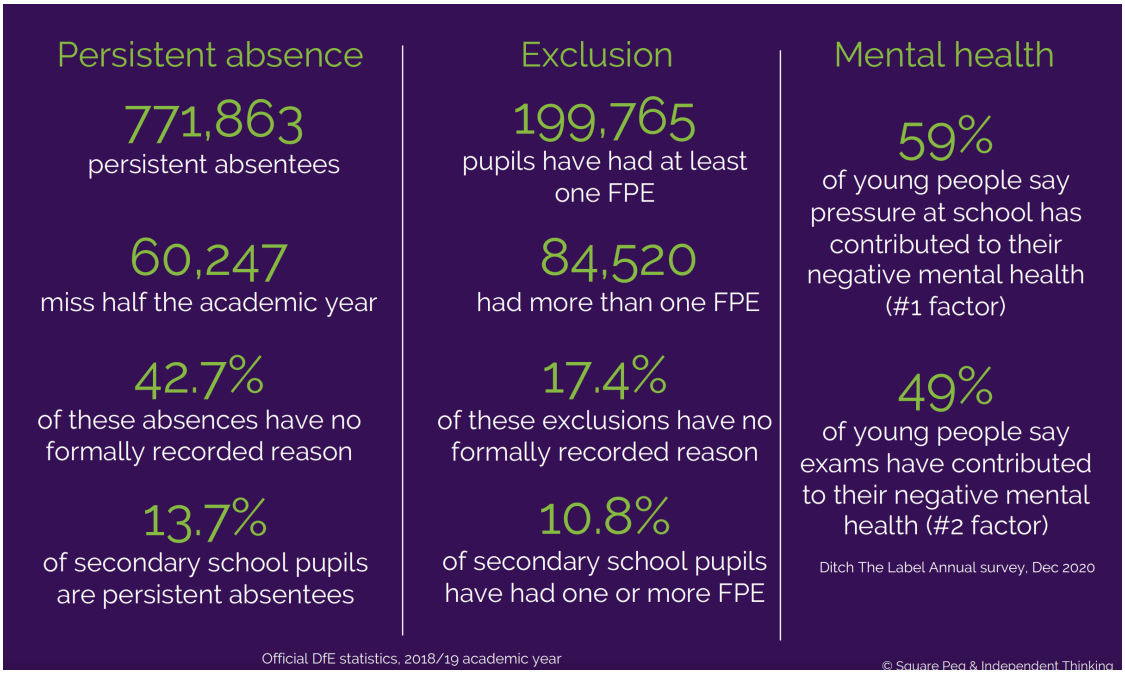
Written evidence submitted by Square Peg (CYP0093)

1. Square Peg

Square Peg is a parent-led Community Interest Company, set up in 2019 to effect change for children and young people experiencing barriers to school attendance. It works alongside another parent-led organisation, Not Fine In School, which supports the same children and families. Square Peg's asset lock is Young Minds, who have been supportive of the organisation since its inception.

Unmet mental health needs are having a major impact on children and young people's ability to attend school. Responses include masking and withdrawal, often leading to school 'refusal', or 'acting out' with challenging behaviour which then leads to isolation, restraint and exclusion. We see both of these as different responses to unmet need.

For context, there were 771,863 persistent absentees in the last set of official statistics, with the reasons for 42.8% of these absences unknown (recorded as 'other' or 'not yet known')[1]. There are also nearly 200,000 pupils who have received at least one Fixed Period Exclusion[2]. There are significant numbers of children with Special Educational Needs and Disabilities (SEND), on Free School Meals and ethnic minorities in both datasets. We believe that mental health is a key driver



behind these statistics.

[1] https://www.gov.uk/government/collections/statistics-pupil-absence
[2] https://www.gov.uk/government/collections/statistics-exclusions

Square Peg recently ran two surveys in the autumn term 2020 (the first pre-half term, and the second post-half term) to highlight the experiences of parents given the Government's renewed focus on attendance. We include some of these results in our submission. Not Fine In School has also run its own surveys in the past relating to some of the issues we discuss here; where relevant these findings have also been included.

2. What progress has the Government made on children and young people's mental health?

(a) Provision of mental health support in schools

The **education system is exacerbating children and young people's mental health problems**, with increased academic pressure, a narrowed curriculum, and budget cuts reducing the numbers of support staff. A heavy administrative burden on teaching staff is also reducing informal time with students. An unhappy and highly stressed teaching profession is unlikely to lead to additional support and the right compassionate mindset to support children and young people.

Current **attendance policy** means that parents face fines and prosecution if absence is marked as unauthorised. The DfE guidance is clear that medical evidence should only be requested if there are concerns about the legitimacy of the absence, but sadly the push for 90%+ attendance by the DfE and Ofsted means that too often absence is only authorised if medical evidence can be provided. Sometimes a GP's letter is sufficient; often it must come from a consultant and contain the specific phrase 'unfit for school'. The enforced attendance narrative since the start of the pandemic has made this situation worse. A recent Square Peg survey (661 respondents, between October half-term and the end of the autumn term 2020) showed that **42%** of parents had been asked for medical evidence (up from 31% in the first half of the term) and that **9%** were concerned that they would be asked to do this. 2 respondents out of 416 in the first survey (pre-half-term) had already been referred for prosecution as a result of their child's low attendance.

The **threat of fines and prosecution** puts huge stress on families. **83%** scored their stress levels at 4 or 5/5. Anxious parents are likely to create more anxiety in their children, which only serves to exacerbate students' mental health problems. **73%** of parents in the second survey had seen an increase in their child's anxiety, with another 15% citing a 'possible' increase. **81%** of children were worried about catching Coronavirus or bringing it back into their families. A staggering **93.5%** of parents were worried (scoring 4 or 5/5) about schools reopening. All of this indicates raised levels of anxiety as schools reopen; a rigidly enforced attendance narrative with sanctions for non-attenders will simply increase mental health problems and put additional pressure on already stretched CAMHS services.

Not all children and young people will want, or be able to access, mental health support delivered in school, particularly where their problems result from an inability to cope in the school setting. If

they are completely unable to attend then no service delivered via school will be accessible (this is also true of much of the academic research which is done via schools). We must recognise that the current system is contributing to these problems, so mental health interventions built into the system are not only ironic, but inaccessible to many.

Problems in the SEND system mean long delays, tribunals and the additional stress/financial burden this puts on families, with children's needs remaining undiagnosed or unsupported in the meantime. We believe the policy responses to attendance and behaviour problems are pushing an increasing number of children and young people with lower levels of anxiety into an anxiety disorder which then becomes a SEND. This only serves to put more pressure on the system in an ever-growing circle of need.

Safeguarding is increasingly the responsibility of schools, with low attendance a red flag on safeguarding policies. The consequential social services referrals for families whose child's mental health problems impact on their ability to attend, becomes an added stressor in an already critical situation. Many parents who invite social services support, in the hope that it will help secure a mental health referral for their child, regret doing so.

In terms of **CAMHS**, some progress has been made. Some local areas have teams, but these are separated from other parts of the system. Mental health services are not commissioned with enough structure or consultation to ensure they are well embedded into other networks like schools, educational psychologists or specialist CAMHS.

There is still **little parity between mental and physical health** – when a child is unable to attend school because of a visible illness/health condition this is readily accepted, whereas when it's an invisible mental health issue (particularly anxiety-related) it's often dismissed as 'just anxiety' and the onus is on parents to provide additional proof from a medical professional. If a GP deems their expertise insufficient, then it's likely to be a long wait for a CAMHS professional, and thresholds are ever-higher (again conflicting with the concept of early intervention).

Mental health support is undermined by culture, and the **approach in many schools is not mental health or trauma-informed**. It is our firm belief that a trauma-informed culture in schools, led by school leadership, would go a long way to resolving the mental health issues in schools, and reducing persistent absence and exclusion. There is growing evidence that this is the case, but more research is needed in this area. More general awareness and better training is needed to change attitudes so that mental health problems arising from anxiety (as above) are not dismissed.

The ongoing focus on **narrow academic achievement** in schools is damaging for too many young people - this very much includes the 'catch-up' narrative post-lockdown which we are seeing and hearing from the Government and in the media. Children and young people pick up on this narrative and it adds to their stress. They don't want to hear they are a 'lost generation', that they're likely to

earn £40,000pa less and that their future opportunities have been jeopardised by school closures. In Ditch The Label's latest survey with young people[3] (December 2020) the top two contributory factors to negative mental health were cited as the pressure of school (#1 at 59%) and the pressure of exams (#2 at 49%).

The **lack of school placements that cater for children with Special Educational Needs & Disabilities** is leading to an explosion of mental health difficulties as a result of unmet need in education and the severe and long-term damage this can cause.

(b) Provision of support for young people with eating disorders

Good progress has been made in many areas around community care, with some well-established, trained and skilled professionals working hard to support young people. However, there **is not enough inpatient care**, and many young people are unable to access inpatient treatment and are therefore inappropriately placed on acute paediatric or adult wards.

There is a **lack of provision for children with eating disorders** (not otherwise specified) and no provision for children with ARFID (Avoidant, Restrictive Food Intake Disorder) in many areas.

(c) Addressing capacity and training issues in the mental health workforce

There is a **massive shortage of skilled staff** including psychiatrists and mental health nurses and there has been no real progress in addressing this. Training for generic CAMHS services is non-existent.

It's hard to understand why funding would be put into a project such as **Trailblazers**, with a new basic mental health training certification, when CAMHS is in such dire need of funding. We would like to see evidence that the Trailblazers project is providing an appropriate service for the level of funding invested, and able to cope with the mental health problems these teams are seeing in schools.

There appears to be **no national 'map' of children and young people's mental health services**, which shows not only what is available in each area, but how effective those services are. There are many private providers, but without clarity on their availability, efficacy and value for money, it's hard to know how school leaders can make informed decisions about the right support for their cohorts of students.

(d) Improving access to mental health services

There is still no specified commissioning for young people who have experienced **trauma**, with a dearth of qualified professionals with experience in this area. Inexperienced professionals dealing with complex trauma can easily re-traumatise children.

[3] https://www.ditchthelabel.org/research-papers/the-annual-bullying-survey-2020/

There is **no triage system** as in A&E. This means that children and young people who are struggling to engage with less experienced professionals (eg. mental health nurses) never get past this point to access the experienced consultants that can help them.

There is still **NO adequate transition from children's to adult services** in most areas; for many families this remains a cliff-edge. We need to specifically commission services for 18-25 year olds if we are to address this long-standing issue.

Autism is often a factor in school absence and anxiety. However, **when autistic children are referred to CAMHS they are dismissed** because 'anxiety is a normal part of autism' (in reality CAMHS are not commissioned to work with anxious autistic children). Often the anxiety is triggered by the school environment being detrimental to autistic children and they do need CAMHS support.

3. **How can inpatient care be improved for children and young people, with less physical and medical restraint?**

There are clearly commissioned trauma-informed inpatient services in every area.

The **education set up in many inpatient units is the best thing about them**. We need to replicate this in every area and set it up to provide educational intervention, combined with jointly commissioned mental health support, so that there are real options for children and young people with mental health difficulties to access education. Too often this is only available at crisis point, when Tier 4 inpatient services become necessary.

The **quality of inpatient services vary hugely**. There has been much media coverage of inadequate services where children and young people are simply medicated or restrained to control their behaviour, with little or no therapy offered. In the private sector and given the cost of these facilities, this is inexcusable.

4. **What wider changes (particularly in the area of early intervention) are needed in the system as a whole?**

We definitely need to move towards **better early intervention** BUT it will take a generation to see the results of this, so **we need funding both for early intervention and therapies now** to avoid a worsening mental health crisis amongst the current generation.

Infant mental health provision should be commissioned in every locality.

We cannot address the problems in children and young people's mental health services without addressing all the **inter-dependent systems** of CAMHS, education (including SEND) and social care. There is little point trying to resolve problems in one if the others remain broken or in crisis.

Lack of coordination between services creates service 'ping pong', particularly where resources are limited. This inevitably leads to gatekeeping and a 'not our problem' syndrome where services argue about who owns the responsibility, whilst the child in question deteriorates. **Inflexibility** across diagnostic pathways, as well as between services, means that children and young people with complex or multiple needs often fare worse.

Access needs to be **timely**, and the professionals delivering support must be **appropriately trained and themselves supported** in their role – one of the issues if teaching staff are expected to support their students' mental health is that they have no mental health support or supervision themselves. Whilst the numbers entering the teaching profession remain high (possibly because it's still seen as a relatively secure job in austere economic times), we are aware that school leaders are leaving in droves. This will lead to younger, less experienced leaders who may struggle to fulfil the ever-increasing responsibilities that come with the job. Teaching staff need support themselves, and the type of supervision offered to other services such as CAMHS. They will be unable to deliver support to students if they are not also being supported.

5. **How can the Government learn from examples of best practice, including from other countries?**

We know that persistent absence, often resulting from students' mental health problems is a **global issue**, and Square Peg sits on the communications committee for INSA, the International Network for School Attendance. At INSA's first annual conference in Oslo in October 2019, it was agreed by the 250+ delegates from 14 countries that the solution to persistent or chronic absence relied on collaboration with parents, and often therapeutic intervention (depending on the nature of the underlying needs). Anxiety may be the trigger, creating mental health problems, but the underlying need can vary hugely.

The academic research around chronic absence hasn't led to any significant breakthroughs, but there are key INSA academics in many other countries (**USA, NL, Scandinavia**) who continue to work in this field. A recent piece of research in Belgium[4] showed a 100% discrepancy between the reasons for school-recorded absence versus parent-reported – this only serves to show that a triangulated approach is needed to properly understand the underlying causes in order to address need(s) and reduce mental health problems.

No one country seems to have the solution to this, but in education terms the Scandinavian and European countries where **children start later** and have a **more play-focused transition** into formal learning, would appear to create happier children as a result. The UK, in contrast, sits near the bottom of the Global Happiness Index.

[4] https://torvub.be/torwebdat/publications/t2019_30.pdf

6. **What measures are needed to tackle increasing rates of self-harming and suicide among children and young people?**

We must focus on **scaffolding families in the early years** through programs like SureStart.

Parenting support needs to be readily available and accessible to all – but it must be individualised, adaptable and trauma-informed so that parents are not offered basic levels of parenting support when they are heading into crisis. Too often parents tell us that their first contact with CAMHS directs them to one or two parenting courses before further support can be accessed – perhaps as a means of gatekeeping precious and limited resources? Clearly this does not constitute early help unless a qualified professional has assessed the mental health problem and recommended a specific parenting course as a key component of the support being offered.

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