would have consistency and deal with the problem you have just identified.

Michelle, you are going to be talking about empowerment of young people and children.

Q31 Michelle Donelan: One of the issues that kept coming up time and time again when we were talking to the young people is that they did not feel that they were really listened to, or part of the process. They felt very excluded and outside of it, and unaware of it, which obviously has long-term effects and is more distressing. So how do you think that looked-after children can be made more of a part of and involved in the whole process?

Kevin Williams: I would say that in terms of our existing care planning processes we have seen some improvements with the introduction of IROs. We have seen that good IROs are now talking with young people in advance of care planning meetings, ensuring that the young person's voice is central to those care planning meetings, so that the young person has the loudest voice and the beginning voice.

We would also like to see that extended to foster carers or the main carer, because too often we think that the social worker and others dominate those conversations, rather than the foster carer and the young person themselves. Obviously the young person is the expert in themselves and the foster carer is probably the second expert in that young person's life.

Lisa Harker: I think it is really important to consider the involvement of children and young people through the whole process, from assessment onwards, and the very best practice does do that and should do that. We can give you some examples of case studies where that does happen, but it is not consistent.

The other thing is, and we can share with the Committee, evidence of an intervention that we piloted at the NSPCC, a form of solution-focused support and counselling for looked-after children. That has shown some really good results in terms of reducing levels of clinical distress and of being sustained beyond the intervention: three months later still seeing an improvement in emotional wellbeing. It is an approach, a way of working with children and young people that starts with their problems and works out solutions together, rather than an intervention that sees the child as a subject of that intervention. So it is changing practice, as well as the system needing to ensure that children and young people have a voice through the whole process.

David Graham: I would suggest that there are two aspects from our point of view. We are a user-led charity, so we run a peer-support programme whereby we support different young people, care leavers, to talk about their experiences and to learn from and support each other with the central aim of developing their voice. So over time their voice, their confidence and their identity become much stronger and they are much more able to talk about who they are and their experience. They then take that into their practitioner meetings and are much more able to participate fully in the decision-making processes that happens around them.

The second part to that is training for those professions. We have seen, probably over the past 10 years, a much greater move towards participation. I am sure that no one will disagree that participation is a good thing, but how do you make it happen? Some professionals need more training to have a better understanding of what that involves, how to support a young person to do that, because you cannot just sit down and say, "We want you to participate", without looking at that young person's support needs. Definitely more training about what real and meaningful participation looks like on the ground.

Q32 Michelle Donelan: You are right, but do you also think that there has been a culture of not informing the children enough and not seeing them as individuals? Some of the young people whom we saw did not even know what the care system was. They felt like they were the only one in it; they did not have a clue what was going on, or how long things were—they seemed very much out of the loop, as if they had not been seen as individuals and they had not been informed. Let alone giving them a voice, they had not even been communicated with.

David Graham: Kevin mentioned language—we talk about a care system and it is always about the system; it is never about the individuals who are in that system. I will not deny that. Yes, we get lots of examples daily whereby the needs of an individual have just been ignored. It is about managing their case or what is happening to them. But, on the other side, I am guessing that that is the best way that it has happened over time. I am not claiming that it is an easy thing to do to sit and meet every individual young person's needs and involve them in doing so. It will take more training and support for professionals to do that.

Kevin Williams: Care planning is an individual activity, so it is the care planning process where we need to focus on the individual. Absolutely, participation is really useful, but what we know from experience and research is that there is a group of young people who involve themselves actively in participation, whereas we separate out participation in that group forum—the focus group-type approach to participation—to individual care planning. We have an individual care planning process that needs to be strengthened and supported to make sure that the child remains central.

Q33 Michelle Donelan: Do there need to be more checks to ensure that that is actually as it says?

Kevin Williams: I think it is the role of the IRO to make sure that the child remains central. So if there is a training element, it is about focusing on the IRO element and role and about ensuring that the foster carer is seen as a key member of the team around the child, along with the professionals who are engaged.

Q34 Michelle Donelan: Do you think that advocacy services are accessible enough, in terms of local authorities and charities?

Kevin Williams: No. When it is best for the individual.

Q35 Michelle Donelan: So that is a massive problem, you say.

Kevin Williams: If you can improve the IRO system there would be less of a need for the development of advocacy services. My approach would be to strengthen the IRO role to ensure that they are doing the roles that the IRO is meant to do, which is about focusing on the central planning for that individual child. Then, on top of that, we need a tier of advocacy.

Michelle Donelan: Okay, so it is layering up.

Sarah Brennan: I am not a foster or looked-after-child expert; my knowledge is around mental health and CAMHS, but one of the things we have introduced in Improving Access to Psychological Therapies is patient-recorded outcomes. I don't know if there are some transferrable skills here, but in all the care plans and all the outcome assessments, there always has to be a young person's assessment of their own development, and that becomes part of the inspection framework.

I would absolutely agree with what everyone is saying about participation, and it has also been shown that that helps build young people's emotional resilience, so, obviously, it is a really important aspect. But maybe there is a way of including their own assessment of their own outcomes and their own development as a requirement in the care planning process. I don't know—that is just a thought.

Q36 Michelle Donelan: Is there any post-leaving evaluation? Do you take young people 10 years after they—I know we are not now supposed to say this—leave the care system, and assess that? Do you develop that as part of the learning process—what went wrong, what was good? What is the formal evaluation process to actually improve the service?

Kevin Williams: There are no longitudinal studies of outcomes for looked-after children. It is one of the areas the Fostering Network is beginning to have some discussions about with a range of funders and universities.

David Graham: Some local authorities will take to care leavers within the first six months of their finally leaving the service, but, as far as I am aware, there is nothing much further than that.

Michelle Donelan: That goes back to the point that the long-term problems could occur 10 years later.

Q37 Chair: That is actually quite an astonishing situation, isn't it? There is no evaluation of what is really a critical service generally and for the individuals concerned.

Kevin Williams: And what that leads to are statements where we look back. So we use statements such as, "One in four of the prison population spent time in care," without fully understanding, actually, the huge numbers of young people who have been in care versus the number of people in the prison system.

Those statements give an indication that the care system will lead to prison, when the evidence that there is around the care system is that the care system works and makes a difference for a large number of children. That is not an excuse for some of the very poor outcomes that there are, and we need to improve those outcomes, but we also need to change the narrative to make sure that we are talking about the positives of care. Again, in terms of emotional wellbeing, if all you hear is, "The care system is going to fail. You are going to end up in prison. You are less likely to go to university," the impact for the individual and for those working in the care system is huge.

Q38 Chair: That is a kind of cultural problem, isn't it?

Kevin Williams: We need to take back that narrative to make sure we are talking positively about care, while recognising we need to do much, much more work.

Q39 Michelle Donelan: But it is all speculative unless you are doing that evaluation and proving that the care system is effective. It is slightly ridiculous, isn't it, that we have a system we are not actually evaluating to see whether it works? The test is people's lives.

Kevin Williams: If we evaluate it while people are in care, we know that it works. There is recent evidence from the Rees Centre, for example, about educational attainment,

where, if you compare groups of children on the edge of care, their educational improvements are better—

Q40 Michelle Donelan: Yes, but your childhood is supposed to be about the formation of your whole life. That is the only test of whether the system is working.

Kevin Williams: Absolutely.

Chair: We are going to have to finish this session. That is a very good point to end on, and it is certainly something the Committee will be considering, so, again, if you have any thoughts about how an evaluation process could be shaped—about the architecture of such a system—that would be really helpful. Thank you very much indeed.

Examination of Witnesses

Witnesses*:* **Tony Clifford**, Head of Virtual School for Children in Care, City of Stoke-on-Trent, **Carol Jones**, Specialist for Leadership and Teacher Professionalism, Association of School and College Leaders, and **Natasha Devon**, founder, Self-Esteem Team, gave evidence.

Q41 Chair: Welcome to the second session of this important day in our inquiry. Could you first say who you are and who you represent?

Tony Clifford: I am Tony Clifford. I am head of the Virtual School for Children in Care in Stoke-on-Trent.

Natasha Devon: I am Natasha Devon, and I am the Department for Education's mental health champion.

Carol Jones: I am Carol Jones. I am the specialist for leadership and teacher professionalism with the Association of School and College Leaders and a former headteacher.

Q42 Chair: Thank you very much. Funnily enough, I am going to be talking about what the National Association of Head Teachers has been saying. It has told us that schools are delivering emotional first aid for students with mental health problems. Carol, what evidence do you have for that?

Carol Jones: It is true to say that many schools are struggling to access resources, particularly CAMHS, due to diminishing resources and school budgets and a lack of consistency in the resources that are available to schools, particularly for mental health and wellbeing. Accessing the kinds of resources that our children need is a challenge for school leaders and for schools in general.

Chair: Natasha. From the vantage point of the DfE?

Natasha Devon: I go into about three schools a week and I completely agree that how much is available to support teachers varies, based on geographical location. My observation is that the threshold for what is considered to require medical intervention has increased over the past decade. What was once considered to be a severe eating disorder is now advocated in *Heat* magazine, and self-harm has been utterly normalised. From that point of view, teachers are dealing with things that were once dealt with by medical professionals.

Tony Clifford: Schools are struggling to access services in a timely manner, but on the other hand there are solutions to how this can be dealt with. Our approach is to co-design services with schools, so that rather than send the child out to a service, you bring the service into the school to work with both the adults around the child and the individual child. You have already had a submission from Bath Spa University, working with a group of virtual heads, about schools becoming attachment aware. It is a service redesign issue in my view.

Q43 Chair: That moves me quite well on to the next question, which is about the extent to which schools are actually commissioning mental health services, perhaps because local authorities do not have adequate provision. Is that something that is happening more and more? How can we calibrate that?

Tony Clifford: There is the possibility that schools will try to commission what they need. My view as a virtual head is that that is not necessarily the most supportive approach for a school. Although the school may then find that that service works with the child, how does it then ensure that all the other professionals around that child—I include foster carers, adoptive parents and people who are working with children on the edge of care as well—can understand what that intervention has provided for that child, so that the adults around the child can respond and adapt to it? There are some risks in single-agency commissioning of services, because unless all the other agencies around that child understand those messages and can work with them, that intervention is very likely to be ineffective.

From the child's point of view, that piece of work with that adult which has helped them to come to terms with trauma and loss may not be replicated in the responses of other adults around them, which can actually exacerbate trauma. Our approach is that schools need to become attachment aware, so that all adults in the school and all the professionals linked to the child have a common understanding. That is safer for the child and more effectively uses scarce resources.

I am delighted by what the NICE guideline says about this, and if I had one key recommendation to the Committee, it would be to ensure that the NICE guideline, jointly commissioned by the DfE and the Department of Health, is implemented in full. Its recommendations are very clear about the understanding that schools need to have around such issues.

Q44 Chair: Natasha, you visit three schools a week. Do you consider Tony's observations to be relevant and appropriate?

Natasha Devon: He is absolutely right that action needs to be joined up between schools and CAMHS. The DfE is trialling in 22 areas around the country a joint training scheme, so that teachers have a professional expert on the end of the phone whom they can call if they are presented with a student who is suffering. From a mental health first aid point of view, there are two things that would be really helpful. The first is that there should be specialised PSHE teachers. PSHE is the one subject in which there is not a specialist teacher in house, so it is left to teachers whose specialisms lie elsewhere to teach what is, in fact, an incredibly important subject in the curriculum. The other thing that every school should have is an in-house counsellor because not every student has the confidence or the knowledge to be able to seek the help they need outside the school environment.

Q45 Chair: Would you mind dropping us a line on your thoughts on PSHE? It is something that we are very concerned about. We are writing to the Secretary of State on a relatively regular basis on the subject. One of my observations is that the Health Committee and the Home Affairs Committee are basically making the same point as we are, which is that more PSHE is needed in schools, and you have just said that as well. To strengthen our case further, I would be grateful if you could write to us about that.

Natasha Devon: Most schools have an understanding—but only because of Ofsted—that PSHE is mandatory and that not having a robust PSHE programme will prevent them from being labelled "excellent". There is an awareness of that but, equally, there is no time in the curriculum for it and there is no budget, which leaves PSHE in a really precarious situation.

sThere is a lot of bad practice going on in schools, in my experience. The first thing is the dreaded PSHE drop-down day where you have to cover everything from how to budget to how to be a man in the modern world to female genital mutilation—it all happens in one day. If you are sick or absent that day, no PSHE for you. You are also completely overwhelmed with the classes that you are presented with. The other is trying to shoehorn PSHE into form time, which is an average of about 20 to 30 minutes when the form tutor also has to register and deal with any disciplinary issues, so they are lucky if they have 10 minutes to cover incredibly important topics. I would like to see space for PSHE on the curriculum and a budget for it because, done right, it is the cornerstone of any wellbeing programme.

Q46 Chair: Thank you very much Natasha. Carol, do you think schools have sufficient funding and resources to deal with mental health issues?

Carol Jones: No. I would like to come back to the point that Natasha was just making about PSHE because it relates to funding as well. The Committee will know that last year there was an inquiry into PSHE, sex education and so on. I think we discovered at that Committee that there was also very good practice. We understand that there is an overcrowded curriculum and pressure on schools to raise achievement in EBacc subjects and traditional subjects. There is, of course, a specific demand.

None the less, there is also very good PSHE practice in some schools. It depends so much on the values and vision of each school. In a diverse school system, everything depends on an individual school's priorities and the time that they give to PSHE in the curriculum. For example, in my former school, we spent a significant amount of time on citizenship, PSHE, sex education, and mental health and wellbeing. Are there enough resources? No, of course not, but how we allocate those resources and how schools choose to use them is autonomous—dependent on each school leader and its governing board. It comes back to the vision and values of each school.

There are some very innovative programmes on emotional health and wellbeing going on in some schools. For example, there is some interesting mindfulness work in schools—perhaps the Committee has looked at that. There is a longitudinal study of students who are undertaking wellbeing and mindfulness training in some of those schools. I am very happy to steer the Committee to some of those programmes should you wish it. There are also some helpful programmes on resilience and character building, which have had increased emphasis more recently. There is growing awareness in schools about the importance of emotional health and wellbeing but we, as schools leaders, always have to balance that—developing our

PSHE programmes—against the priorities given to raising achievement and standards in traditional subjects, Ebacc and so on.

Chair: You have moved on to Caroline's questions. Caroline, would you like to probe further?

Q47 Caroline Nokes: I might go back to Tash on this one. Presumably we all agree that if you want young people to develop emotional resilience and wellbeing, there needs to be space in the curriculum for them to be taught that in schools. Is PSHE necessarily the right place for that?

Natasha Devon: PHSE needs to be part of a spectrum of different solutions. It does not work in isolation, but it can be the catalyst—it lights a fire under the wellbeing programme and it can re-engage students with the topic and give them a renewed interest in it.

Q48 Caroline Nokes: I think it would not be too much to say that some of the young people who had been in care that spoke to us had a pretty negative view of the PSHE teaching they had received. Is that common? What more could be done to ensure that PSHE teaching is of the highest quality possible? Tony, you look like you want to say something.

Tony Clifford: I do, because the importance of PSHE is well stated by colleagues, but unless the messages that children are hearing in those lessons are played out across the whole school, what they hear in that subject will sound to them not authentic to that school's approach, which is what Carol has alluded to. I would certainly argue—we probably agree—that good mental health is at the heart of learning and that attachment is the core of learning as well.

Bergin and Bergin's 2009 research talks about secure attachment being at the heart of learning and that teaching and learning is an attachment-like piece of work. Actually, what we need to see is this built into the whole school's learning approach. We talked about initial teacher education and the importance of teachers coming into the profession understanding that this is a core learning process. We must emphasise that this is not an add-on; this is the basic of what is going on in good teaching and learning in any school and you can see it happening in a classroom. That works well for children in care and it works well for about 40% of children who will have some kind of mental health issue arising from childhood trauma.

Q49 Chair: This inquiry is about looked-after children and that is what we have to drill down and focus on.

Tony Clifford: Absolutely, but this is not an either/or for a headteacher who has scant resources; this is a both/and. We need to be mindful of the pressures on heads. Actually, if you do this for children in care, who may be a small part of your population, you will benefit your whole school. Certainly, our research shows that.

Q50 Caroline Nokes: The Committee has previously said that PSHE should be statutory. If you talk to organisations like the Girl Guides, they say that it should be statutory and I think that you, Tash, would argue that. You are the DfE's champion on mental wellbeing. If we are saying it, you are saying it and most of the youth groups out there are

saying it, what more can we do to make progress and ensure that PSHE is embedded in the national curriculum and that the DfE accepts that?

Natasha Devon: That is a really good question. As far as I am aware—this is just anecdotal—Nicky Morgan is in favour of it being made statutory, so the question is: what more can we do? My hunch is that financial considerations are at the root of the decision not to make it statutory, because as soon as you make it statutory you have to give it a budget.

Caroline Nokes: Thank you for that. I will finish with a question on teacher training. We have heard a bit about initial teacher training and Tash mentioned having counsellors in every school. Who is the right person to deliver this sort of activity? Is it teachers? Can we skill them up adequately for them to be able to embrace the whole range of mental wellbeing issues our young people might face, or should it be specialists from outside?

Carol Jones: We need a combination of both. Initial teacher education is currently being looked at by the expert group and when Sir Andrew Carter reported and made his recommendations about developing a core curriculum for initial teacher education, he very helpfully suggested that there should be a focus on special educational needs. And, in addition to subject pedagogy, there should be a focus on teachers understanding how the brain works and how children learn and the emotional and mental wellbeing of children. That is very helpful and something we would support.

I suppose that having a very well educated set of new teachers coming into the profession would be helpful. I was very interested in Ian Mearns's point to the previous panel that there should be ongoing professional development for all teachers to understand how children learn and the emotional and mental wellbeing of all of our young people and, indeed, of our teachers as well. This should form part of the whole school culture in looking at what is an effective learning environment for everybody—adults and children. It is so helpful to have teachers themselves well equipped and prepared to teach a focused curriculum, whether it be through PHSE or other aspects of the curriculum, on emotional health and wellbeing.

It is also very helpful to have experts in the field. I am interested in Tony's idea of having a co-ordinated approach to bringing experts into schools to train and support the entire teaching and support staff population, so that we all, as a school, have an understanding of how important our awareness is in supporting our looked-after children's emotional health and wellbeing.

Q51 Lucy Frazer: When we met the children in care, one of the girls came up with an idea. She said, "When you search 'self-harm' on Tumblr, it says, 'Do you need help?'" Is that something that social media should be doing? Can we encourage that in other types of social media?

Tony Clifford: Can I chip in here? What you are asking links to what has just been said. If you imagine what happens there—if we give that young person access to a service very rapidly through social media, for example, and that young person then begins to realise that there is help and that they can begin to make sense of their own behaviour and how they are feeling, what then happens when that young person goes back into school and nobody else within the school environment understands the understanding they have now gained?

I would say that we need to develop a core set of understandings around all professionals working with these young people—a baseline set of understandings, through the methodologies that have just been described. We then need—this goes back to the question about training—to bring in our specialists to work with the whole team around that

young person, so that they can further make sense of what that behaviour looks like in practice.

This is about enabling people to become emotionally literate, so that they can make sense of the young person's behaviour and of what some of the more dramatic self-disgust and self-harming behaviours really mean and where they are coming from. You then begin to contain that anxiety within the system that so often leads to the child being shot straight out into something else. There is a linear pathway that is very risky. It can begin with that social media interaction. A rapid intervention service in the moment sounds wonderful, but if the system does not understand it and cannot contain it, that young person is, to some extent, being sold a lie. We have to be careful.

Q52 Lucy Frazer: The message could be, "Go and speak to your teacher."

Tony Clifford: Absolutely, but if the teacher knows nothing about it, their response in the moment could exacerbate the child's trauma. What we do is bring in our educational psychologists. We use the pupil premium funding that virtual heads now have—funding that is personalised to the child and follows them—in Stoke to have an additional educational psychologist who will work with not just the teacher who gets the initial response from the young woman or young man, but the whole team around them. That begins to contain the very traumatic set of circumstances for the child and for the team, and you begin to get an attachment community around that young person. That is how in Stoke we have maintained zero permanent exclusions for children in care since 2009.

Q53 Lucy Frazer: I just want to understand this: is there a role for social media?

Natasha Devon: Research that has been conducted by YoungMinds—we work closely with them, and I know you have had them here—suggests that if a child is suffering from a mental health issue, the first thing they are most likely to do is turn to the web, so there is a role, but with two provisos. First, what the internet can do—Tumblr is a perfect example—is bring everything to an equal level, whether that is really sound advice by a top psychologist or something that has been written by a random blogger. We need to give young people the ability to discern what they are seeing, which is why critical thinking with regard to the web is a huge part of the lesson that I teach in schools. I also think that regulation is really key, because a lot of other people don't understand that pro-self-harm and pro-anorexia websites often begin as support forums, but they attract people who have issues and are not regulated.

Q54 Suella Fernandes: I have a quick follow-up for Carol. Some of the mental health issues relate, in my observation, to anxiety, low self-esteem, eating disorders and the failure to build relationships. You mentioned the use of mindfulness. I wonder whether you could say a bit more about how that has worked, what form it has taken and what effect it has had on those particular issues.

Carol Jones: Mindfulness is being used in several schools now. In fact, I think that seven pilots are working with the Wellcome Trust and Oxford University, which are looking at the impact of mindfulness in schools. They ensure that a group of teachers are trained in teaching mindfulness to young people. So far, it looks very positive. It looks as if it is having an impact not only on their own behaviour, emotional states, wellbeing and so on, but on the children around them and the ethos of the school.

Q55 Suella Fernandes: Can you give a concrete example?

Carol Jones: Yes. The Camden Academy[1] is currently running the programme and has had teachers trained in such a model, and there are other schools as well. I can research them and send that to the Committee. Certainly, they have seen a reduction in incidents of challenging behaviour and violence, an improvement in the general ethos of the school and a reduction in exclusions. It is probably worth looking at that in more detail. We certainly welcome the outcomes of the longitudinal, long-term study—Oxford University's work with the Wellcome Trust. It is obviously not a panacea for everything; it is a more preventive, long-term programme that will hopefully have a more general impact on the schools that are involved.

To return to the emotional crises for some children, we know that accessing CAMHS and the other organisations that we have referred to is problematic for some schools. In crisis situations, some schools are resorting to referring children to A&E and so on. We need to be aware of the crisis, as opposed to the long-term preventive work that some schools are beginning to involve themselves in.

Q56 Chair: When we spoke to young people before our formal sessions, many of them made the point that schools and CAMHS don't always work well together. That obviously caused them anxiety and sometimes further difficulties. How can we improve that relationship?

Tony Clifford: I want to pick up on what has been said. I am going to repeat myself, in a sense. In Stoke, we work with heads, CAMHS and educational psychologists to co-design a whole-school approach. The young person's frustration will be that, if they have had a good CAMHS intervention and they go into classrooms in which teachers don't understand, they won't get the response they were looking for. That won't help them or the teacher. We are duty-bound, however we co-design and co-commission, to ensure that our experts in the field are able to influence the culture around the child.

My optimistic view is based on working with a group of virtual heads. We have seen that you can do whole-school training at a fairly simple level to explain that the brain is pattern-seeking and survival-oriented, and that connections on the outside build connections on the inside—simple stuff—and teach people emotion coaching that draws on mindfulness, in terms of staff managing their own responses and feelings in the moment to help the child manage their responses and feelings in the moment, which is an attachment-like relationship.

For example, in a small-scale study in which we tracked 85-plus young people across 10 schools, you can see a halving of behavioural incidents in school, a halving of fixed-term exclusions and SDQ scores—it is really important that we implement them across the piece—lowering for those children. That is a very small-scale piece of research, and one of the things that we must do is further research into cost-effective interventions that can be done in school—not the high-level, reactive stuff but the low-level, preventive stuff. We need to give heads a very clear message about what they can do to make that difference to the whole-school culture. There are huge pressures on heads—I have been a head, as well as being a virtual head—and they have massive competing agendas. We need to bring them clear

[1] Witness clarification: UCL Academy in Camden

research that says, "If you do this across the whole of your school, it is doable and it will make this much difference." It very much has to be an outcome-based approach.

Q57 Michelle Donelan: You said before that the rate of exclusion was zero for a period of time following the attachment studies, but what other proof is there that it actually helps the mental health of looked-after children?

Tony Clifford: My reference to the rate of exclusion is in my local authority, and it actually predates attachment-aware schools. When I came in in 2009, we didn't have this programme, but I recognised that, to make the difference, it was no good my going to a headteacher and saying, "You can't do this, and you can't do that, because you are damaging children" unless I also brought them a training programme that made sense to them, that they could incorporate into a very packed curriculum and that was deliverable on the ground. That is why we do that.

We have drawn on the work of Bath and North East Somerset Council and Bath Spa University, which were leaders in the field, but this is now being spread across the country. The evidence base is small but growing, and I ask the Committee to look at the Bath and Bath Spa submission because it contains some very interesting data on what you would hope is happening as a result of that whole-school approach. We certainly need to do more research in this area.

Q58 Michelle Donelan: Do you think that relatively small change can have a significant impact on children's lives?

Tony Clifford: Absolutely, because if you look at the disproportionate effect of permanent exclusion on a child's life, what happens is the domino effect. The child can no longer be in that school, the foster carer cannot cope, the placement breaks down, the child moves out of area and, as we have already described, they then have to start from scratch in a new environment. We absolutely have to create stability for that child, and the Rees-Bristol research on how we improve educational attainment for children in care talked about linking educational attainment data to social care data and SDQs. If you put those factors together, stability is the key. We will create stability when we have attachment-aware schools.

Q59 Michelle Donelan: Can you build attachment theory into other areas of mental health support, such as health assessments?

Tony Clifford: Yes, because if we are trying to take a holistic view of the child, I would argue that we shouldn't just be trying to create a whole series of medical diagnoses. I work with young people who will sometimes have five different "disorders"—they will have OCD, ODD, ADHD, ASD—but when you look at the heart of that, and I am thinking about a particular young person at the moment, his fundamental issue was his attachment difficulties. Those diagnoses, which are high-level, expensive diagnoses to make, could have led that young person to a very, very expensive placement that we actually could not find nationally.

What we have done instead is to continue working with the whole team around that child. He has stayed where he is living, he has stayed in his educational provision and he will go into a mainstream college, which will cost about a hundredth of what it would have cost to put him into the provision into which he might otherwise have gone, so it is cost-effective to

build this into the totality of our approach from the highest end to your basic school understanding.

Q60 Suella Fernandes: How effective do you think virtual schools are in supporting the mental health of looked-after children?

Tony Clifford: The virtual head has been a statutory post since 2014. A group of us were privileged to work with the Children and Families Minister on an expert group, and across that group of virtual heads, our No. 1 thing that we most wanted was for schools to become attachment aware. We also wanted the pupil premium to sit with the virtual head, so that the money could follow the child.

I would like to put those two things together, because they are linked. Colleagues have talked very well about the value of personalised budgets, and what we are really saying is: given the instability in many of these young people's lives and how long it may take them to recover from trauma and abuse, how do we keep the plan close to that child? I think the virtual head has a key role. It is a challenge back to my colleagues nationally that we take this on board and that we actually co-design what is necessary in a local authority area to meet the needs of our children. We are beginning to do that. We are a very new professional body and, at the moment, we are trying to form ourselves into a national association, having already got a national steering group. But if you looked at our development plan, that will be No. 1 on the list.

We realise that I have 880 children in 185 different settings and the number of young people I am working with is growing at an incredibly rapid, and to some extent, anxiety-provoking rate. I cannot do that on my own. What I can do is task myself to co-design with colleagues what is necessary to hold that child. That is a legitimate challenge back to me. The data that come out should demonstrate that that piece of work, which goes back to the research question, has made the difference.

The Rees-Bristol research is very encouraging in that respect, because it describes care as a protective option. The problem we have is that we tend to measure the impact of care against too limited a dataset and tend to compare care with the whole population rather than with, for example, the child-in-need population. If you do that and make the right comparison, you see a huge impact. Part of that lies with the work of a teacher with a child, which is a relational activity that we must support, so I build from that child outwards, in terms of our system design. It is the right challenge and it is the heart of what I do in my job.

Q61 Caroline Nokes: Can I just ask about the mental health services and schools link pilots? Specifically to Natasha, how do you think this is working and how does it fit in with your role?

Natasha Devon: It has only been running on the ground for a matter of weeks, so it would be really difficult to tell you how it's working. One of the key things about my role, I feel, is that I am able to provide a voice for teachers at Government level, because I meet and converse with so many of them. Certainly from a teacher's point of view, what they would appreciate is knowing where their responsibility ends and CAMHS responsibility begins.

There are three layers to mental health in school: there is prevention, mental health first aid, and then, there is when you need to refer something on because it has become bigger than either of those. Within prevention and mental health first aid, in terms of wellbeing in school, a programme that includes lots of different things is the main place where that needs

to be administered. However, having listened to all the comments that have been made here today, I would be really wary of designing any kind of one-size-fits-all approach for schools. You can go to two state comprehensives that are two miles down the road from each other and they will have a completely different culture from one another.

Q62 Caroline Nokes: Can I ask a really specific question on that? Have you identified any differences between local authority maintained schools and academies?

Natasha Devon: Yes. Academies tend to have more freedom to design their wellbeing programme in their school, so, in my experience, they are trying more innovative things, which sometimes really work and sometimes don't. They will go one of two ways, but what I would like to see is the DFE providing a menu of suggestions for teachers, because even each year group within a school is different. Each form is different, and teachers know their pupils the best. If we can take the best parts of mindfulness, CBT and all the other things that we know work and improve the culture in a school, and then give teachers a menu of options that they can design specifically for their school, that bespoke approach is going to be the most effective.

Q63 Caroline Nokes: To take you back to the specific remit of what we are looking at, do you know if any work has been done in these pilots to specifically target looked-after children, or is it a whole-school methodology?

Natasha Devon: As far as I know, they have not specifically targeted looked-after children.

Q64 Caroline Nokes: Do you think there are likely to be any qualitative outcomes that would indicate a difference?

Natasha Devon: Everything is being means-tested, so there will be some kind of evidence that you can look at.

Tony Clifford: In Stoke, we are looking at working with our heads to design what they need for their schools. I would support your view that a one-size-fits-all approach—"You must only do this one intervention for every child"—is clearly not sensible. This is more analogous to—within literacy, you would expect all teachers of literacy to understand phonics. That still allows teachers to be immensely creative about how they work with children to give them a love of reading in their classroom.

In the same way, if we have a common set of understandings about how children learn and how attachment and trauma can affect learning, you free up teachers to be creative and to pick up some amazing interventions, like mindfulness. You liberate them to work with the child safely. I absolutely support the view that you should then say to that teacher, "This is what you can do; it's doable in the moment, but around that are professionals who will work with you and support you."

The level of supervision for teachers in schools compared with the level of supervision for social workers, foster carers and CAMHS workers is a real cause for concern. I would say the level of supervision for heads is also. Therefore, you will get fight, flight and freeze responses that can lead to permanent exclusion, and you will have heads saying, "I couldn't do anything else other than permanently exclude this child. I am heartbroken by having to do

it." What we have to ask ourselves is: where was the support for that person in that moment to make those decisions? It is often sadly lacking.

That core understanding is a protective factor. The huge drop-out of newly qualified teachers often lies in the fact that they are, in terms of their emotional literacy, sadly lacking. That is not a criticism of them; it is a criticism of how our initial teacher training equips those young people to understand what they are seeing in the children they are working with.

Q65 Caroline Nokes: Can I take you back to what you said about a lack of support for heads and ask you the same question I asked Tash? Is there a difference between support for heads in academies and in the local authority maintained sector?

Tony Clifford: For me, as a virtual head, there is no difference between how I would work with a head in a free school, an academy or a maintained school. From my point of view, these are all my children—these are all my schools, and I am corporate parent. That is an expectation I have of myself, because I am working with 185 different schools and you have to get to the heart of the matter with all of them.

Some of this stuff sounds deceptively simple, but if you peel back the layers in the tragic story of a young person who has had multiple care placement breakdowns and been to multiple schools, you will find the same pattern repeated. I was a head in a special school—a very high end one—having worked in maintained standard schools. I was picking up children at 15, and when I read their case file, the pattern of behaviour that brought them to me, having been permanently excluded from everywhere else, was the same pattern of behaviour they displayed as a five-year-old when they first got permanently excluded.

The pattern was repeated over and over again. Nobody had unpicked that pattern, and at the heart of that pattern was the child's damaged attachment to their birth parents, their ongoing display of that trauma and the lack of capacity and understanding around them to contain those issues. As a five-year-old, it was doable; as a 15-year-old regularly assaulting whoever happened to be around, that became increasingly difficult and expensive for the system. The core understanding is essential to maintain the young person and to maintain our heads and our teachers; we have to put the whole thing together.

Carol Jones: I think the high-risk accountability system that we have applies to all school leaders, irrespective of whether those schools are maintained or academies. We are all subject to the same scrutiny. Therefore, that puts pressure on school leaders, particularly headteachers. I do not think it makes any difference as to whether they are maintained schools or academies.

To return to the freedoms or the opportunities to which you referred previously, again it is impossible to decide whether this is attributable to being a head of an academy or of a maintained school. So much depends on the values and the school vision, and that can vary from academy to academy and from maintained school to maintained school. A school that has, at its heart, a vision that ensures that all children are supported and that emotional health and wellbeing are secure will ensure that it delivers a curriculum in an appropriate way, irrespective of whether it is through PSHE or other aspects of the curriculum. It is impossible to decide whether this is about maintained schools or academies.

Tony Clifford: In an increasingly free market in education, the virtual head has the pupil premium and we say to schools, "No personal education plan, no pupil premium,"

which is a child-based commissioning approach and is what we shared with the Minister. That gives us some direct commissioning power with schools that are not doing what they ought to do—that can happen—and we need that protective factor for a child so that we can support good schools by giving them the funding they need when they need it for that child. We can explain to schools what the expectations are about getting that funding. We need that funding directly to go with that child via a virtual head, otherwise we could lose that protective factor in the system, and that is very risky for the child.

Q66 Chair: Can I just ask about the care plans? We discussed them a lot in the previous session but they have not really cropped up in this session. Were those useful instruments for helping to solve some of the problems that you have talked about, Tony?

Tony Clifford: Yes. As I am sure you know, every child, as part of their care plan, has to have a personal education plan. We have those in place from age two and, for us, that goes all the way through to 25 if that young person stays in education. That plan needs to contain in it sharp targets for professionals to support that child. They are about learning but they are therefore about all the things that support learning, including mental health.

Our plans will include, for example, funding to support the adults around that child with the mental health issues so that that child can learn. That is where I would argue that the accountability joins up for that child. There is a concern that sometimes our personal education plans for young people are not good or sharp enough and are not completed in a sufficiently timely manner. But, actually, they can be a very powerful instrument.

The leverage of the pupil premium—because a school, through writing a good personal education plan can pull down its £1,500 or £1,900 of pupil premium—is enough to actually bring in an educational psychologist to work with a whole team around that child for a number of sessions, which can make a huge difference to the child. There is a way of joining this up. Sharp plans are vital for accountability. That is something that Ofsted ought to be looking for in its inspections because if you inspect a school it is a fairly quick win to say, "Do you have a child in care? Could I see their personal education plan? Let me have a look at what is in there about that child's mental health and how those needs are being met because when something goes wrong, that is what I will be coming back to." That is a huge challenge. These are appropriate challenges for us and they do support the child.

Carol Jones: I would agree that personal education plans are very helpful because they bring all the agencies together. We have already alluded to the fact that there can be a tension between, for example, CAMHS and schools, but the personal education plan and the meetings that surround that ensure that the child is at the centre. All the agencies come together with that child to draw up very clear targets and aspirations for and with that child, and that is very helpful. The relationships can also become quite well established at the beginning of that PEP plan. So, yes, we see this as a positive move.

Having said that, of course we might bring all the agencies together but we cannot always ensure that those agencies are well resourced. For example, there are schools that might not be able to access CAMHS and certainly cannot access educational psychologists. Gone are the days where many of us—I say this as a previous London head—could readily access ed psychs. They would often be absent at the PEP meetings and so on simply because the resources were not there. So, it is a good idea and, yes, a good way of holding all professionals to account and ensuring that the looked-after child is at the centre of the care plan. Nevertheless, we need to ensure that this can be backed up with adequate resources.

Natasha Devon: I just want to add to that. A couple of weeks ago I spent a day at the Red Balloon centre. I do not know if you are familiar with it. It is a place for severely bullied and traumatised children, many of whom have come from care. The centres are able to provide not only one-to-one tutoring, but counselling, and things such as nutritious meals and the entire care package at a cost of £10,000 per child per academic year. When you match that against the overall cost of where their life was probably taking them, it is nothing—so it can be done relatively cheaply.

Q67 Chair: I think that charity is a particularly good one, actually.

Natasha Devon: It is amazing.

Chair: Thanks for mentioning it today and thank you all for coming to this interesting, informative session.