Social, emotional and mental wellbeing in primary and secondary education

Consultation on draft guideline - Stakeholder comments table
14/01/22 – 25/02/22

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Anna Freud Centre				**Question 4, Please tell us if there are any particular issues or evidence relating to COVID-19 that we should take into account when finalising the guideline for publication:** As is acknowledged, this guidance was written pre-Covid but this does seem to make it very out of date. To issue guidance without the overriding context of the past two years appears odd. Covid-19 has caused additional strain on school staff who were struggling to cope with supporting pupil mental health and the rising rates of mental health problems before the pandemic. The pandemic has exacerbated these challenges and increased the likelihood of mental health problems for some young people. The pandemic has made it more crucial than ever for the recommendations detailed in the guidance to be implemented, with a greater focus on supporting mental health and wellbeing within schools through a WSA so that schools are able to have a clear sense of the mental health needs in their setting, pathways to providing support, and	Thank you for your support regarding whole-school approaches. This guideline was not written pre-covid, however because covid is ongoing, the evidence about its effects on children and young people's social, emotional and mental wellbeing is in large part not published, because studies are ongoing. The committee heard expert testimony about the impact of the pandemic, particularly on neurodiverse children and young people and were careful to underpin all of the recommendations with that understanding. Regarding prioritisation of mental health, unfortunately NICE has no control over what is prioritised in the curriculum at a school level.

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				various support options. Ideally, this would involve setting more time aside for socialisation opportunities which young people missed out on during lockdowns which are key developmentally. Ensuring mental health is prioritised throughout the curriculum and school community and signposting opportunities are available. Some indication of this in the guidance is necessary to make it timelier. Evidence emerged rapidly and continues to emerge, and there were opportunities for the guidance to better reflect this through work that was already happening. The Emerging Evidence series synthesised some of the research that emerged around the mental health impacts for children and young people early on in the pandemic, with recommendations for young people, parents and carers, clinicians and schools and colleges based on the evidence. Evidence such as this could have been reflected in the guidance both in terms of setting the stage for the current state of mental health and wellbeing in young people, the current challenges, as well as disproportionately affected	

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				groups and the greater need for identification and WSA. Acknowledging that as part of the Covid response children have been encouraged to have increased anxiety in relation to their own health and the health of others. It will take time for these levels of increased anxiety to reduce. There were a number of children that felt safer being at home and not being in school. There has been an impact on emotionally based school avoidance for children and young people. Impact of COVID varies according to a number of variables, age, family circumstances, income etc. Therefore, some children potentially benefitted from smaller classes and/or 1-1 help at home from parents, whilst others missed out on social interaction and many aspects of their education. Transition points for some young people were significantly impacted. The pandemic has also resulted in Children and Adolescent Mental Health Services (CAMHS) support now being even harder to access.	

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Anna Freud Centre	Guideline	General	General	**Question1, Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why:** Implementing a whole school approach (WSA) has the potential to have the biggest impact. However, this will pose a challenge, embedding a WSA requires leadership, resource and commitment. A successful WSA must engage a range of internal and external stakeholders, changing whole-school cultures within school relationships as well as with external agencies. It can be difficult for CCGs and schools to work together to identify opportunities for joint practice to support the social, emotional and mental wellbeing of children and young people. Schools often have limited knowledge of locally available services and options, and there aren't always clear paths or procedures for linking with these agencies. The voices of schools are often not heard in the commissioning processes. In addition, a whole school approach requires leadership to embed various aspects within the	Thank you. Your comments resonate with the committees agreement that a whole school approach is the foundation for children and young people's social, emotional and mental wellbeing, and implementing such an approach is the core of this guideline, which also refers to engaging with stakeholder and local communities as well as with local services as you suggest. The recommendations about local support (1.1.19 – 1.1.22) aim to improve the engagement between schools and local health and care services. The committee was aware of different guidance to support the implementation of whole school approaches, but limited the recommendations to areas where they had considered the evidence of effectiveness. The level of granularity that you suggest is too specific for a generic guideline that aims to be universally applicable and the decisions about implementing the guidelines in local areas will need to be made by commissioning and service provider networks in those areas.

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				school/college environment, and staff often do not have the time or resource to be able to do so. While a WSA has significant benefits if implemented well, motivating schools to do so will remain a challenge, as it requires considerable resource, energy, and long-term planning. More specific recommendations as to how schools can embed a WSA (eg. 5 Steps to Mental Health and Wellbeing (annafreud.org) would be helpful. Despite the PHE & DfE documentation on WSA which was first published in 2015 and updated in 2021 – schools across England have not widely implemented it, which highlights a challenge in the translation of policy into practice. There is risk that this guidance suffers the same fate – and consideration needs to be given into how the suggestions in this guidance, can be made more accessible and usable for the intended audience. Schools need dedicated time, resource and support to embed a WSA. In addition, identification remains a challenge for schools and colleges. While there is much	

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				guidance around this available, it remains an intimidating area and with little top-down guidance over what should be done. Schools often struggle to implement effective evaluation or use outcome measures often due to lack of training and support. Guidance suggesting in more detail how this could/should be done would instil more confidence or pointing to evidence-based resources to do so. Identifying those children who are internalising social, emotional and mental health needs (e.g. anxiety) is a challenge, but once identified can have a large, positive impact. While sections 1.1.6 and 1.1.7 highlight key aspects of joint working to support a WSA, these are major undertakings with no guidance on how to do so. The DfE Link Programme has been targeting this since 2015 and has suggested a high need of support for schools and colleges to connect with mental health services and the wider community. Areas have required a high level of support and direction in making these connects, and it remains a challenge, so broad	

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				guidance suggesting this is not enough for it to be implemented.	
Anna Freud Centre	Guideline	General	General	**Question 2, would implementation of any of the draft recommendations have significant cost implications:** The introduction of supervision would have cost implications in terms of training and human resource development. The recommendations around staff development/training and wellbeing will have cost implications. The recommendation of relational as opposed to behavioural approaches have substantial cost implications at least in the short term. Many schools have a limited capacity to move from behavioural to relational approaches, e.g. there will be not only a staff development need but also acknowledgement that relational approaches are (at least in the short to medium term) more time-consuming to implement than behavioural models. Many schools and trusts have	Thank you. .NICEs resource impact team have produced a statement to support the implementation of this guideline. It can be found on the guideline webpage.

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				investigated considerably in behavioural approaches training.	
Anna Freud Centre	Guideline	General	General	**Question 3, What would help users overcome any challenges:** Additional resources for Senior Mental Health Lead in school settings. Training and protected time in order to gain knowledge of the local support options and pathways. An identified role within each Local Authority with capacity for supporting joint working between schools and health, planning and taking action. We have seen throughout the Link Programme that the greatest impact and best outcomes have been where there is a clear strategic and operational lead with at least part of their role dedicated to actioning joint working across Schools and Health. Schools sharing expertise and resources with each other will be beneficial in overcoming challenges in implementing the guidelines. Local SMHL networks and learning from Successful school/MHST relationships.	Thank you. NICEs resource impact team have produced a statement to support the implementation of this guideline. It can be found on the guideline webpage. The local resourcing of school staff and joint working across schools and health is a matter for local commissioning arrangements.

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Anna Freud Centre	Guideline	General	General	The committee membership is notable for the absence of significant representation (or voice) from the key stakeholders. And, in a world where we expect significant contribution from people – Children and Young People and parents & carers – with lived experience of mental health difficulties and services, this appears to be totally absent. The work of Mental Health Support Teams and the learning from the Link Programme are not reflected in the guidelines.	Thank you. NICE Public Health Committees are recruited through a standardised process. All NICE committees include lay members. Children and young people were not included on this committee due to legal restrictions on involving minors in this kind of work, however because of this, NICE identified additional funding to undertake primary research with children and young people (including those with SEND and those excluded from school) to explore their views on the draft recommendations. The report of this research can be found on the guideline webpage. The committee discussed Mental Health Support Teams but decided not to make direct reference to them as a resource. They noted that these services were not yet in place in all areas and would not be until 2025 at the earliest. Until more is known about the effectiveness of MHST, the committee agreed they were just one of several different services and occupations that might be involved in CYP's social, emotional and mental wellbeing and did not want single them out at this time. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation about compiling a directory of the local offer directory and keeping it up to date (recommendation 1.1.20). The committee also discussed the DfE link programme but decided not to mention this in the guideline they had not analysed the evaluation and learning from the programme in detail.

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Anna Freud Centre	Guideline	General	General	There is no mention of Mental Health Support Teams. The Designated Mental Health Lead is not mentioned. 1.1.16 mentions appointing a 'lead person'. This is likely to seem quite odd to education settings.	Thank you. The committee discussed this but decided not to make direct reference to Mental Health Support Teams as a resource. They noted that these services were not yet in place in all areas and would not be until 2025 at the earliest. Until more is known about the effectiveness of MHST, the committee agreed they were just one of several different services and occupations that might be involved in CYP's social, emotional and mental wellbeing and did not want single them out at this time. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation about compiling a directory of the local offer directory and keeping it up to date (recommendation 1.1.20).
Anna Freud Centre	Guideline	General	General	There is hardly any mention of inequalities, for example the impact of deprivation. For many education settings this just misses the context in which they operate.	Thank you. We have added this to the equality impact assessment for the guideline. The committee made reference where possible to the need to be culturally competent and engaging outward with local communities and to involving parents and carers in designing and implementing whole-school approaches
Anna Freud Centre	Guideline	General	General	It does not acknowledge the primary function of schools and colleges as places of learning. Emotional wellbeing needs to be understood within this context. There is no mention of the Ofsted framework. Ofsted are only mentioned in relation to an out-of-date document on early help. Emphasising the importance of ensuring that children have their emotional needs	Thank you. The committee discussed this but agreed that it was not necessary to explicitly acknowledge the primary function of schools and colleges as places of learning in the guideline. They agreed that this was already known.

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				addressed in order to improve their availability for learning is crucial to engage education professionals.	
Anna Freud Centre	Guideline	General	General	There is no mention of digital technology or the impact of social networking.	Thank you. The committee did not see any evidence about the impact of digital technology or social networking and so were unable to comment on it.
Anna Freud Centre	Guideline	General	General	The guidance reverts to 'schools' very often, rather than acknowledging the range of settings in which children receive their education. There is also no reference to the different governance arrangements such as Multi Academy Trusts.	Thank you. It is now stated at the start of the guideline that "Recommendations relating to parent or carers might be less relevant to older young people, especially those in post-16 education settings and may need to be interpreted accordingly".
Anna Freud Centre	Guideline	General	General	This is a public health document without adequate clinical representation. There appeared to be one educational psychologist on the topic expert list. No child psychiatrist, clinical psychologist, or the like.	Thank you. The roles that need to be represented on the committee were agreed during the scoping of this guideline. A psychiatrist was not identified as a key member of the committee since they would normally deal with children and young people who had mental ill-health rather than those who were at risk of poor social, emotional or mental wellbeing.
Anna Freud Centre	Guideline	General	General	From a Children and Young People's mental health point of view there is little here that would guide schools to act in ways likely to reduce referrals to Children and Young People Mental Health services. Therefore, it's not very satisfactory from a clinical or Public Health point of view.	Thank you. The guideline doesn't set out to reduce referrals. Increasing the social, emotional and mental wellbeing of children and young people should reduce referrals to mental health services and guideline attempts to help those involved make more appropriate referrals for mental health.

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Anna Freud Centre	Guideline	General	General	The recommendations can only speak to the available evidence and the evidence that is available will depend on the research questions asked and the papers retrieved. Therefore, the Guidance reflects that the field is not well researched from our point of view.	Thank you for this information.
Anna Freud Centre	Guideline	4	14 - 15	1.1.5 - How would schools monitor and evaluate a whole-school approach? Support and guidance needed here.	Thank you. The committee decided not to provide examples of how to monitor and evaluate whole-school approaches. They were mindful that different schools will have their own systems and there is no one correct way to conduct monitoring and evaluation.
Anna Freud Centre	Guideline	4	21 - 22	1.1.6 - The final three bullet points refer to the work of the DfE Link Programme – it would be good to refence the evaluation and learning from the programme	Thank you. The committee discussed this but decided not to include a link to the DfE programme because they had not analysed the evaluation and learning from the programme in detail.
Anna Freud Centre	Guideline	4	5 – 8	1.1.2. - Many schools have a limited capacity to move from behavioural to relational approaches, e.g. there will be not only a staff development need but also acknowledgement that relational approaches are (at least in the short to medium term) more time-consuming to implement than behavioural models. Is there a way to acknowledge this in the guidelines? Also issue of conflict with the stated ethos of some schools and trusts.	Thank you. Individual schools are best placed to make decisions about how far and how quickly they can move to a whole school approach. The guideline acknowledges this and discusses the time and resources issues in the rationale and impact section.

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Anna Freud Centre	Guideline	5	1 - 5	1.1.6 - The final three bullet points refer to the work of the DfE Link Programme. it would be good to refence the evaluation and learning from the programme	Thank you. The committee discussed this but decided not to include a link to the DfE programme because they had not analysed the evaluation and learning from the programme in detail.
Anna Freud Centre	Guideline	5	6 - 9	1.1.7 – Clarity on whether governors also require training?	Thank you. The committee discussed this but decided not to explicitly state whether governors require training. They believed that it was implied that those responsible for social, emotional and mental wellbeing curriculum content should have adequate skills and training.
Anna Freud Centre	Guideline	6	9	1.1.16 - It would be useful to employ the term Designated Mental Health Lead as this used by the DfE	Thank you. The committee decided not to explicitly specify a lead, as schools / colleges should have freedom to decide who would suit the role best. However, they did agree to clarify that the lead person should be senior person with authority to make decisions and authorise expenditure.
Anna Freud Centre	Guideline	8	15 - 23	1.3.1 - It's not clear who it is recommended should conduct the assessment of need – is it school staff? Training and support is required. Providing additional guidance here would be beneficial. To what extent do the tools and techniques recommended need specialist expertise to administer and when interpreting the results?	Thank you. The committee decided not to specify who should conduct the assessment as this will vary across schools / colleges and there is no one role that would always be best suited for this job. Levels of expertise to administer and interpret results will also vary depending on the tools and techniques used.

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Anna Freud Centre	Guideline	8	3 - 5	1.2.6 - Mindfulness in schools is one of the interventions being trialled as part of the DfE RCT Education for Wellbeing. The trial is ongoing.	Thank you for this information.
Anna Freud Centre	Guideline	9	6	Box 1 would benefit from a clarification on which are adverse childhood experiences (ACEs) and which are behaviours that might derive from ACEs. It would be generally useful in this section to acknowledge that education settings will all be covered by local safeguarding arrangements and that these are relevant.	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Anna Freud Centre	Guideline	9	8	Education settings should always be making reference to local safeguarding arrangements and thresholds	Thank you for this information.
Anna Freud Centre	Guideline	9	18	Should schools be using any tools without adequate training, for example on how they should be administered and shared with parents and young people	Thank you. The committee considered this point but thought it was safe to assume that staff would be trained before using a particular tool.
Anna Freud Centre	Guideline	10	14	It would be helpful when referring to targeted support to think about guidance for education settings on how to commission and monitor those delivering such support, including counsellors. The introduction of Mental Health Support Teams in many areas could be referenced here.	Thank you. The commissioning and monitoring of services is a matter for local schools and authorities to agree.

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Anna Freud Centre	Guideline	11	7	Peer to peer support can be helpful but a greater level of advice and consideration is needed on how such schemes are delivered and peers offered appropriate support	Thank you. The committee did not look for evidence about delivering peer to peer support, and therefore was not able to recommend one particular method of delivery over another.
Anna Freud Centre	Guideline	13	8	It would be helpful here to be more precise about what is meant by Adverse Childhood Experiences: possibly a link to a trusted site.	Thank you. Changes to the guideline mean that the definition of adverse childhood experiences has been removed.
Anna Freud Centre	Guideline	13	17	The suggested document is now 7 years old and is quite specific. A link to the Early Intervention Foundation for example might be more useful.	Thank you. The committee agreed to change this as you suggest.
Anna Freud Centre	Guideline	20	21, 22	The need to monitor and evaluate the whole-school approach is mentioned but how would this be done/ what measures could/should be used? Links to trusted resources would be helpful	Thank you. Different schools will have different monitoring systems in place. For this reason the committee agreed that individual schools should be able to implement the monitoring system that matches beast with what they currently do.
Anna Freud Centre	Guideline	20 21	27 – 28 5 - 6	Schools would benefit from clear guidance on how to make the links with external agencies, including mental health services and local public health departments. Particularly in relation to page 5, lines 5 & 6, which references schools do not always have the mechanisms in place for working with local key services.	Thank you. The committee discussed this but decided that mental health services will vary across the country and therefore, how to make links with these agencies will also vary. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date.
Anna Freud Centre	Guideline	22	27	This section is quite confusing. Local authorities are not responsible for child mental health services. It is not clear what risk analysis was being suggested that local authorities would set out.	Thank you. This has been clarified.

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Anna Freud Centre	Health economic tool	General	General	Question 5, Please tell us if you have any comments on the tool, its usability or its content: A very helpful tool. Consider zooming in on the screen for the video, as even on a desktop it can be difficult to view, and those on a laptop may struggle, even in full screen mode.	Thank you. It's possible to crop the video size down so that the content is zoomed in. However, this will inherently mean that the quality of the text will be worsened in the process. There may not be any more we can do with this other than encourage full screen is selected on the viewers device.
Anna Freud Centre	Health economic tool	General	General	It is unclear whether in the intervention cost table, additional lines of cost can be added to the top two granular tables to calculate the total intervention cost.	Thank you. On this page there is a model information button. This tells you that the orange cells are only placeholders and are free to be updated by the model user. Therefore, placeholder rows can be used to include additional lines of cost.
Association of Colleges	Guideline	4	2	By sticking with the title 'Whole School' and not including the word College shows a lack of understanding that colleges are different. The most obvious way in which most colleges are different, is that they include elements of adult education – so a 'whole College' approach has to go beyond children and young people. Unfortunately, a generalisation like this means this guidance misses the mark on post 16 education.	Thank you. We have added a comment about a range of educational settings at the start of the guideline to clarify that we are talking about all schools and post-16 educational establishments.
Association of Colleges	Guideline	5	4	• If the whole college approach is to be taken then this would require engagement with CYP **and** adult MH services	Thank you. The guideline is aimed mostly at primary and secondary education. We acknowledge that for post-16 education the recommendations may need to be interpreted in the context of adult services.

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Association of Colleges	Guideline	5	21	The college setting is very different to schools in most instances. The nature of most colleges is to have significant numbers of pastoral and other support staff who are available to support students. Whilst it is right that teachers should be able to recognise the pastoral needs of their learners, it would be reasonable that this should say 'teacher **and** all student facing staff'. This has resource implications in terms of what is required for CPD across the workforce.	Thank you. The committee discussed this and decided not to amend it as, in a perfect world, all staff would have this training. They acknowledged that it was unlikely to happen in most places but agreed this was a decision for individual schools and colleges.
Association of Colleges	Guideline	5	25	By focusing on schools and not understanding colleges means this statement misses the point that many colleges recruit from multiple areas crossing many commissioner boundaries. This means that colleges must be aware of the local offer in all the areas that they operate. This also has resource implications as it requires engagement with multiple partners.	Thank you. The committee also decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date
Association of Colleges	Guideline	6	1	Involving parents and carers in a post 16 setting is significantly different from a school setting. This should be recognised in some way along with the challenges associated with student rights to confidentiality	Thank you. It is now stated at the start of the guideline that "Recommendations relating to parent or carers might be less relevant to older young people, especially those in post-16 education settings and may need to be interpreted accordingly".
Association of Colleges	Guideline	10	18	By not identifying different age groups for recommendations makes the guidance less relevant to settings with older students such as colleges – so	Thank you. The committee agree and have added the following to the box on page 4 at the beginning of the guideline: "Recommendations relating to parents or carers might be less

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				to say 'talk to parents or carers' before deciding on support does not acknowledge that older learners will be responsible for that decision.	relevant to older young people, especially those in post-16 education settings and may need to be interpreted accordingly."
Association of Colleges	Guideline	11	12	This whole section is written without reference to transition to college and with no research considered looking at transition into key stage 5. Currently, about twice as many 16-year-olds go into college compared to staying on in a school setting, this is at a significant time of life and can be when transition between CYPMH services and AMHS is occurring for those who are receiving support. In addition to this, second years in a college setting will usually be preparing for transition into work or university. To miss out the college setting is a huge gap in this piece of work.	Thank you. The committee agree and have added the following to the box on page 4 at the beginning of the guideline: "Recommendations relating to parents or carers might be less relevant to older young people, especially those in post-16 education settings and may need to be interpreted accordingly."
Association of Paediatric Chartered Physiotherapists	Evidence Review A	38		While the review reports it is representing young adults up to age 25 with SEN, no studies were included beyond age 19 years	Thank you. Unfortunately, there were no studies identified that met the inclusion criteria that included participants beyond the age of 19 years. If any had been found, they would have been included.
Association of Paediatr	Evidence	6	6	There is no discussion around outcome measures for non-verbal children and children with complex neurodisability (our SEND cohort). I feel it's important	Thank you. For children with complex disability studies included in the review would have needed to rely upon teacher and parent reported outcomes. Any studies that used modified

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ic Chartered Physiotherapists	Review B			that these children and young adults have a voice and how this is captured needs to be discussed and accommodated.	tools to measure outcomes for people with SEND would have been reported. The committee have received comments about the need to focus more on communication needs within the guideline itself from you and other stakeholders. They have added communication for people with SEND, especially regarding them having a voice and being heard. See recommendation 1.1.15. Additionally, the committee did note a lack of evidence about whether children and young people with special educational needs were at a higher risk of poor social, emotional and mental wellbeing and made a research recommendation about this (see other recommendations for research in the guideline).
Association of Paediatric Chartered Physiotherapists	Evidence review B	13	2	Lots of studies for key stage 1 -4. Only 1 study included children up to age 20 years. No studies captured our SEND children up to age 25 years	Thank you for this information. We concur.
Association of Paediatric Chartere	Evidence review C	16	7-14	We acknowledge the mismatch between their teachers' perceptions and the demonstrable outcomes evaluated from the children and young people. We would recommend clearer agreement about the outcomes expected to monitor the children's social, emotional and	Thank you. Outcomes captured in the evidence reviews are outlined in the protocol and decided in collaboration with the committee prior to conducting the systematic review. The review protocols that detail the inclusion and exclusion criteria

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d Physiotherapists				mental wellbeing, including those with physical disabilities and special educational needs.	for each review can be found in appendix A of each review document.
Association of Paediatric Chartered Physiotherapists	Evidence review C – Overall comment			We welcome the range of age groups represented with different stakeholders including staff, parents and children and young people and acknowledge a limitation in the quality of research available. The needs of non-verbal children are not highlighted, and this omission does not enable their voices to be heard.	Thank you. Studies involving non-verbal children that met the inclusion criteria were not identified in the evidence review. The review protocols that detail the inclusion and exclusion criteria for each review can be found in appendix A of each review document. The committee noted the lack of evidence about people with communication needs and decided to make amendments to certain sections of the guideline to highlight the importance of communication needs and skills. This included recommendations 1.1.4, 1.1.8, 1.1.15, 1.2.5, 1.3.6 and 1.4.2.
Association of Paediatric Chartered Physiotherapists	Evidence review D	48	11-15	we welcome the recommendation for further longitudinal research with underserved and vulnerable groups such as those who communicate differently	Thank you for your support.
Association of Paediatric Chartered	Evidence review D	49	31-37	the physical activity recommendations are welcomed; however, consideration needs to be given to adaptations of sports and recreational activities for those with disabilities.	Thank you. You raise an important point, however adaptations of sports and recreational activities for people with disabilities are outside the remit of this guideline. The only recommendation for physical activity is for considering rhythmic physical activity (1.2.8), and this is adaptable and

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Physiotherapists					accessible since it includes activities like bouncing and banging.
Association of Paediatric Chartered Physiotherapists	Evidence review D	50 51	232	The adverse impact of disabled children and their families during COVID restrictions has been underestimated and we welcome the need for further research to learn how best to support their social, emotional and mental wellbeing.	Thank you for your support.
Association of Paediatric Chartered Physiotherapists	Evidence review E	Overall comment		It was disappointing that only 1 study met the criteria and reinforces the need for more research.	Thank you. The committee agreed with your view.
Association of Paediatric Chartered	Evidence review E	Overall comment		While the Strengths and Weaknesses questionnaire is held up a gold standard for evaluating social, emotional and mental wellbeing, it has limitations for non-verbal populations. Further consideration should be given to find ways to evaluate this population of disabled children to give them a voice.	Thank you. The committee noted the limitations of the tool, and following this consultation agreed that they needed to be much more specific in the guideline about meeting the needs of children and young people with communication needs. They have added this to recommendations throughout the guideline.

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Physiotherapists					
Association of Paediatric Chartered Physiotherapists	Evidence review E	11	24	The SPECTRUM database should be updated to include the Be-Well checklist (Oliver et al 2020). Oliver, C, et al 2020, 'The behaviour and wellbeing of children and adults with severe intellectual disability and complex needs: the Be-Well checklist for carers and professionals', Paediatrics and Child Health.	Thank you. NICE does not have the ability to update the SPECTRUM database.
Association of Paediatric Chartered Physiotherapists	Evidence review G	6	7-11	Targets used for SEND will require to be specialised i.e. methods to evaluate outcomes for children with compromised communication, vision, hearing and with Learning Disabilities will require ongoing specialist interventions. This will incur extra costings so therefore increased funding	Thank you. . The committee agreed and were clear that schools needed to engage with local specialist services and that local authorities and integrated care systems should support this (see recommendations 1.1.19 – 1.1.22). The commissioning and resourcing of these services is a matter for local commissioning arrangements.
Association of Paediatric Chartered Physiotherapists	Evidence review G	6	13	Table 1: What are the validated measure for SEND? Many outcome measures for this group do not currently exist i.e. how to measure "knowledge" and academic progress and attainment in a child with profound neurodisabllity who has no communication	Thank you. The searches identified several studies that looked at interventions in people with SEND (see table 2). The final column details the outcomes measured, and they all used the strengths and difficulties questionnaire, usually alongside other measures..

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Association of Paediatric Chartered Physiotherapists	Evidence review G	7	4	Child/student with profound disability is unable to report	Thank you. The committee responded to comments in this consultation about communication needs by ensuring that these were highlighted in the guideline wherever relevant.
Association of Paediatric Chartered Physiotherapists	Evidence review G	9	1	Table 2: Looking at these studies the profoundly disabled child with communication needs does not seem to be included. Also the studies include ? only English pupils. Equality and Diversity would include Scottish, Welsh and Irish pupils. https://www.gov.uk/government/publications/equality-act-2010-advice-for-schools https://www.gov.uk/government/organisations/department-for-education/about/equality-and-diversity https://www.equalityhumanrights.com/en/publication-download/what-equality-law-means-you-education-provider-schools https://www.equalityhumanrights.com/en/publication-download/technical-guidance-schools-scotland	Thank you. The committee responded to comments in this consultation about communication needs by ensuring that these were highlighted in the guideline wherever relevant. The studies included several that focussed on people with SEND, but these are all milder and probably do not include children with very limited communication. The studies were not limited to England – you can see the origin of the studies in the first column of the table.

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Association of Paediatric Chartered Physiotherapists	Evidence review H	50	3-14	What methods are used to identify depression, anxiety or stress in profound disability? Are these disabilities fully recognised and understood? Emotional well-being for all: mental health and people with profound and multiple learning disabilities British Journal of Learning Disabilities Kieron Sheehy,Melanie Nind First published: 04 February 2005 evidence is presented that those with profound and multiple learning disabilities are the most likely to experience challenges to their mental health and the least likely to receive appropriate support. A strategy for developing our understanding and good practice in the area is suggested https://www.nice.org.uk/guidance/ng11/documents/challenging-behaviour-and-learning-disability-final-scope3 https://www.mencap.org.uk/sites/default/files/2016-11/PMLD%20factsheet%20about%20profound%20and%20multiple%20learning%20disabilities.pdf	Thank you. The committee agreed that understanding and involving people with communication needs is of vital importance in promoting their social, emotional and mental wellbeing, and was careful to add communication needs to relevant recommendations as a result of this consultation.
Association of Paediatr	Evidence	v	Cost benefit	It may not be possible to express financial benefits in interventions with SEND/profound disability due to specialisms and individual need. i.e. these young people	Thank you. The economic model is designed as a guide for decision makers. Each young person may respond to treatment differently and quality of implementation will vary. That said, the model is meant to condense the economic

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ic Chartered Physiotherapists	Review J		model	cannot be "pigeon holed" and require one to one individual assessment and care which incurs significant financial cost. Quantitative and qualitative audit of this group of pupils should show the benefits of quality of care and cost effectiveness cannot be considered in this approach.	evidence available across cohorts of young people and calculate the impact an intervention could have on outcomes given the studies that are available. We have made it clear in the report this is very much a general guide and it should not be the sole source of evidence in decision making.
Association of Paediatric Chartered Physiotherapists	Evidence Review J	ii	2. Objectives	We don't know what these interventions are for SEND/profound disability so therefore cannot analyse whether they are cost effective.	Thank you. Eligibility criteria for the evidence reviews included the SEND population. However, no studies were identified for this population. Thus a limitation of the model is that the interventions included are based on evidence relating to the young people in the studies rather than specific to the SEND population.
Association of Paediatric Chartered Physiotherapists	Evidence Review J	7	i Abstract	The school is identified as one of the best places for assessment of children's mental health- therefore appropriate tools and training should be a priority for SEND/profound disability in education settings.	Thank you. The committee agreed and made recommendations to ensure teachers have access to CPD to support this. See recommendation 1.1.8
Association of Paediatric	Guideline	8	6	I agree that regular rhythmic activity should be included into the universal curriculum. Reference to children with complex neurodisabilty having assisted physical	Thank you. The committee decided not to reference to children with complex neurodisability in recommendation 1.2.7. They

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Chartered Physiotherapists				movement activities included into their curriculum is also beneficial	agreed that adjustment for neurodiverse people has been adequately considered throughout the guideline.
Association of Paediatric Chartered Physiotherapists	Guideline	9	6	I agree with the key risk factors stated. Have looked after children, children who have experienced the bereavement of a parent or close family member and immigrants who may have limited English language been considered also?	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Association of Paediatric Chartered Physiotherapists	Guideline	11	21	The sub heading states Transitions between schools, classes or leaving education however no consideration has been made for the work required for SEN children transitioning into further education or adult services. This is a huge step both for the young person and the parents and often causes a great deal of uncertainly and anxiety. Reference to the NICE Guidelines transition from Children's to Adults Services states that transition should begin from year 9.	Thank you. The committee agreed to add in 'and for leaving education completely' into recommendation 1.5.2. The committee also agreed that the guideline generally takes into account the needs of neurodiverse children and young people and therefore did not single out this population in this section.
Association of Paediatric	Guideline	17	2-4	It is important to emphasise that those children without a physical voice should be supported via technology in the spiral curriculum to enable their voices to be heard.	Thank you. You raise an important point, however, it is outside the scope of this guideline. Please see the scope document on the NICE website.

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Chartered Physiotherapists					
Association of Paediatric Chartered Physiotherapists	Guideline	26	31	It needs to be acknowledged that it is not always possible to use tools and techniques with disabled children that suit typically developing children. Due to the nature of different disabilities, there is not yet a valid and reliable tool to capture the well-being of those with complex disabilities. Social, emotional and mental wellbeing has to be evaluated on an individual basis.	Thank you. Recommendation 1.3.6 has also been updated to note that "any communication needs" should be taken into account when selecting an assessment tool / technique.
Association of Paediatric Chartered Physiotherapists	Guideline Section 1.3.4	9	11	When referring to children with disabilities or special educational needs, reference needs to be made to those with physical, communication and learning disabilities. As these children may have difficulty in understanding or participating in pg 8 lines 3-8 1.2.6 Mindfulness 1.2.7 Physical activity. It is not yet known how to measure the well-being of children with complex disabilities (Mpundu-Kaambwa et al. 2018). The Be-Well, checklist should be considered as a tool to support those with complex disabilities (Oliver et al 2020). It is unknown at present if group activities can support the well-being for children with complex disabilities, individual support is	Thank you. This is covered in recommendation 1.1.4 which highlights that neurodiversity and communication needs should be taken into account from a whole-school perspective. The Be-Well checklist was not identified in the evidence review F on assessment tools, or during committee discussion. Mpundu-Kaambwa 2018 – the population is not selected for children at risk of poor social, emotional and mental wellbeing. We are unable to determine the title of Oliver 2020.

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				recommended due to their variation in expressing themselves. Mpundu-Kaambwa, C. et al. 2018. A review of preference-based measures for the assessment of QoL in children and adolescents with cerebral palsy. Quality of Life Research 27(7), pp. 1781-1799.	
Association of Paediatric Chartered Physiotherapists	Guidelines	9	18	Targeted support – who will be responsible for delivering this? It is quite a specialist area and expecting education staff to know what tools is appropriate to use in different situations is a big ask. To ensure equity across schools and boroughs this guideline should be more specific in how it will be implemented and by whom. Employing external counsellors or psychologists will have a financial implication.	Thank you. Responsibility for delivering targeted support will vary depending on the resources and services schools will have access. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date.
Association of Paediatric Chartered Physiotherapists	Overall comment on entire guidance			Reading through the allocated documentation there is no consideration for the SEND/profoundly disabled pupils needs throughout. This highlights a significant equality or discriminatory issue which requires to be addressed	Thank you. The committee discussed this and were careful to ensure that the guidance adequately considers neurodiversity and communication needs throughout. Neurodiversity is mentioned in several recommendations, such as 1.1.1, 1.1.4, 1.1.8, 1.1.15, and 1.4.2.

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Association of Paediatric Chartered Physiotherapists	Review evidence I	9	Table 2	Studies include children up to age 17 years. No studies specific to our SEND children and young adults up to age 25 years	Thank you. No studies involving SEND children and young people up to the age of 25 years met the inclusion criteria for evidence review I. The review protocols that detail the inclusion and exclusion criteria for each review can be found in appendix A of each review document.
Barnardo's	Guideline	5	18	We agree that specific supervision and CPD for staff in their pastoral roles is fundamental in delivering a whole school approach to wellbeing and mental health. This should include training and support to deliver trauma-informed practice. We suggest that the guidance be more explicit in relation to the difference between line management supervision and reflective practice supervision, the latter being more suited to the demands on teachers delivering on their pastoral responsibilities.	Thank you. We have modified the wording of this recommendation and hope it is clearer.
Barnardo's	Guideline	6	2	This guide point would benefit from being extended to include a statement on the need for schools to access the voices of a representative cross section of parents/carers school community. This would avoid the risk of some groups of parents being excluded in having their voices heard, these are the groups whose children are most likely to need support and could benefit from a whole school approach to social, emotional, and mental wellbeing.	Thank you. This is covered in recommendation 1.1.15, which states "Ensure that the opinions of all members of the school community are taken into account and make appropriate adjustments to take into account neurodiversity and communication needs".

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Barnardo's	Guideline	6	13	It is unclear form this guideline who within the school will be leading on the incredibly important task of building and establishing a culture which is 'psychologically safe' for all. The evidence on whole school approaches suggest that an influential senior leader would be best placed to do this, such as a head teacher or deputy head teacher.	Thank you. The committee decided not to explicitly specify a lead, as schools / colleges should have freedom to decide who would suit the role best. However, they did agree to clarify that the lead person should be senior person with authority to make decisions and authorise expenditure.
Barnardo's	Guideline	9	6	In the list of 'some key risk factor for social, emotional and mental wellbeing' should include children providing unpaid care for family members. The intention to include young carers in the school census suggests that their wellbeing and educational needs are recognised. Many of these children will have been caring for family members with health needs that have made them more at risk from covid, therefore the pressure on these children will have been, and continues to be, significant.	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Birmingham Educational Psychology Service	Guidelines	General	General	I would just like to see the guidance give a little more guidance regarding how schools can work more effectively with parents and carers as I think that this is key in terms of ensuring positive outcomes.	Thank you. The committee agreed that working with parents and carers is key and reflected this in recommendations 1.1.6, 1.1.14, 1.4.3 and 1.5.7. However, they did not specifically look at evidence about what was effective in improving parent and carer engagement in schools. Therefore they did not say anything specific about this.
Birmingham Educatio	Recommendations	9	1	In Box 1 where it identifies risk factors, I think it should make reference to extended non-school attendance. I also think 'behavioural difficulties'	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the

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nal Psychology Service	Identifying at risk children & young people 1.3.2			would best be labelled as 'externalising behaviours' so that people are clear that the behaviours are often the result of an underlying issue.	Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Birmingham Educational Psychology Service	Recommendations Targeted Support 1.4	10	9	Targeted support. I think this section should mention something about deciding the outcomes that you are working towards so that we can be clear whether the 'targeted support' has had an impact. How will we know if the intervention/support has been successful?	Thank you. The committee decided that it should be up to the school / college to decide how to evaluate interventions. The committee noted that this may vary across different settings and therefore did not add a point about deciding outcomes.
Birmingham Educational Psychology Service	Recommendations Targeted Support 1.4.3	10	18	It talks about talking to parents/carers when deciding whether to offer targeted support. I think there should be mention of parents and carers at the earlier assessment stage (1.3.3) in terms of us looking at children holistically and working with parents to gather information etc, rather than just informing them that we're considering offering targeted support. They should be part of the information gathering.	Thank you. The committee discussed this but decided not to specifically mention parents and carers in recommendation 1.3.3. They agreed parents and carers should be involved in children and young people's social and emotional wellbeing but thought explicitly mentioning them in this recommendation would make it appear like an exception. Parent and carer involvement has been highlighted in other recommendations, such as 1.1.6, 1.1.14, 1.4.3 and 1.5.7. Additionally, parent and carer input falls under "information from a variety of sources" in recommendation 1.3.2.

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Birmingham Educational Psychology Service	Recommendations Support with School Related Transitions 1.5	11	12	Transitions: I think there is a lot of good advice here, but it is very within child. I think mention of considering what adaptions could be made to the environment to support transitions (based on what we know about the individual) would be useful and acknowledge that it's a two-way process.	Thank you. No evidence was identified in the review regarding adaptations to the environment.
Birmingham Educational Psychology Service	Recommendations Support with School Related Transitions 1.5.3	12	13	Talks about helping the Children & Young People to cope with the loss of important relationships following the transition, but it doesn't talk about 'key worker' roles or similar, or about how we can help CYP to establish new relationships with a key adult. It would also be useful to make reference to the benefits of having a 'safe space', particularly during times of transition.	Thank you. The committee were mindful of the many people who may be involved in helping children and young people cope with the loss of important relationships. Therefore, they decided not to single out specific roles. The benefits of safe space were not identified in the evidence reviews or discussed by the committee, therefore it has not been referenced in this section of the guideline.
Birmingham Educational	Recommendations; Whole	6	2	Where it talks about 'involving families and pupils. I think it would be useful if the guidance made some recommendations about how settings might go about doing this in a way that isn't tokenistic. It	Thank you. The committee were mindful that there are multiple methods to involving families and pupils and did not want to specify a particular technique.

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Psychology Service	School Approach 1.1.14			would also be good if it made reference to co-production.	
British Association for Counselling and Psychotherapy		General	General	BACP welcome the guidelines to support a 'whole school' approach to promote the social, emotional and mental wellbeing of children from key stage 1 to 5 (and from 18 to 25 with SEND needs in FE settings). Interestingly, 'whole school' can lose meaning out of educational settings, with the Welsh Government leading on a change of vocabulary to a 'whole system' approach, thus more inclusive of both health and social care, which perhaps describes integrated practice more accurately. BACP particularly welcome the more relational approaches recognising psychological safety and fully support the recommendation regarding integrating wellbeing and behaviour policies so there is more consistency in responses to social and emotional wellbeing in schools and colleges. This also allows greater understanding of trauma informed approaches and the complexities of neuro-diversity, essential training for both support and teaching staff across all key stages. While we recognise the Government has committed to increasing mental health support for children and young people, **we are concerned that the existing plans do not provide the coverage and pace of expansion required to tackle the growth in demand**. It will take time to train the	Thank you. This guideline is aimed at educational settings and those who work with them and the committee agreed that the term whole school approach is well understood in the field. We have also clarified that the term 'whole school approach' also applies to other educational settings, including post-16 education. The committee discussed the roll-out of the MHST but agreed it was too early in that process to consider it for this guideline. They noted that in many areas it may not be in place until 2025. They made reference to the rollout of mental health support teams in the rationale and impact section of the guideline headed "Identifying children and young people at risk of poor social, emotional and mental wellbeing"

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				additional mental health support team (MHST) workforce. What's more, whilst those psychological well-being practitioners are trained to work with lower-level spectrum mental health issues, counsellors can work with more complex issues. They have the specialist skill set to best meet the needs of more of those who are struggling most and are easily integrated into the whole school approach, providing universal access for all. We believe that embedding these trained, specialist, children and young people counsellors and psychotherapists into the workforce will help to tackle the growing mental health needs of our children and young people. This helps support the Government's important ambition to **'*build back better*'** from the pandemic and the focus on ***levelling up*** all areas of the UK and greatly compliments the social and emotional wellbeing needs of children and young people across all educational settings, including Pupil Referral Units. See example of a third sector school counselling service in Stockport, Beacon Counselling, providing support across a range of schools, including a PRU.	
British Association for Counselling and			20 1.1. 11	*'' Make peer supervision available for teachers and other school staff.''* In order for supervision to be embedded in practice, we recommend robust supervision policies to change the culture of how supervision is perceived and to embed it in practice,	Thank you. Local schools will need to develop their own policies for supervision since local arrangements will vary depending on the school and its culture, and local services.

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Psychotherapy				providing staff with the time and space to deliver and receive supervision. BACP have a training model covering developing either peer supervision or supervising others frameworks, based on the work of Page and Wosket (2001) *The cyclical model of Supervision, Psychology Press.* Information on the peer supervision training is outlined in the above point. The Anna Freud Centre plan to deliver BACP and AoC's model of peer supervision training and will test run the training in schools in Leicestershire.	
British Association for Counselling and Psychotherapy		5	18 1.1. 10	''*Support staff in their pastoral roles by giving them protected time for supervision and continuing professional development"*, whilst this is a welcomed recommendation, staff either need to access training courses enabling them to offer safe, boundaried, reflective practice supervision skills training, so as to offer either peer, group or one-to-one supervision; or, external supervision will need to be brought into schools, which is often not financially viable or sustainable. One course, piloted in Greater Manchester between BACP and the Association of Colleges, funded by Greater Manchester Healthy Schools and Colleges Partnership, trained those with good listening skills in educational settings (who were interested in developing as a supervisor) with the skills, knowledge and framework to offer in-house reflective practice supervision. Details of the training packages can be found here. A network of trainers (who are also counselling supervisors), are able to deliver the programme, at a cost of	Thank you for this information. The committee did not wish to recommend how training should be implemented as it will vary across different educational settings.

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				£135 per head if 15 participants sign up for the two and a half day's training course (delivered online). The findings and impact of the pilot will be published in Spring 2022. The key message here is staff need to be suitably trained to deliver non managerial supervision in order to process the mental health caseloads that teaching and support staff hold. By training staff this offers a sustainable structure to embed reflective practice supervision into everyday practice. The alternative is to consider paying for services from trained clinical supervisors with rates starting at £45 and upwards for a one-hour session.	
British Association for Counselling and Psychotherapy		6	18 1.1. 18	'' *Adopt a 'graduated response' (or 'step up–step down') approach to support (moving between universal and targeted support as relevant) as an integral part of the whole-school approach alongside broader universal content. Ensure that staff understand this approach and have the right support to implement it''* An essential offer of the whole school approach is the ease at which access to early help school- based counselling can be offered. School counselling can be used as a step up from more generic Mental Health Support Team interventions in the 35% of schools which have access to this provision by 2022 and is also a step up from pastoral support. School counselling can form part of the transition plan to CAMHs, or when a referral is a made that doesn't meet the threshold. In	Thank you. The committee discussed the different people who might deliver interventions at length, and agreed that there was no single 'right way'. They noted that different schools have different ways of deploying their resources and therefore agreed that it would not be helpful for them to specify who should deliver any particular intervention. They agreed that individual schools needed to do it in a way that matched their ethos and school team. The committee agreed that more research might make it clearer which people are best placed to deliver these interventions (see research recommendation 3) Cooper 2021 was included in evidence review evidence review G. Therefore, evidence for this study was considered when developing recommendations on targeted support (section 1.4).

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				the report ''Fixing a Failing System'', a diagram on page 17 describes level 1 to level 3, with school counselling sitting at Level 2, between universal support and CAMHs: '' *Level 2 is the provision of targeted in-school services, including counselling. If level 1 is implemented effectively, it should reduce the number of students who need to use these services. However, there will still be some students who will need these services and therefore it is important that they are both available and effective''*. School counselling provides young people with an "empathic, non-judgmental, and supportive relationship to find their own answers to their problems'' (Hill, Roth, Cooper, 2013). This is offered within a safe and boundaried space for children and young people to talk about their difficulties, within a relationship of agreed confidentiality. There is robust research evidence that school-based counselling has a significant positive impact on young people's levels of psychological distress, self-esteem and achievement of personal goals (Cooper et al., 2021)[i], over and above the positive effects that a school's existing pastoral care provision can provide. Counsellors who work with children and young people (CYP) are professionally trained specialist workers who either hold a diploma in counselling at Level 4 (involving at least four years of studying), a top up CYP level 5 diploma if their core training was adult based, or a degree in counselling or psychotherapy. CYP counsellors work to a competence framework and are	

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				members of a voluntary regulated professional membership body such as BACP. School counsellors often offer drop-ins, assemblies, staff training and develop accessible publicity linked to how children and young people can directly refer. They are an integrated and embedded part of the whole school approach. [1] Cooper, M., Stafford, M. R., Saxon, D., Beecham, J., Bonin, E. M., Barkham, M., Bower, P., Cromarty, K., Duncan, C., Pearce, P., Rameswari, T. & Ryan, G. (2021). Humanistic counselling plus pastoral care as usual versus pastoral care as usual for the treatment of psychological distress in adolescents in UK state schools (ETHOS): a randomised controlled trial. The Lancet Child & Adolescent Health. https://doi.org/10.1016/S2352-4642(20)30363-1	
British Association for Counselling and Psychotherapy		10	14 1.4.2	Targeted support – trained CYP specialist counsellors can support school staff to either co-run or independently deliver groupwork sessions linked to, for example, anxiety and low mood, self-harming (including disorderly eating), or general self-esteem. This is common practice in many secondary schools, PRUs and colleges, with outcome measures, such as Strengths and Difficulties Questionnaire used to generate a robust evidence base with feedback collated from school staff/parents and carers/CYP, both pre and post group work	Thank you for this information. Counsellors are an example of the trained experienced practitioners referred to in recommendation 1.4.2.
British Association of Art therapists, British				Furthermore, poor sleep, which can be due to on-going stress, can detrimentally affect levels of alertness, concentration and cognitive function. Poor nutrition due to poverty can have a similar effect. These are just a few of the established links. There is a need for action rather than more research. .	Thank you. Unfortunately we are unable to ascertain which part of the guideline or which review your comment relates to. The papers you reference were found by our searches but did not meet the inclusion criteria for any of the reviews. The review protocols that detail the inclusion and exclusion criteria

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Association for Music Therapy, British Association of Drama Therapists & Association for Dance Movement Psychotherapy UK.				Freilich, R., and Shechtman, Z. (2010). The contribution of art therapy to the social, emotional, and academic adjustment of children with learning disabilities. Arts Psychother. 37, 97–105. https://doi.org/10.1016/j.aip.2010.02.003 Hashemian, P., and Jarahi, L. (2014). Effect of painting therapy on aggression in educable intellectually disabled students. Psychology 05, 2058–2063. https://doi.org/10.4236/psych.2014.518208 Pasiali V & Clark C (2018) Evaluation of a music therapy social skills development program for youth with limited resources. *Journal of Music Therapy,* 55(3), 280-308. https://dx.doi.org/10.1093/jmt/thy007	for each review can be found in appendix A of each review document. The reason for exclusion of these studies are as follows: Freilich 2010 used an active control group (academic assistance). Hashemian 2014 was conducted in a non-OECD country (Iran). Pasiali 2018 did not use a control group.
British Association of Art therapists, British Association for				Further References Center on the Developing Child (2022). In brief: The impact of early adversity on children's development. Harvard University. https://developingchild.harvard.edu/resources/inbrief-the-impact-of-early-adversity-on-childrens-development/	Thank you. Unfortunately we are unable to ascertain which part of the guideline or which review your comment relates to. None of these documents meet the inclusion criteria for any of the evidence reviews underpinning this guideline. The review protocols that detail the inclusion and exclusion criteria for each review can be found in appendix A of each review document.

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Music Therapy, British Association of Drama Therapists & Association for Dance Movement Psychotherapy UK.				Ferguson HB, Bovaird S & Mueller MP (2007) The impact of poverty on educational outcomes for children. *Paediatrics and Child Health,* 12, 701-6. https://doi.org/10.1093/pch/12.8.701 Marmot, M., Allen, J., Boyce, T., Goldblatt, P. and Morrison, J. (2020), Health Equity in England: The Marmot Review 10 Years on, Institute of Health Equity, London, available at: https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on Marmot, M., Allen, J., Boyce, T., Goldblatt, P. and Morrison, J. (2020), Health Equity in England: The Marmot Review 10 Years on, Institute of Health Equity, London, available at: https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on Stopbullying.gov (2020) Bullying and youth with disabilities and special health needs. https://www.stopbullying.gov/bullying/special-needs (accessed 15-2-22) Timpson E (2019) *Timpson review of school exclusion*. Department of Education. London. https://assets.publishing.service.gov.uk/government/uplo	The reasons for exclusion are as follows: Center on the Developing Child (2022) is a series of summaries of scientific presentations and would be excluded on the basis of study design. Ferguson 2007 is not a comparative intervention study and would be excluded on the basis of study design. The remaining documents are policy documents and these are not considered by NICE as a source of evidence durting the reviewing process. The policy context is added from the expertise and experience of the guideline committee.

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				ads/system/uploads/attachment_data/file/807862/Timpson_review.pdf	
British Association of Art therapists, British Association for Music Therapy, British Association of Drama Therapists & Association for Dance Movement Psychot	1.2.4 and 1.2.5 Guideline	7	18-21	Universal Curriculum Content: We support the recommendation to integrate relevant activities into all aspects of education to reinforce curriculum lessons about social and emotional skills and wellbeing (1.2.4) and use non-judgemental 'strengths-based' approaches to support children and young people's social, emotional and mental wellbeing (1.2.5). We believe that the use of the arts, especially when facilitated by qualified practitioners such as arts therapists (ie drama, music, art and dance movement psychotherapists) can provide non-intrusive, attractive, non-judgemental and strength-based ways through which children can be supported to develop social, emotional skills and wellbeing. Examples of how the arts therapies can contribute to a relational to the social, emotional and mental wellbeing of children and adolescents can be found in the following peer-reviewed journal articles and chapters: Articles:	Thank you for your support. The references in this comment were checked and none met the inclusion criteria for any of the evidence reviews (as outlined in the review protocols). The individual protocols detailing the inclusion criteria for each review can be found in appendix A of each review. The reasons for why the cited references do not meet our inclusion criteria are as follows: Anderson et al. 2020 is a non-UK-based qualitative study. Barbaroux et al. 2019 did not include outcomes for social, emotional and mental wellbeing and did not use a control group. Greene et al. 2018 the intervention of a one-off theatre trip would be out of scope. Habibi et al. 2018 did not include outcomes for social, emotional and mental wellbeing. Ibrahim et al. 2021 did not include outcomes for social, emotional and mental wellbeing.

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herapy UK.				Anderson, R,.C, Haney, M. Pitts, C. Porter, L. Bousselot, T. (2020) 'Making mistakes can be beautiful': Creative engagement in arts integration for early adolescent learners. The Journal of Creative Behavior, 54(3), 662-675. https://dx.doi.org/10.1002/jocb.401 Barbaroux, M. Dittinger, E. Besson, M. (2019) Music training with Demos program positively influences cognitive functions in children from low socio-economic backgrounds. PLoS ONE, 14(5), 2019, ArtID e0216874. https://dx.doi.org/10.1371/journal.pone.0216874 Greene JP, Erickson HH, Watson AR & Beck MI (2018) The play's the thing: Experimentally examining the social and cognitive effects of school field trips to live theater performances. Educational Researcher, 47(4), 246-254. https://dx.doi.org/10.3102/0013189X18761034 Habibi A, Damasio A, Ilari B, et al. (2018) Childhood music training induces change in micro and macroscopic brain structure: Results from a longitudinal study. Cerebral Cortex, 28(12), 4336-4347. https://dx.doi.org/10.1093/cercor/bhx286	Price-Mohr et al. 2021 did not include outcomes for social, emotional and mental wellbeing. Provenzano et al. 2020 did not include a control group. Schmidt et al. 2012 was not in English language. Tierny et al. 2015 did not include outcomes for social, emotional and mental wellbeing.

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				Ibrahim, D,. A. Godfrey, E,.B. Capella, E,. Burson, E. (2021) The art of social justice: Examining arts programming as a context for critical consciousness development among youth. Journal of Youth and Adolescence. 2021, No Pagination Specified. https://dx.doi.org/10.1007/s10964-021-01527-8 Price-Mohr, R. & Price, C. (2021) Learning to play the piano whilst reading music: Short-term school-based piano instruction improves memory and word recognition in children. International Journal of Early Childhood, 53(3), 333-344. https://dx.doi.org/10.1007/s13158-021-00297-5 Provenzano, A,. M. Spencer, M,. S. Hopkins, M. Ellis, J. Reischl, C,. H. Karr, K. & Savas, S,. A. (2020) Effects of a university-school partnered after-school music program on developmental health, social, and educational outcomes. Journal of the Society for Social Work and Research, 11(3), 443-462. https://dx.doi.org/10.1086/709175 Schmidt, S. (2012) Music education and training in central America and the promotion of the Central American Youth Orchestra as a social-therapeutic intervention. [German]. Musik-, Tanz- und	

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				Kunsttherapie, 23(1), 40-47. https://dx.doi.org/10.1026/0933-6885/a000066 Tierny, A,. T. Krizman, J. & Kraus, N. (2015) Music training alters the course of adolescent auditory development. PNAS Proceedings of the National Academy of Sciences of the United States of America, 112(32), 10062-10067. https://dx.doi.org/10.1073/pnas.1505114112	
British Association of Art therapists, British Association for Music Therapy, British Association of Drama Therapists &	1.2.7 Guideline	8	6-8	Physical Activity We agree with the recommendation for regular physical activity, and we suggest regular organised physical activities including dance as well as arts activities should be much more strongly worded rather than only to 'consider'. Children's development on all fronts needs to be supported, not only cognitive, and without opportunities to express themselves and learn other than through cognitive and verbal activities, children's development (including their cognitive development) is likely to suffer. For a significant proportion of children their life outside school cannot offer all that is needed due to socioeconomic deprivation and other challenges affecting their families. It is also surprising that no	The references in this comment were checked and none met the inclusion criteria for any of the evidence reviews. The individual protocols detailing the inclusion criteria for each review can be found in appendix A of each review. Bungay 2013 is a rapid review and would be excluded on the basis of study design. Duberg 2020 – intervention is not school-based. Duberg 2013 – intervention is not school-based Gardner 2008 – intervention is not school-based Kim 2007 – the majority of participants are undergraduate students, which is out of scope. Mansfield 2018 – interventions are not school-based.

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Association for Dance Movement Psychotherapy UK.				research on children's developmental needs was cited to make the recommendation about physical activity. The following studies are relevant and are missing from the reviewed evidence: Bungay, H., & Vella-Burrows, T. (2013). The effects of participating in creative activities on the health and well-being of children and young people: a rapid review of the literature. Perspectives in Public Health, 133(1), 44–52. https://doi.org/10.1177/1757913912466946 Duberg, A., Jutengren, G., Hagberg, L., & Möller, M. (2020). The effects of a dance intervention on somatic symptoms and emotional distress in adolescent girls: A randomized controlled trial. Journal of international medical research, 48(2), 0300060520902610. Duberg, A., Hagberg, L., Sunvisson, H., & Möller, M. (2013). Influencing self-rated health among adolescent girls with dance intervention: a randomized controlled trial. JAMA pediatrics, 167(1), 27-31. Gardner, S.M., Komesaroff, P., & Fensham, R. (2008) Dancing beyond exercise: young people's experiences	Martinez-Lopez 2021 focussed on outcomes of cognitive function, which are out of scope. Rodgers 2016 included a universal intervention but was not a RCT. Studer-Luthi 2012 is not written in German. Studies not written in English language were out of scope.

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				in dance classes, Journal of Youth Studies, 11:6, 701-709, DOI: 10.1080/13676260802393294 Kim, S., & Kim, J. (2007). Mood after Various Brief Exercise and Sport Modes: Aerobics, Hip-Hop Dancing, ICE Skating, and Body Conditioning. Perceptual and Motor Skills, 104(3_suppl), 1265–1270. https://doi.org/10.2466/pms.104.4.1265-1270 Mansfield, L. Kay, T. Meads, C, et al. Sport and dance interventions for healthy young people (15–24 years) to promote subjective well-being: a systematic review. BMJ Open 2018;8:e020959. doi:10.1136/ bmjopen-2017-020959 Martinez-Lopez E.J., Ruiz-Ariza A., de la Torre-Cruz M & Suarez-Manzano S. (2021). Alternatives of physical activity within school times and effects on cognition: A systematic review and educational practical guide. Psicologia Educativa, 27(1), 37-50. https://doi.org/10.5093/psed2020a16 Rodgers L & Furcron C (2016) The dynamic interface between neuromaturation, risky behavior, creative dance movement, and youth development programming.	

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				American Journal of Dance Therapy, 38(1), 3-20. https://dx.doi.org/10.1007/s10465-016-9216-2 Studer-Luthi B & Zuger B (2012) Effects of dance intervention on body concept and cognitive abilities of normally developed children. [German] *Musik-, Tanz- und Kunsttherapie*, 23(2), 70-77. https://dx.doi.org/10.1026/0933-6885/a000077	
British Association of Art therapists, British Association for Music Therapy, British Association of Drama Therapists & Association for	1.4 Guideline	10	14-17	Targeted Support: We agree with the recommendation to consider a range of targeted support that can enable children and young people to express difficult feelings. Arts therapies are particularly suitable for enabling children and young people to work towards articulating such feelings in words, by first facilitating nonverbal forms of expression and representation, either by making visual images or marks in art therapy, through dance movement therapy or in dramatherapy (Moula et al, 2020). We suggest that the guideline considers the fact that half of arts therapists participating in a national survey of practitioners (Karkou 2010) work with children and young people in schools; 40% were dance movement psychotherapists, 30% music therapists who participated worked in schools 17.4% of the dramatherapists, 7.5% of the art therapists. These	Thank you for your support. The references in this comment were checked and none met the inclusion criteria for any of the evidence reviews (as outlined in the review protocols). The

Dance Movement Psychotherapy UK.				percentages appear to have gone up in more recent years (Moula et al, 2020; Carr et al, 2017). See below evidence that should be included showing how using the creative arts therapies in schools can offer positive improvements in psychosocial and behavioural domains amongst students. <u>Systematic reviews:</u> Bosgraaf, L., Spreen, M., Pattiselan, K., & van Hooren, S. (2020). Art Therapy for Psychosocial Problems in Children and Adolescents: A Systematic Narrative Review on Art Therapeutic Means and Forms of Expression, Therapist Behavior, and Supposed Mechanisms of Change. Front Psychol, 11, 584685. https://doi.org/10.3389/fpsyg.2020.584685 Cohen-Yatziv, L., & Regev, D. (2019). The effectiveness and contribution of art therapy work with children in 2018 -what progress has been made so far? A systematic review. International Journal of Art Therapy, 24(3), 100–112. https://doi.org/10.1080/17454832.2019.1574845 Frydman, J. S., Hyman, S., & Caputo, S. (2022). Creative arts therapy in the United States school system: An integrative systematic review of empirically	individual protocols detailing the inclusion criteria for each review can be found in appendix A of each review. The reason for exclusion for each of the references are as follows: Bosgraaf 2020 is a narrative review and would be excluded on the basis of study design. Cohen-Yatziv 2019 – the population was not targeted for children at risk of poor social, emotional and mental wellbeing. Frydman 2022 is outside the date range of our searches. McDonald 2018 did not include relevant outcomes. Moula, Aithal et al. 2020 – included references within the review were checked and none met the inclusion criteria for any of the evidence reviews. Moula 2020 – Included references within the review were checked and none met the inclusion criteria for any of the evidence reviews. Yuan 2018 – included references within the review were checked and none met the inclusion criteria for any of the evidence reviews. Gwinner 2016 is a qualitative study conducted outside of the UK.

				evaluated interventions from the past decade. *Psychol Schs*, 59, 535– 556. https://doi.org/10.1002/pits.22629 McDonald, A., & Drey, N. S. (2018). Primary-school-based art therapy: A review of controlled studies. International Journal of Art Therapy: Inscape, 23(1), 33–44. https://doi.org/10.1080/17454832.2017.1338741 Moula Z, Aithal S, Karkou V and Powell J (2020) A systematic review of child-focused outcomes of arts therapies delivered in primary mainstream schools for children aged 5-12. Children and Youth Services Review, 112(c) https://doi.org/10.1016/j.childyouth.2020.104928 Moula, Z. (2020). A systematic review of the effectiveness of art therapy delivered in school-based settings to children aged 5–12 years. International Journal of Art Therapy: Inscape, 25(2), 88–99. https://doi.org/10.1080/17454832.2020.1751219 Yuan, S., Zhou, X., Zhang, Y., Zhang, H., Pu, J., Yang, L., Liu, L., Jiang, X., & Xie, P. (2018). Comparative efficacy and acceptability of bibliotherapy for depression and anxiety disorders in children and adolescents: A meta-analysis of randomized clinical trials.	Moula, Karkou and Powell 2020 combined outcome data for several interventions, rendering it unusable. Siegel 2016 was conducted in a population of hospitalised children, which is out of scope. Bazargan 2016 was conducted in a non-OECD country (Iran). Beebe 2010 – the population was not targeted for children at risk of poor social, emotional and mental wellbeing (children with asthma). Deboys 2017 – interventions did not aim to promote social, emotional and mental wellbeing. Lyshak-Stelzer 2007 was conducted in a population of youth with PTSD in an inpatient psychiatric facility, which was out of scope. McDonald 2020 only provided limited qualitative data from a forcoming paper. The data was not considered usable in our evidence reviews. Ramin 2014 was conducted in a non-OECD country (Iran). Karkou 2010 is a book chapter and therefore out of scope. Panagiotopoulou 2018 – the population was not targeted for children at risk of poor social, emotional and mental wellbeing.

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				Neuropsychiatr Dis Treat, 14, 353–365. https://doi.org/10.2147/NDT.S152747 Primary research including randomised controlled trials and controlled studies: **Arts therapies** Gwinner K (2016) Arts, therapy, and health: Three stakeholder viewpoints related to young people's mental health and wellbeing in Australia. *The Arts in Psychotherapy,* 50, 9-16. https://dx.doi.org/10.1016/j.aip.2016.05.016 Moula Z, Karkou V and Powell J (2020) An investigation of the effectiveness of arts therapies interventions on measures of quality of life and wellbeing: A pilot randomised controlled study in mainstream primary schools, Frontiers in Psychology. https://doi.org/10.3389/fpsyg.2020.586134 Siegel, J., Iida, H., Rachlin, K., and Yount, G. (2016). Expressive arts therapy with hospitalized children: a pilot study of co-creating healing sock creatures©. J. Pediatr. Nurs. 31, 92–98. https://doi.org/10.1016/j.pedn.2015.08.006	Choi 2010 was conducted in a population selected for hughly aggressive behaviour, which was out of scope. Goldbeck 2012 included a community-based intervention, which was out of scope. Kim 2017 2012 included a community-based intervention, which was out of scope. Pasiali 2018 did not use a control group. Joronen 2012 included a universal intervention and the study design was quasi-experimental, which was out of scope.

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				Art therapy Bazargan, Y., and Pakdaman, S. (2016). The effectiveness of art therapy on reducing internalizing and externalizing problems of female adolescents. Arch. Iran. Med. 19, 51–56 DOI: 0161901/aim.0010 Beebe, A., Gelfand, E. W., and Bender, B. (2010). A randomized trial to test the effectiveness of art therapy for children with asthma. J. Allergy Clin. Immunol. 126, 263–266.e1. https://doi.org/10.1016/j.jaci.2010.03.019 Deboys, R., Holttum, S., & Wright, K. (2017). Processes of change in school-based art therapy with children: A systematic qualitative study. *International Journal of Art Therapy*, 22(3), 118-131. https://doi.org/10.1080/17454832.2016.1262882 Lyshak-Stelzer, F., Singer, P., Patricia, St. John, P., and Chemtob, C. M. (2007). Art therapy for adolescents with posttraumatic stress disorder symptoms: a pilot study. Art Therapy 24, 163–169. https://doi.org/10.1080/07421656.2007.10129474 McDonald, A. & Holttum, S. (2020) Primary-school-based art therapy: A mixed methods comparison study	

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				on children's classroom learning. *International Journal of Art Therapy* 25(3), 119-131. https://dx.doi.org/10.1080/17454832.2020.1760906 Ramin, A., Mousavi, M., and Sohrabi, N. (2014). Effects of art therapy on anger and self-esteem in aggressive children. Procedia Soc. Behav. Sci. 113, 111–117. https://doi.org/10.1016/j.sbspro.2014.01.016 **Dance movement therapy** Karkou V., Fullarton, A. and Scarth S. (2010) Finding a Way Out of the Labyrinth through Dance Movement Psychotherapy: Collaborative Work in a Mental Health Promotion Programme for Secondary Schools, in V Karkou (ed) Arts Therapies in Schools: Research and Practice. London: Jessica Kingsley, 59-84. Panagiotopoulou E (2018) Dance therapy and the public school: The development of social and emotional skills of high school students in Greece. *The Arts in Psychotherapy,* 59, 25-33. https://dx.doi.org/10.1016/j.aip.2017.11.003 **Music therapy**	

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				Choi AN, Lee, MS, Lee JS (2010) Group music intervention reduces aggression and improves self-esteem in children with highly aggressive behavior: A pilot controlled trial, Evidence-Based Complementary and Alternative Medicine, 7, 2, 213-217, https://doi.org/10.1093/ecam/nem182. Goldbeck L & Ellerkamp T (2012) A randomized controlled trial of multimodal music therapy for children with anxiety disorders. *Journal of Music Therapy* 49(4), 395-413. https://dx.doi.org/10.1093/jmt/49.4.395 Kim J (2017) Effects of community-based group music therapy for children exposed to ongoing child maltreatment & poverty in South Korea: A block randomized controlled trial, The Arts in Psychotherapy, 54, 69-77, https://doi.org/10.1016/j.aip.2017.01.001 Pasiali V & Clark C (2018) Evaluation of a music therapy social skills development program for youth with limited resources. *Journal of Music Therapy,* 55(3), 280-308. https://dx.doi.org/10.1093/jmt/thy007 **Dramatherapy** Joronen, K., Konu, A., Rankin, H. S., and Åstedt-Kurki, P. (2012). An evaluation of a drama program to enhance	

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				social relationships and anti-bullying at elementary school: a controlled study. *Health Promot. Int.* 27, 5–14. doi: 10.1093/heapro/dar012	
British Association of Art therapists, British Association for Music Therapy, British Association of Drama Therapists & Association for Dance Movement Psychot	Evidence Review D	5	17 Table row 4	The restriction to only studies that explicitly reported adjusted hazard ratios, adjusted risk ratios or adjusted odds ratios is questionable: it is likely to have led to the exclusion of some studies with good designs and appropriate statistical tests, capable of robustly testing for effects of SEN on wellbeing, but that did not use these specific indicators.	Thank you. The review was looking at broader risk factors than just special educational needs for poor social, emotional and mental wellbeing. Review D includes studies that are comparative, that is studies where the numbers of events of interest in one group of people were compared with the number of events in a different group of people. For these kinds of studies rate data are the standard form to present results. That is HR, OR, RR for categorical data. The committee identified ratio type outcomes as the most useful for this review because it allowed for direct comparisons between groups of the number of people with each risk factor with poor SEMW. For this reason, other types of outcomes (such as mean difference) were not included in this evidence review.

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herapy UK.					
British Association of Art therapists, British Association for Music Therapy, British Association of Drama Therapists & Association for Dance Movement Psychotherapy UK.	Evidence Review D	5-6	1.1.2 Search protocol	We are concerned that no mention was given of any date cut-off in the search protocol, but a date cut-off of 1995 was mentioned as a reason for excluding a study in several places in Appendix J (excluded articles). It is important that a reasonable justification is given for any date cut-off that has been applied. Interest in the effects of children's disabilities and difficulties has been long-standing, with well-established links between these and their wellbeing and life outcomes. Research on it goes back well beyond 1995.	Thank you. In the row for "Other exclusion criteria" of the protocol for this review it states "Studies published before the year 1995 will be excluded". The protocol can be found in appendix A of each review document. The search date limits are selected with the intention of making the literature both relevant to the modern school environment, and manageable. The committee did not believe the pre-1995 school environment was similar enough to todays school environment to merit attention.

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British Association of Art therapists, British Association for Music Therapy, British Association of Drama Therapists & Association for Dance Movement Psychotherapy UK.	General	General	General	We expected there to be a recommendation to avoid excluding children from school on the grounds of poor behaviour. School exclusions (both permanent and temporary) in England have risen steadily over the past decade, and those most likely to be excluded are the pupils on free school meals or with special educational needs or poor emotional wellbeing (Marmot et al., 2020). The most probable reason is that these difficulties are often expressed in the form of poor behaviour (Timpson, 2019). The rise in exclusions may be partly due to central policies and how schools respond, given the options facing them (Marmot et al., 2020). However, this does not negate the need for schools to reduce exclusions to a minimum. Permanent school exclusion can reduce children's life chances and severely affect their future wellbeing (Marmot et al., 2020). Arts therapies can help with problematic behaviour that may contribute to exclusion: **Peer reviewed Arts therapies articles to reduce exclusion** Choi A-N, Lee MS & Lee J-S (2010) Group music intervention reduces aggression and improves self-esteem in children with highly aggressive behaviour: A	The committee did not look at the evidence for the effectiveness of excluding children from school, but agree that the use of relational approaches in school will lead to a reduction in the kinds of behaviour that get children and young people excluded from school. They also agreed that relational approaches would reduce the reliance on exclusion as a punishment for poor behaviour. The references in this comment were checked and none met the inclusion criteria for any of the evidence reviews (as outlined in the review protocols in appendix A of each of the reviews). Choi 2010 was conducted in a population selected for hughly aggressive behaviour, which was out of scope. Koshland 2004 is a book chapter and therefore out of scope. Maierna 2019 included a universal intervention but was not a RCT.

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				pilot controlled trial. *Evidence-Based Complementary and Alternative Medicine,* 7, Article ID 465730. Koshland L, Wilson J & Wittaker R (2004) PEACE through dance/movement: Evaluating a violence prevention program. American Journal of Dance Therapy, 26(2), 69-90. https://doi.org/10.1007/s10465-004-0786-z Maierna MS & Camodeca M (2019) Theatrical activities in primary school: Effects on children's emotion regulation and bullying. *International Journal of Bullying Prevention,* 3, 13-23. https://doi.org/10.1007/s42380-019-00057-z	
British Association of Art therapists, British Association for Music Therapy, British Associat	Guideline	4	2-3	Whole School Approach: We support the recommendations for a whole school, relational approach, avoiding purely behavioural approaches, maximising accessibility, recognising neurodiversity and a trauma informed approach. We would like to add a recommendation of considering the widest possible range of therapeutic interventions when these are indicated, including arts therapies. Our reasoning is that arts therapies enable children to begin to express complex and confusing emotions through visual, embodied, dramatic or musical channels, which can be easier and feel safer initially than trying to use	Thank you. The references in this comment were checked and none met the inclusion criteria for any of the evidence reviews (as outlined in the review protocols). The individual protocols detailing the inclusion criteria for each review can be found in appendix A of each review. The reasons for why the cited references do not meet our inclusion criteria are as follows: Anderson et al. 2020 is a non UK-based qualitative study. Mayer et al. 2019 is a narrative review and would be excluded on the basis of study design.

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ion of Drama Therapists & Association for Dance Movement Psychotherapy UK.				words (see Mayer, 2019; Nabors et al, 2016; Stace, 2014; Quibell, 2010). These permitted forms of expression can be a pathway to articulating complex difficulties in words and learning new ways to communicate them to others and get support when needed, rather than acting them out in class and being seen as behaving badly (see McDonald et al., 2019 for theoretical explanation). Further discussion on the role of arts therapies in a whole school approach can be found in numerous publications on the topic: Articles and chapters: **Arts and arts therapies** Anderson RC, Haney M, Pitts C, Porter L & Bousselot T (2020) 'Making mistakes can be beautiful': Creative engagement in arts integration for early adolescent learners. *The Journal of Creative Behavior,* 54(3), 662-675. https://dx.doi.org/10.1002/jocb.401 Mayer, S.S. Enhancing the Lives of Children in Out-Of-Home Care: An Exploration of Mind-Body Interventions as a Method of Trauma Recovery. *Journ Child Adol Trauma* 12, 549–560 (2019). https://doi.org/10.1007/s40653-019-0250-3	Barbaroux et al. 2019 did not include outcomes for social, emotional and mental wellbeing and did not use a control group. Greene et al. 2018 the intervention of a one-off theatre trip would be out of scope. Habibi et al. 2018 did not include outcomes for social, emotional and mental wellbeing. Price-Mohr et al. 2021 did not include outcomes for social, emotional and mental wellbeing. Provenzano et al. 2020 did not include a control group. Schmidt et al. 2012 was not in English language. Tierny et al. 2015 did not include outcomes for social, emotional and mental wellbeing. Athanasiadou et al. 2017, Joseph et al. 2017, Karkou et al. 2017 and Koshland et al. 2010 appear to be book chapters and are therefore out of scope. Higenbottam 2004 did not include a control group. Ibrahim et al. 2021 did not include outcomes for social, emotional and mental wellbeing.

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Music and music therapies Barbaroux M, Dittinger E & Besson M (2019) Music training with Demos program positively influences cognitive functions in children from low socio-economic backgrounds. *PLoS ONE,* 14(5), 2019, ArtID e0216874. https://dx.doi.org/10.1371/journal.pone.0216874 Greene JP, Erickson HH, Watson AR & Beck MI (2018) The play's the thing: Experimentally examining the social and cognitive effects of school field trips to live theater performances. *Educational Researcher,* 47(4), 246-254. https://dx.doi.org/10.3102/0013189X18761034 Habibi A, Damasio A, Ilari B, et al. (2018) Childhood music training induces change in micro and macroscopic brain structure: Results from a longitudinal study. *Cerebral Cortex,* 28(12), 4336-4347. https://dx.doi.org/10.1093/cercor/bhx286 Price-Mohr R & Price C (2021) Learning to play the piano whilst reading music: Short-term school-based piano instruction improves memory and word recognition in children. *International Journal of Early Childhood,*	Liu 2017 is a dissertation. McDonald et al. 2019 only includes limited qualitative data from a forthcoming paper. Sonia 2014 is a case study. Quibell 2010 is a book chapter. Tang et al. 2020 includes individuals at risk for clinical psychosis and would be excluded on the basis of population. Corbett et al. 2019 did not include outcomes for social, emotional and mental wellbeing. Books were not included in any of the evidence reviews and therefore the books cited in this comment would have all been excluded.

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				53(3), 333-344. https://dx.doi.org/10.1007/s13158-021-00297-5 Provenzano AM, Spencer MS, Hopkins M, Ellis J, Reischl CH, Karr K & Savas SA (2020) Effects of a university-school partnered after-school music program on developmental health, social, and educational outcomes. *Journal of the Society for Social Work and Research,* 11(3), 443-462. https://dx.doi.org/10.1086/709175 Schmidt S (2012) Music education and training in central America and the promotion of the Central American Youth Orchestra as a social-therapeutic intervention. [German]. *Musik-, Tanz- und Kunsttherapie,* 23(1), 40-47. https://dx.doi.org/10.1026/0933-6885/a000066 Tierny AT, Krizman J & Kraus N (2015) Music training alters the course of adolescent auditory development. *PNAS Proceedings of the National Academy of Sciences of the United States of America,* 112(32), 10062-10067. https://dx.doi.org/10.1073/pnas.1505114112 **Dance and dance movement therapy**	

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				Athanasiadou F and Karkou V (2017) Establishing Relationships with Children with Autism Spectrum Disorders through Dance Movement Psychotherapy: A Case Study using Artistic Enquiry, in S. Daniel and C Trevarthen (eds) Rhythms of Relating in Children's Therapies. London: Jessica Kingsley, 272-293. Joseph J and Karkou V (2017) Holding and adolescent angst: Significant moments within a dance movement psychotherapy group in a mainstream school in H. Payne (ed) Dance Movement Psychotherapy: Theory, Research and Practice. London: Routledge, 201-222. Karkou V and Joseph J (2017) The Moving and Movement Identities of Adolescents: Lessons from Dance Movement Psychotherapy in Schools. In R MacDonald, D Heardgreaves, D Miell (eds) The Handbook of Musical Identities. New York: Oxford University Press, 232-244. Koshland L (2010) PEACE through Dance/Movement Therapy: The Development and Evaluation of a Violence Prevention Programme in an Elementary School. In V Karkou (ed) Arts Therapies in Schools: Research and Practice. London: Jessica Kinglsey, 43-58	

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				Art and art therapy Higenbottam W (2004) In her image: A study in art therapy with adolescent females. *Canadian Art Therapy Association Journal,* 17(1), 10-16. https://dx.doi.org/10.1080/08322473.2004.11432256 Ibrahim, D,. A, Godfrey, E,. B. Capella, E. & Burson, E. (2021) The art of social justice: Examining arts programming as a context for critical consciousness development among youth. *Journal of Youth and Adolescence*. 2021, No Pagination Specified. https://dx.doi.org/10.1007/s10964-021-01527-8 Liu, C. (2017). Examining the effectiveness of Solution-Focused Art Therapy (SF-AT) for sleep problems of children with traumatic experience. Avaliable online at: https://www.semanticscholar.org/paper/Examining-the-Effectiveness-of-Solution-Focused-Art-Liu/07047beab98ae0d76fad50d96ebc13f0da2d6ffb McDonald, A., Holttum, S., & Drey N.StJ. (2019) Primary-school-based art therapy: exploratory study of changes in children's social, emotional and mental health. *International Journal of Art Therapy,* 24(3), 125-138. https://doi.org/10.1080/17454832.2019.1634115)	

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				Sonia M. Stace (2014) Therapeutic Doll Making in Art Psychotherapy for Complex Trauma, Art Therapy, 31:1, 12-20, DOI: 10.1080/07421656.2014.873689 **Drama and Dramatherapy** Quibell T (2010) The Searching Drama of Disaffection: Dramatherapy Groups in a WHole-School Context. In V Karkou (ed) Arts Therapies in Schools: Research and Practice. London: Jessica Kinglsey, 114-128. Tang SX, Seelaus KH, Moore TM, Taylor J, Moog C, O'Connor D, et al. (2020) Theatre improvisation training to promote social cognition: A novel recovery-oriented intervention for youths at clinical risk for psychosis. *Early Intervention in Psychiatry,* 14(2), 163-171. https://dx.doi.org/10.1111/eip.12834 Corbett BA, Ioannou S, Key AP, Coke C, Muscatello R, Vandekar S & Muse I (2019) Treatment effects in social cognition and behavior following a theater-based intervention for youth with autism. *Developmental Neuropsychology,* 44(7), 481-494. https://dx.doi.org/10.1080/87565641.2019.1676244	

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				Examples of books that explore the role of arts therapies in whole school approaches using research evidence include: <u>Books:</u> Karkou V (2010) Arts Therapies in Schools: Research and Practice. London: Jessica Kinglsey. Stepney, S. A. (2017). Art therapy with students at risk: Fostering resilience and growth through self-expression. Springfield IL: Charles C Thomas. Strange, J., Achenbach, C., Nicolette, O., O'Neill, N., Brackley, J., Williams, F., ... & McTier, I. (2011). Music therapy in schools: Working with children of all ages in mainstream and special education. London: Jessica Kingsley. Holmwood, C. (2014). Drama education and dramatherapy: Exploring the space between disciplines. London: Routledge. Leigh, L., Gersch, I., Dix, A., & Haythorne, D. (Eds.). (2012). Dramatherapy with Children, Young People and	

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				Schools: enabling creativity, sociability, communication and learning. London: Routledge. Daniel S and Trevarthen C (eds) Rhythms of Relating in Children's Therapies. London: Jessica Kingsley.	
British Association of Art therapists, British Association for Music Therapy, British Association of Drama Therapists & Association for Dance	Guideline	12	13-17	Life and school transitions: We suggest arts therapies could be mentioned here as there is some evidence to suggest that working creatively can support young people through transitions. Barlow W (2021) Primary-secondary transition – building hopes and diminishing fears through drama. Frontiers in Education, 06. https://doi.org/10.3389/feduc.2020.546243 Spier E (2010) Group art therapy with eighth-grade students transitioning to high school. Art Therapy. 27(2), 75-83. https://dx.doi.org/10.1080/07421656.2010.10129717 Walsh-Bowers RT (1992) A creative drama prevention program for easing early adolescents' adjustment to school transitions. The Journal of	Thank you. The references in this comment were checked and none met the inclusion criteria for any of the evidence reviews (as outlined in the review protocols). The individual protocols detailing the inclusion criteria for each review can be found in appendix A of each review. The reasons for why the cited references do not meet our inclusion criteria are as follows: Barlow 2021 does not focus on the acceptability or barriers / facilitators of an intervention. Spier 2010 did not include a control group. Walsh-Bowers 1992 was published before 1995

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Movement Psychotherapy UK.				Primary Prevention, 13(2), 131-147. https://dx.doi.org/10.1007/BF01325071	
British Association of Art therapists, British Association for Music Therapy, British Association of Drama Therapists & Association for Dance Movement	Guideline	12	13-17	We suggest the importance of a specific mention of refugees and asylum seekers. Arts therapies (dance, music, art, drama) may be helpful for this group when transitioning to their new school particularly when there are language and communication barriers (Marsh, 2012; Rousseau et al, 2005). The Arts therapies can also be an effective method to reduce post-traumatic stress disorder, depression and trait anxiety symptoms among refugee children' (Urgurla et al, 2016) . Evidence in using the arts therapies to support refugees and asylum seekers is below: Beh-Pajooh, A., Abdollahi, A., and Hosseinian, S. (2018). The effectiveness of painting therapy program for the treatment of externalizing behaviors in children with intellectual disability. Vulnerable Child. Youth Stud. 13, 221–227 https://doi.org/10.1080/17450128.2018.1428779 Grasser LR, Al-Saghir H, Wanna C, Spinei J &	Thank you. The committee decided it would be too specific mention refugees and asylum seekers in this section of the guideline. However, the committee were mindful that these groups should be mentioned in the EIA. The references in this comment have been checked and only Rousseau et al. 2014 met the inclusion criteria. This study has already been included in evidence review I. The reasons for why the remaining cited references do not meet our inclusion criteria are as follows: Beh-Pajooh et al. 2018 was conducted in a non-OECD country (Iran) Grasser et al. 2019 children with PTSD do not meet the inclusion criteria for evidence review I on transitions. Marsh 2012 is a case study.

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Psychotherapy UK.				Javanbakht A (2019) Moving through the trauma: Dance/movement therapy as a somatic-based intervention for addressing trauma and stress among Syrian refugee children. Journal of the American Academy of Child & Adolescent Psychiatry, 58(11), 1124-1126. https://dx.doi.org/10.1016/j.jaac.2019.07.007 Marsh K (2012) "The beat will make you be courage": The role of a secondary school music program in supporting young refugees and newly arrived immigrants in Australia. Research Studies in Music Education, 34(2), 93-111. https://dx.doi.org/10.1177/1321103X12466138 Rousseau C, Beauregard C, Daignault K, Petrakos H, Thombs BD, Steele R, et al. (2014) A Cluster Randomized-Controlled Trial of a Classroom-Based Drama Workshop Program to Improve Mental Health Outcomes among Immigrant and Refugee Youth in Special Classes. PLoS ONE 9(8): e104704. https://doi.org/10.1371/journal.pone.0104704 Rousseau, C Drapeau A, Lacroix L, Bagilishya D, Heusch N (2005) Evaluation of a classroom program of creative expression workshops for refugee and immigrant children Journal of Child Psychology and	Rousseau et al. 2005 focusses on an intervention that is delivered outside the normal academic curriculum to children going through a transition, which is out of scope. Ugrulu et al 2016 children with high rates of PTSD do not meet the inclusion criteria for evidence review I on transitions.

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				Psychiatry, 46 (2) 180-185, 10.1111/j.1469-7610.2004.00344 Ugurlu, N. Akca, L. Acarturk, C. (2016) An art therapy intervention for symptoms of post-traumatic stress, depression and anxiety among Syrian refugee children, Vulnerable Children and Youth Studies, 11:2, 89-102, DOI: 10.1080/17450128.2016.1181288	
British Association of Art therapists, British Association for Music Therapy, British Association of Drama Therapists &	Guideline	26	3-6	We were puzzled to see the statement that there was a lack of evidence that children with special educational needs (SEN) are at higher risk of poor wellbeing. Not only is there a large body of evidence about the links between children's emotional wellbeing and their educational needs, but wellbeing is built into the SEN definition. Aside from this, there are several ways in which poor wellbeing and other components of SEN can be linked. For example, other children may bully those with behavioural issues or disabilities (stopbullying.gov, 2020), or both SEN and emotional difficulties may stem from poverty, on-going stress, or adverse childhood experiences (Center on the Developing Child, 2022; Ferguson et al., 2007; Marmot et al., 2020). Furthermore, there is a well-established link between	Thank you. The papers you reference did not meet the inclusion criteria for any of the reviews. The review protocols that detail the inclusion and exclusion criteria for each review can be found in appendix A of each review document. The reasons for why the cited references do not meet our inclusion criteria are as follows: Aithal et al. 2021 was published after the date of our final searches. Mayer-Benarous et al. 2021 was an SLR that included non-randomised studies. Only SLRs that contained RCTs and cRCTs were included in evidence review B on universal interventions. Simhon et al. 2019 included children with sensory processing disorder, which was out of scope.

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Association for Dance Movement Psychotherapy UK.				one component of emotional wellbeing – anxiety/fear - and capacity to focus and learn: some anxiety can be helpful but high levels of stress, anxiety or fear have long been known to interfere with cognitive functioning in both children and adults (e.g. Suinn et al., 1988). Children with SEN struggle emotionally (Wigham et al, 2020) and the impact of their disability can mean they find it hard to communicate their needs (Simhon et al, 2019; Pater et al, 2021)). Children and young people with SEN often have poorer physical health than the wider population, are more likely to die with common health conditions and have a higher prevalence of psychiatric illness. A high proportion of arts therapists (art, music, drama and dance) work on school sites on a part-time or sessional basis. They often work with the SEN representative, teachers and parents (Godfrey & Haythorne, 2013) as well as providing one-to-one or group therapy sessions for children and young people. Having Arts therapists in schools avoids the necessity to take children out of school to attend a mental health service. They can also potentially intervene at an earlier point than referral to CAMHS.	Wigham et al. 2020 only included studies of children in hospital, which was out of scope. Thayer et al. 2021 was a summative, longitudinal program evaluation research design, which was out of scope. Cibrian et al. 2020 did not include social, emotional and mental wellbeing outcomes. LaGasse 2014 was a community-based study rather than school-based, which was out of scope. Pater et al. 2021 was a multiple case study design, which was out of scope. Sharda et al. 2019 did not contain any elements in the abstract that would indicate it would be included in the evidence reviews. Salomon-Gimmon et al. 2019 contained case studies, which were out of scope. Aithal et al. 2021 included a physical activity intervention, which was out of scope. Alrazain et al. 2018 ad Alotaibi et al. 2017 were book chapters, which are out of scope.

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				Examples of the use of the arts therapies with children with physical, intellectual or neurodiverse needs are listed here. Systematic reviews: Aithal S, Moula Z, Makris S, Karaminis T, Powell J, Karkou V (2021) A Systematic Review of the Contribution of Dance Movement Psychotherapy towards the Wellbeing of Children with Autism Spectrum Disorders. Frontiers in Psychology https://doi.org/10.3389/fpsyg.2021.719673 Mayer-Benarous, H., Benarous, X., Vonthron, F., & Cohen, D. (2021). Music Therapy for Children With Autistic Spectrum Disorder and/or Other Neurodevelopmental Disorders: A Systematic Review. Front Psychiatry, 12, 643234. https://doi.org/10.3389/fpsyt.2021.643234 Simhon, V., Elefant, C., & Orkibi, H. (2019). Associations between music and the sensory system: An integrative review for child therapy. The Arts in Psychotherapy, 64, 26–33. https://doi.org/10.1016/j.aip.2018.11.005 Wigham, S., Watts, P., Zubala, A., Jandial, S., Bourne, J., & Hackett, S. (2020). Using Arts-Based Therapies to Improve Mental Health for Children and Young People With Physical Health Long-Term	Hartshorn et al. 2001 was published before 2007, which is out of scope for the evidence reviews on universal and targeted interventions. Beh-Pajooh et al. 2018 was conducted in a non-OECD country (Iran) Freilich et al. 2010 did not contain any elements in the abstract that would indicate it would be included in the evidence reviews and was excluded at title and abstract screening. Hashemian et al. 2014 was based in a non-OECD country (Iran). Chaplan-Hoang et al. 2021 was not school-based. Godfrey et al. 2013 did not include qualitative data on acceptability, barriers or facilitators of interventions. Khalili et al. 2018 was based in a non-OECD country (Iran). O'Sullivan et al. 2015 and Tytherleigh et a. 2010 were book chapters, which were out of scope.

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				Conditions: A Systematic Review of Effectiveness. Front Psychol, 11, 1771. https://doi.org/10.3389/fpsyg.2020.01771 Primary research including randomised controlled trials and controlled trials: Arts therapies Thayer F & Bloomfield B (2021) An evaluation of a developmental individual differences relationship-based (DIR)-Creative arts therapies program for children with autism. The Arts in Psychotherapy, 73 2021, ArtID 101752. https://dx.doi.org/10.1016/j.aip.2020.101752 Music therapy Cibrian, F,. L. Madrigal, M. Avelais, M. Tentori, M. (2020) Supporting coordination of children with ASD using neurological music therapy: a pilot randomized control trial comparing an elastic touch-display with tambourines. Res Dev Disabil. 106:103741. https://doi.org/10.1016/j.ridd.2020.103741 LaGasse, A,. B. (2014) Effects of a music therapy group intervention on enhancing social skills in children with autism. J Music Ther.51:250–75. https://doi.org/10.1093/jmt/thu012 Pater, M. Spreen, M. & Van Yperen, T (2021) The developmental progress in social behaviour of	

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				children with Autism Spectrum Disorder getting music therapy. A multiple case study. Children and Youth Services Review, 120 2021, ArtID 105767. https://dx.doi.org/10.1016/j.childyouth.2020.105767 Sharda, M., Silani, G., Specht, K., Tillmann, J., Nater, U., & Gold, C. (2019). Music therapy for children with autism: investigating social behaviour through music. The Lancet Child & Adolescent Health, 3(11), 759-761.https://doi.org/10.1016/S2352-4642(19)30265-2 Salomon-Gimmon M & Elefant C (2019) Development of vocal communication in children with autism spectrum disorder during improvisational music therapy. Nordic Journal of Music Therapy, 28(3), 174-192. https://dx.doi.org/10.1080/08098131.2018.1529698 Dance movement therapy Aithal S, Karkou V, Makris S, Karaminis T and Powell J (2021) A Dance Movement Psychotherapy Intervention for the Wellbeing of Children with Autism Spectrum Disorders: A Pilot Intervention Study. Frontiers in Psychology, https://www.frontiersin.org/articles/10.3389/fpsyg.2021.588418/full Alrazain B, Zubala A and Karkou V (2018) Movement-based arts therapy for children with	

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				attention deficit hyperactivity disorder (ADHD) in the Kingdom of Saudi Arabia. In A Zubala and V Karkou (eds) Arts Therapies in the Treatment of Depression: International Research in Arts Therapies. In collaboration with European Consortium for Arts Therapies Education (ECArTE). London: Routledge, pp. 68-84. Alotaibi A, Karkou V, Van Der Linden M and Irvine L (2017) Movement Therapy Programme with Children with Mild Learning Difficulties in Primary Schools in Saudi Arabia: Links between Motion and Emotion in V Karkou, S Oliver and S Lycouris (eds) The Oxford Handbook of Dance and Wellbeing. New York: Oxford University Press, 479-492. Hartshorn, K., Olds, L., Field, T., Delage, J., Cullen, C., and Escalona, A. (2001). Creative movement therapy benefits children with autism. Early Child Dev. Care 166, 1–5. doi:10.1080/0300443011660101 Art Therapy Beh-Pajooh, A., Abdollahi, A., and Hosseinian, S. (2018). The effectiveness of painting therapy program for the treatment of externalizing behaviors in children with intellectual disability. Vulnerable Child. Youth Stud. 13, 221–227 https://doi.org/10.1080/17450128.2018.1428779	

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				Freilich, R., and Shechtman, Z. (2010). The contribution of art therapy to the social, emotional, and academic adjustment of children with learning disabilities. Arts Psychother. 37, 97–105. https://doi.org/10.1016/j.aip.2010.02.003 Hashemian, P., and Jarahi, L. (2014). Effect of painting therapy on aggression in educable intellectually disabled students. Psychology 05, 2058–2063. https://doi.org/10.4236/psych.2014.518208 Dramatherapy Chaplan-Hoang, A. (2021). Dungeons, Dragons, and Drama Therapy: A Digital Approach for Teenagers on the Autism Spectrum. Godfrey, E. Haythorne, D. (2013) Benefits of Dramatherapy for Autism Spectrum Disorder: A Qualitative Analysis of Feedback from Parents and Teachers of Clients Attending Roundabout Dramatherapy Sessions in Schools. Dramatherapy. 2013;35(1):20-28. doi:10.1080/02630672.2013.773131 Khalili, Z., & Ansarishahidi, M. (2018). Effectiveness of drama therapy on social skills and emotional recognition of children with high-functioning autism spectrum disorder. Empowering Exceptional Children, 9(1), 65-78.	

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				O'Sullivan, C., & Wilde, O. (2015). Drama and Autism. Encyclopedia of Autism Spectrum Disorder, 1-13. DOI 10.1007/978-1-4614-6435-8_102102-1 Tytherleigh L. and Karkou V. (2010) Dramatherapy, Autism and Relationship Building, in V Karkou (ed) Arts Therapies in Schools: Research and Practice. London: Jessica Kingsley, 197-216.	
British Association of Behavioural and Cognitive Psychotherapies			Appendix K	BABCP did not understand the rationale for excluding study number 22 – elevated social anxiety or text anxiety would appear to fit the criteria (i.e. elevated anxiety).	Thank you. Study number 22 was conducted in a non-OECD country (Romania). Non-OECD countries were excluded from this evidence review. The review protocols that detail the inclusion and exclusion criteria for each review can be found in appendix A of each review document.
British Association of Behavioural and Cognitive Psychotherapies			Appendix K	Reference 62 the target was anxiety – it is not clear why this was excluded.	Thank you. Study 62 did not include a control group. Studies without a control group were excluded from this review. The review protocols that detail the inclusion and exclusion criteria for each review can be found in appendix A of each review document.

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British Association of Behavioural and Cognitive Psychotherapies			Appendix K	Reference 70 the target was anxiety – it is not clear why this was excluded	Thank you. Study 70 included participants that were already receiving treatment for anxiety or depression, which were not included in this evidence review. The review protocols that detail the inclusion and exclusion criteria for each review can be found in appendix A of each review document.
British Association of Behavioural and Cognitive Psychotherapies			Appendix K	Reference 83 parent intervention, target at risk children – why was this excluded?	Thank you. Study 83 included an intervention aimed at parents. Parent interventions were not included in this review. The review protocols that detail the inclusion and exclusion criteria for each review can be found in appendix A of each review document.
British Association of Behavioural and Cognitive			Appendix K	Reference 87 target is depression symptoms – why was this excluded?	Thank you. Study 87 included participants with clinically relevant depression, rather than those at risk of depression. These participants were not included in the evidence review. The review protocols that detail the inclusion and exclusion criteria for each review can be found in appendix A of each review document.

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Psychotherapies					
British Association of Behavioural and Cognitive Psychotherapies	Draft Guidance				Blank entry.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	8	10-14	Evidence review for whole school approaches BABCP welcome the priority given to reports from the child / young person when assessing the impact of interventions on their social, emotional or mental well-being. Evidence suggests that parents and teachers do not observe or report internalising problems that are experienced and reported by children and young people and thus that they tend to under report the severity of the child's experiences or symptoms e.g. Orchard, F., Pass, L., Cocks, L., Chessell, C., & Reynolds, S. (2019). Examining parent and child agreement in the diagnosis of adolescent depression. *Child and adolescent mental health*, *24*(4), 338-344.	Thank you for your support. Orchard 2019 was not an intervention study and did not contain relevant outcome data.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	Page 122	Appendix B	BABCP suggest that additional search terms should be added i.e. sleep (and related phrases) and 'diet' and related phrases	This search aimed to identify school-based interventions relating to various aspects of social and emotional wellbeing. The search strategy includes a large number of named interventions, and terms to describe the type of interventions that may be delivered in a school setting. Some of these may include sleep or diet related impacts. Although those terms suggested, and others like them, are not explicitly listed in the strategy, they are also not excluded so any intervention which covered sleep or diet related issues and could be delivered in a school-based setting would have been picked up by the searches.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A		28-34	Only 9 studies that assessed the effectiveness of 'whole school' interventions in primary schools were identified. This is both surprising and concerning to BABCP. BABCP also note a recent meta-analysis that identified 45 studies and 30 different whole school interventions (Goldberg et al, 2019). This study concluded that these approaches had small but significant improvements in a range of outcomes. Goldberg, J. M., Sklad, M., Elfrink, T. R., Schreurs, K. M., Bohlmeijer, E. T., & Clarke, A. M. (2019). Effectiveness of interventions	Thank you. The published evidence is one part of the evidence that committees take into account when they are making recommendations. The role of an expert committee is to layer their experience and expertise, their knowledge of practice and the policy context and the views of expert stakeholders and witnesses to create recommendations. In addition to evidence from the published literature, the committee were aware of the policy drivers supporting implementation of whole school approaches, and the promising evidence from practice that these are a good thing to do. Goldberg 2019 was captured within our searches. The included references within this systematic review and meta-

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				adopting a whole school approach to enhancing social and emotional development: a meta-analysis. *European Journal of Psychology of Education*, *34*(4), 755-782. BABCP suggests that this meta-analysis casts doubt on the adequacy of the search strategy used and recommends that the search strategy is reviewed, revised and re-run. BABCP further suggests that the limited amount of data reviewed, combined with the low quality of the data (as indicated in table 1.1.6) is insufficient to justify the recommendation that schools should take a 'whole school approach' to well-being	analysis were checked against our own inclusion criteria for evidence review A. Goldberg 2019 has wider inclusion criteria compared to evidence review A. For instance, more than half of the studies included in Goldberg 2019 would be excluded from evidence review A on the basis of either being published before 2007, conducted in a non-OECD country or having a non-randomised study design. Two studies that would not have been excluded for the criteria above were not captured by our searches, but still did not meet the inclusion criteria for evidence review A. The remaining inclusions from Goldberg 2019 were captured by our searches and either included in evidence review A or excluded based on the PICOS criteria.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A		15-16	BABCP agree that teacher reported outcomes are the optimal way to assess behavioural (i.e. observable) outcomes but note that this is only relevant if these behaviours are exhibited in the classroom. Teachers may not be able to report on playground behaviours or covert behaviours (e.g. bullying) and alternative methods should be used to assess these.	Thank you. We agree this is the case, and for that reason include not only teacher reported outcomes but also child/young person reported outcomes and parent reported outcomes.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence review A		27	It would have been helpful to summarise the key reasons for excluding 201 references (for example, no data were reported, not a trial, no follow up data provided etc). BABCP considers that this is particularly important because only 9 studies were reviewed for primary schools.	Thank you. It is standard NICE practice to outline reasons for exclusion in the appendix of the evidence review (Appendix J). most common reasons for excluding studies at full-text in evidence review A were the study being conducted before 2007 and the study not being concerned with a whole-school approach.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	Page 31	1.1.10	As highlighted above the economic evidence based on Bowden (2020) and Hummel (2009) do not refer to any effectiveness study and their validity and relevance are hard to assess without this context. What were the interventions, why were they not reported previously, and were they effective? BABCP were not able to identify any assessment of quality for these studies and suggests that this should be provided.	Thank you. The Bowden study considered the City Connects programme intervention. It is a cost-benefit analysis that makes assumptions about effectiveness. The economic benefits of City Connects were based on educational attainment, measured as a reduction in the high school dropout rate, and educational achievement, measured by increases in math and ELA test scores in grades 6–8. The effects were estimated based on literature. Hummel (2009) is the economic report for the economic model produced for the previous guideline PH20 and was not identified in the cost-effectiveness searches. It presents a framework for assessing bullying interventions, not a specific intervention. It assumed a 15% reduction in victimisation.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	Pages 18-23	1.1.6 Summary of the effe	BABCP found these tables extremely difficult to navigate and to understand. The outcome measure used to calculate comparative risk (column 2) is not specified in many of the comparisons – this makes it impossible to assess the validity of the measure and thus its meaning. For	Thank you. The summary in 1.1.6 is in standard Cochrane format for summary of evidence tables and is produced in this format by the GRADEPro software. The second column is blank for continuous outcomes because it is not possible to calculate an absolute risk based on these outcomes. To improve the clarity of these tables, we have added the scale and range of scores for each outcome where applicable.

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			ctiveness evidence	example, on page 20, how were the following outcomes assessed: 'family conflict' 'emotional problems' 'academic outcomes'? In marked contrast, on page 22, bottom 3 rows, the measure used (the Strengths and Difficulties Questionnaire; SDQ) is specified and thus interpretation of the data is possible. BABCP suggests that outcome measures are routinely identified. The reporting of data does not summarise or integrate the result. However, close inspection of the data presented in this table suggests that differences between intervention groups and control groups were not significant (confidence intervals cross zero in almost every case), study quality was 'very low', and follow up time was inadequate. BABCP suggest that these results are not sufficiently robust to justify the recommendation to implement 'whole school approaches' into primary schools if the aim is to increase social, emotional, or mental well-being amongst children.	The published evidence is one part of the evidence that committees take into account when they are making recommendations. The role of an expert committee is to layer their experience and expertise, their knowledge of practice and the policy context and the views of expert stakeholders and witnesses to create recommendations. In addition to evidence from the published literature, the committee were aware of the policy drivers supporting implementation of whole school approaches, and the promising evidence from practice that these are a good thing to do.

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				BABCP suggests that the recommendation in the guidance is amended to reflect the low quality of the evidence and the lack of effectiveness.	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	Page 19	1.1.6 Summary of the effectiveness evidence	Table that begins on page 19 suggests that the KiVA anti-bullying interventions had significant positive effects on bullying perpetration, bullying victimisation and 'well-being' at school. Although trial quality was low these results are encouraging. BABCP note that, having read Axford et al. (2020), KiVA was not delivered as a 'whole school approach'. It contained universal and target interventions but was focused on reducing bullying and not on wider well-being or mental health outcome. BABCP suggests that the guidelines are made much clearer and more specific – of the limited and low quality data available, the KiVa intervention, which targets bullying, may be an effective intervention in primary schools.	Thank you. The committee agreed that because it contained both universal and targeted components and had a wellbeing outcome and a conduct disorder outcome (bullying) that it met the criteria to be included in the review. The effectiveness data and quality of evidence are laid out in a standard format in the evidence review. For a discussion about the quality of the evidence please see the committee discussion of the evidence section of the evidence review. After consideration of the entire evidence base on whole-school approaches, the committee did not wish to explicitly mention the KiVa intervention in the guideline.
British Association of Behavioural and	Evidence review A	Page 24	1.1.7 Econom	BABCP is puzzled at the decision to conduct a cost effectiveness analysis on whole school approaches in primary schools given that the data extracted (table 1.1.6) suggest that interventions are unlikely to be	The committee requested a generalised modelling approach to consider potential cost-effectiveness of a broad range of approaches. The inputs are based on the evidence reviewed

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Cognitive Psychotherapies			ic evidence	effective and are of very low quality. It is also concerning that only 2 studies were identified. BABCP note that 3 studies are included in Table 1.1.8 which is hard to understand if only 2 studies were found. BABCP suggest that this discrepancy is reconciled in the evidence review.	and recommendations are based on committee consideration of that evidence. Section 1.1.7 describes the economic studies included. It notes that 2 studies were identified by the searches and a 3rd (Hummel 2009) study – the report of the economic model undertaken for NICE guidance PH 20 – has been included for completeness. This explanation is also included in footnote A for the Hummel 2009 study in Section 1.1.8. No changes are necessary.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	Page 25	1.1.8	What intervention study was Bowden (2020) related to? If it was not reported in Tables 2-4) how does it contributed data on cost effectiveness? BABCP suggests that further information about the quality of the effectiveness study and the results of the effectiveness study are provided?	The Bowden study considered the City Connects programme intervention. It is a cost-benefit analysis that makes assumptions about effectiveness. The economic benefits of City Connects were based on educational attainment, measured as a reduction in the high school dropout rate, and educational achievement, measured by increases in math and ELA test scores in grades 6–8. The effects were estimated based on literature. The study is included in the table in Section 1.1.8. An evidence table for the Bowden study providing further details is in appendix H of the review.
British Association of Behavioural and	Evidence review A	Page 26	1.1.8	What intervention study was Hummel (2009) based on? Was it reported in Tables 2-4? If not why not?	Hummel (2009) is the economic report for the economic model produced for the previous NICE guideline (PH20) and was not identified in the cost-effectiveness searches. It presents a framework for assessing the cost-effectiveness of bullying interventions, not a specific intervention.

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Cognitive Psychotherapies					
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	Page 27	1.1.8	BABCP note that Persson (2018) cost effectiveness data refer to the KiVA intervention program, which was effective (point 12 above). This study also suggests that the KiVA program was cost effective but there are valid questions about how these data would generalise to the UK/England context. BABCP suggest that the guidance lacks specificity and overstates the likely benefit of 'whole school approaches' in primary schools.	The intervention considered is relevant to the UK context, but caution is required when transferring the results of the study given the difference in prices and healthcare systems between the UK and Sweden. The committee considered the generalisability when looking at the evidence. The published evidence is one part of the evidence that committees take into account when they are making recommendations. The role of an expert committee is to layer their experience and expertise, their knowledge of practice and the policy context and the views of expert stakeholders and witnesses to create recommendations. In addition to evidence from the published literature, the committee were aware of the policy drivers supporting implementation of whole school approaches, and the promising evidence from practice that these are a good thing to do.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	Pages 10-11	Table 2	BABCP note that the majority of the 9 studies that were identified and appraised focused on behavioural outcomes (bullying and/or pro-social behaviours) and that none of the studies focused on emotional or mental well-being. It appears that impacts on emotional and mental well-being have been inferred.	Thank you. The review protocol for this review (see appendix A of the review or the PICO summary on p.7) included observed behavioural outcomes, including conduct problems (bullying). Papers also measured wellbeing at school, school connectedness, co-operation, classroom climate and other outcomes. All of these outcomes relate directly to poor social, emotional and mental wellbeing. No studies targeting sleep or diet were identified because they were not searched for. The review question for this review is "What principles or combination of principles of whole-school approaches to

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				If so, BABCP suggests that this significant limitation should be acknowledged and highlighted in the guidance. BABCP were surprised that no intervention studies targeting 'healthy habits" e.g. sleep, diet, or activity level were identified in the literature review. These are plausible 'whole school interventions' that have been evaluated (e.g. School breakfast clubs) and which have impacts on children's emotional, social and mental well-being (as well as other relevant outcomes e.g. cognition and academic performance). BABCP are concerned that the search criteria may have been unnecessarily limited and/or that studies that target these outcomes were excluded at the screening stage. Referring to the search criteria (page 122) BABCP note that keywords 'sleep', diet', do not seem to have been included but noted that ''physical activity' was included (line 60). BABCP suggest that this omission is reviewed and that both the search criteria and the screening and exclusion of studies are re-examined so that robust evidence that	promote social, emotional and mental wellbeing in children in primary education are effective and cost-effective?". Sleep and diet are not components of whole school approaches (although education about them might form part of the universal curriculum).

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				examines whole school approaches to 'healthy habits' (e.g. sleep, diet, activity) is included.	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	2.1.3 Page 34	8-12	BABCP welcome the priority given to reports from the child / young person when assessing the impact of interventions on their social, emotional, or mental well-being. Evidence suggests that parents and teachers do not observe or report internalising problems that are experienced and reported by children and young people	Thank you for the support.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	2.1.3. Page 34	13-14	BABCP agree that teacher reported outcomes are the optimal way to assess behavioural (i.e. observable) outcomes but note that this is only relevant for behaviours that are exhibited in the classroom. Teachers may not be able to report on playground behaviours or covert behaviours (e.g. bullying) and alternative methods should be used to assess these.	Thank you. We agree this is the case, and for that reason include not only teacher reported outcomes but also child/young person reported outcomes and parent reported outcomes.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	2.1.4 Page 34	25-28	It would have been helpful to summarise the key reasons for excluding 201 references (e.g. no data reported, not trials, no follow up data etc). This is particularly important given that only 16 studies were reviewed for secondary schools.	Thank you. It is standard NICE practice to outline reasons for exclusion in the appendix of the evidence review (Appendix J). The most common reasons for excluding studies at full-text in evidence review A were the study being conducted before 2007 and the study not being concerned with a whole-school approach.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	Pages 51 - 59	2.1.6 Summary of the evidence	These tables are extremely difficult to navigate and to understand. The outcome measure used to calculate comparative risk (column 2) is not specified in many of the comparisons – this makes it impossible to assess the validity of the measure and thus its meaning. For example, on page 56/587 how were the following outcomes assessed and by whom "conduct problems: 'family conflict' 'emotional problems' 'academic outcomes'? In marked contrast, on page 58, the measure used (the Strengths and Difficulties Questionnaire; SDQ) is specified and thus interpretation of the data is possible. The reporting of data does not summarise or integrate the result – however the data presented in this table suggests that differences between intervention groups and control groups were very small or that there was no difference between them (as would be expected in a universal intervention), study quality was poor, and follow up time was inadequate. BABCP suggest that these results are not sufficiently robust to justify the recommendation to implement	Thank you for your comment. The summary in 2.1.6 is in standard Cochrane format for summary of evidence tables. The second column is blank for continuous outcomes because it is not possible to calculate an absolute risk based on these outcomes. To improve the clarity of these tables, we have added the scale and range of scores for each outcome where applicable. The published evidence is one part of the evidence that committees take into account when they are making recommendations. The role of an expert committee is to layer their experience and expertise, their knowledge of practice and the policy context and the views of expert stakeholders and witnesses to create recommendations. In addition to evidence from the published literature, the committee were aware of the policy drivers supporting implementation of whole school approaches, and the promising evidence from practice that these are a good thing to do.

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				'whole school approaches' into secondary schools if the aim is to increase social, emotional, or mental well-being amongst children.	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	Page 61	2.1.7 Economic evidence	BABCP suggest that a clearer link is made between the cost effectiveness studies and the effectiveness studies on which they are based. BABCP agrees that generalising economic data from countries beyond the UK is problematic and that this limits generalisability of the results.	Cost-effectiveness studies are not necessarily based on effectiveness studies. For example, the effect size used in Persson was based on a systematic review of published literature. whereas the effect size in Legood was based on evidence from the Inclusive trial.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	Pages 11-13	Table 3	Studies that are described in this table frequently used behavioural interventions as their primary procedure e.g. (Sorlie et al. 2013) 'School-wide positive behaviour support strategies" "Monitoring of student behaviour" "collectively applied school-wide corrections" "classroom management skills for teachers" and Ward (2013) Positive Behavioural Interventions (PBIS) which was "Designed to improve students' social and academic outcomes and to support staff in their endeavours to teach appropriate behaviours and correct misbehaviour"	Thank you. The committee reconsidered the evidence at length. They agreed that there was evidence to support both cognitive behavioural approaches and relational approaches (through expert testimony and their own expertise and experience). They also reworded the guideline to remove negative references to behavioural approaches. The committee's intention had been to communicate that punitive behavioural approaches alone were not helpful in the context of whole-school approaches, but this had not come across in the guideline in the way they intended. NICE does not consider its review process to be unsafe.

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				The guidance suggests that behavioural interventions should not be used but these studies suggest that these interventions may be effective. The guidance further suggests that' relational' interventions should be used. BABCP could find no evidence from these tables that any 'whole school approaches' used 'relational' interventions. BABCP requests that the committee justify the basis for their endorsement of relational approaches, or that the recommendation is removed from the guidance. BABCP suggest that this interpretation of the evidence presents a threat to the credibility of the recommendations made by the committee. BABCP also suggests that therefore the review process, the appraisal of research findings, and the interpretations made by the committee are unsafe and should be revised.	
British Association of Behavioural and	Evidence review A	3.4.1.1 Page 68	14-17	BABCP note with interest that only 3 qualitative studies were reviewed and that all related to secondary schools. It is not clear why the quantitative studies that provided data relating to acceptability were not included.	Thank you. The review question for section 3 was about the acceptability of whole school approaches. In the PICO table (table 9 on p.66 of the review) and in the review protocol

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Cognitive Psychotherapies				BABCP suggest that the reasons for excluding quantitative studies are provided. BABCP also suggest that the quantitative data related to acceptability may provide additional and important information for the guidelines.	(appendix A) it sets out that only qualitative studies and surveys will be used. Evidence review A is a mixed methods evidence review that examines both the quantitative and qualitative evidence for whole school approaches and attempts to integrate this evidence to see where links can be made. See section 5 of evidence review A for details of this integration.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	3.1.4.161	12-1322	Many studies were excluded and these are listed in Appendix J BABCP suggests that it would be helpful to provide a summary table of the reasons for exclusion and the number of studies excluded for each reason.	Thank you. It is standard NICE practice to outline reasons for exclusion in the appendix of the evidence review (Appendix J). The most common reasons for excluding studies at full-text in evidence review A were the study being conducted before 2007 and the study not being concerned with a whole-school approach.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	3.1.6 Pages 72-78	Table 12	BABCP are concerned that the results presented here, from only 3 studies, which related to three different interventions, are insufficiently broad or relevant to make policy recommendations or guidelines.	Thank you. The 3 studies here are for one section of this 4-part mixed methods review. In total 28 studies reported in 45 papers contributed to the evidence base for the whole school approach recommendations. The published evidence is just one part of the evidence that committees take into account when they are making recommendations. The role of an expert committee is to layer their experience and expertise, their knowledge of practice and the policy context and the views of expert stakeholders and witnesses to create recommendations. In addition to evidence from the published literature, the committee were aware of the

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					policy drivers supporting implementation of whole school approaches, and the promising evidence from practice that these are a good thing to do.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	15-17	Table 4	In Appendix J of Evidence Review A the Whole school approach is defined as *The whole-school approach is an integrated approach that includes and goes beyond teaching and learning in the classroom to all aspects of the life of a school including culture, ethos and environment, as well as partnerships with parents or carers and families, outside agencies, and the wider community.* Table 4 shows the components of 'whole school approaches' that each study targeted i.e. ethos and environment, needs, parents/carers, student voice, staff development, and leadership and management. Only 6 studies (not 9) are listed in Table 4. It is notable that most of the studies of a 'whole school approach' focused on only one or two components, none of them involve any student 'voice' and only one included any engagement with the leadership team/school management team.	Thank you. Appendix J is a list of excluded studies and does not define a whole school approach. All 9 studies identified are listed in table 4 which breaks down the interventions to show which parts of the intervention map onto the core elements of a whole school approach. Most of the interventions map onto most of the core components of the whole school approach and the committee were content that they were adequate, alongside their expertise and experience to support their decisions.

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				BABCP suggests that none of these studies has evaluated the effectiveness of a 'whole school approach' and that therefore the results of these studies are not adequate to inform guidance on this area of practice.	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	4.1.4.1 Page 81	11-12	Many studies were excluded and these are listed in Appendix J BABCP suggest that it would be helpful to provide a summary table of the reasons for exclusion and the number of studies excluded for each reason	Thank you. It is standard NICE practice to outline reasons for exclusion in the appendix of the evidence review (Appendix J). The most common reasons for excluding studies at full-text in evidence review A were the study being conducted before 2007 and the study not being concerned with a whole-school approach.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	Pages 91-92	5.1	BABCP noted the committee's considerations of the evidence from qualitative and quantitative research. BABCP are concerned that the committee's deliberations appear not to have considered the limitations of the data (both in quantity and quality) and that this may lead to over-confidence in their conclusions. BABCP suggest that these limitations are acknowledged and that they are used to modify the conclusions that the committee drew.	Thank you. Section 5.2.2 reflects the committee's discussion of the evidence and notes their concerns about generalisability, the timing and follow up times of studies, the focus of the evidence on bullying rather than other social, emotional and mental wellbeing outcomes, difficulties in understanding the control groups in the studies, issues with cluster RCTs and the lack of evidence on adverse outcomes. They also note in 5.2.3 that the evidence is all of moderate to low confidence in GRADE, but that it matches their expertise and experience and the testimony of invited experts.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	5.2.193	3	BABCP suggest that 'The outcomes that matter most' are important to identify. BABCP suggest that the committee should consult children, young people, parents, school staff and other stakeholders to decide which outcomes 'matter most'. It may also be important to acknowledge that different stakeholders may value outcomes differently – so that there is not a consensus on 'what matters most'. BABCP suggest that this section be retitled 'What the committee considered mattered most' or 'The outcomes that mattered most to committee members'	Thank you. This section is headed 'the committees discussion of the evidence'. This makes it clear that the subheading refers to committee discussions. The committee did commission research with children and young people to hear their opinions on the draft recommendation. This research was undertaken by the University of Manchester. The report of this research is available on the guideline webpage.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	5.2.3 Page 97	39-47	BABCP are concerned that the evidence reviewed did not reflect a 'whole school approach' because most interventions did not involve parents or children/ young people. BABCP suggest that this is acknowledged here and in the guidance.	Thank you. Some of the whole school approaches involved student voices, but the committee are not responsible for the content of the interventions. The committee agreed that parent and pupil voices are key to implementing a whole school approach and recommend this in the guideline. Please see the section on 'Involving families and pupils' recommendations 1.1.14 and 1.1.15.
British Association of Behavioural and	Evidence review A	5.2.3 Page 98	17-25	BABCP recommend that this paragraph be amended to include reference to the role of the Mental Health Support Teams and their intermediate role between schools/colleges and children's mental health services.	Thank you. The committee decided not to make direct reference to mental health support teams as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in

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Cognitive Psychotherapies				The information below (highlighted) is copied from https://www.england.nhs.uk/mental-health/cyp/trailblazers/ MHSTs have three core functions: • to deliver evidence-based interventions for mild-to-moderate mental health issues; • support the senior mental health lead (where established) in each school or college to introduce or develop their whole school or college approach and; • give timely advise to school and college staff, and liaise with external specialist service to help children and young people to get the right support and stay in education.	particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. Mental health support teams are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	5.2.3 Page 96	32-38	BABCP is also greatly concerned about reasoning implied by the following statement: - *"They heard that relational approaches aim to build resilience within the school community as a whole and help children better express their unmet emotional needs within trusted relationships. Conversely, behavioural*	Thank you. The committee reflected on this statement and agreed that it was not accurate and did not accurately represent what they wanted to say. The statement has been rewritten. The presentations from experts are all included in the evidence on the guideline webpage. It became clear during consultation that these had not been easy to find and so NICE has

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				approaches are very limited and do not take into account human cognition. The committee discussed the expert testimony and agreed that it was in line with their beliefs and expertise and with the views of young people expressed in focus groups that were conducted to underpin this guideline. On that basis, the committee recommended a relational approach be taken at whole school level. The committee recognised the importance relational approaches put on psychological safety for children and staff." This statement appears to be based on the 'expert' testimony of one headteacher and the opinions of the committee. The minutes of 17th August 2021 suggest that the expert is a primary school teacher. BABCP considers that headteachers are like to be experts in education, school management, and aspects of child development; however, headteachers are rarely experts in psychological interventions, their scope of practice, or their effectiveness. Thus, BABCP do not consider that	compiled all of the expert testimony into a single document (Evidence review K). Further details on the provision of expert testimony can be found in the NICE methods manual. The manual is currently being updated and will include more detailed information about expert testimony. The guideline does not imply that psychological safety is only important to relational approaches, but suggests that all schools should have a culture that promotes psychological safety (recommendation 1.1.2). Relational approaches are defined in the terms used in this guideline section of the guideline. Please also note that the focus group report is not the expert testimony. As detailed above, the expert testimony is in evidence review K on the guideline webpage. The focus group report is an externally commissioned piece of work to gather children and young people's views on the draft recommendations.

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				this witness is an expert in psychological interventions, or specifically in 'behavioural approaches'. The evidence reviewed did not highlight or describe 'relational approaches' or demonstrate their efficacy. BABCP suggest that giving such weight to personal testimony is inappropriate and contrary to the principles of evidence-based practice. BABCP also note that all ethical approaches to intervention (including behavioural, cognitive, educational, etc) place the highest importance on psychological 'safety'; this is not a special feature of relational approaches and it is highly misleading to imply that it is. BABCP is extremely concerned about the recommendation to introduce 'a relational approach'. BABCP do not agree that the evidence supports this recommendation. Furthermore, the committee has not defined what a 'relational approach' is, has not identified programmes that adopt a 'relational approach' and this	

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				recommendation could not therefore be implemented by schools. BABCP also strongly disagree with the statement that behavioural approaches are 'very limited'. BABCP do not agree that this witness has expert knowledge about behavioural approaches, the range of ways in which they are used, and their efficacy and acceptability. Behavioural approaches are highly effective treatments for many different child, adolescent, and adult problems, including sleep problems, tics, behavioural problems, anxiety, OCD, and depression. Behavioural approaches form the basis of NICE recommended treatments for adults and children with PTSD, OCD, anxiety disorders and depression. They are recommended by NICE to prevent and treat anti-social and conduct problems in children and young people and have been adapted to support parents and families. BABCP is concerned that an area of practice has been excluded by the committee based on personal opinion	

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				alone and that this personal opinion is contrary to a wide range of research evidence and NICE guidelines. BABCP requests that the negative statement about behavioural approaches is removed and that the committee reconvene and seek expert advice on the use of behavioural approaches in schools. BABCP also have concerns about the relevance of the expert's statement *'…and do not take into account human cognition'.* Behavioural approaches are often combined with cognitive approaches and should be based on an assessment of a child's context, history, and environment (including family and school). Human cognition is considered and incorporated into assessment and formulation but would not be the focus of a wholly behavioural intervention. However, behavioural and cognitive approaches are routinely integrated as	

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				evidenced by the widespread use of 'cognitive behavioural' approaches. BABCP suggest that this statement is irrelevant and thus should be discounted and removed as evidence from this document. *'The committee discussed the expert testimony and agreed that it was in line with their beliefs and expertise'* BABCP is also concerned that the committee held views expressed in this statement and that committee members expressed such opinions without supporting evidence. BABCP has also read the report of the focus groups referred to with great care. The results of this focus group study do not support the statement made above. It is also misleading for the committee to state that 'relational' approaches place importance on psychological safety as this implies that other approaches do not. BABCP would like to inform the committee that all ethical psychological practice takes 'psychological	

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				safety' seriously and considers it important. BABCP is unaware of any evidence that 'relational' approaches have any special advantages in this regard BABCP requests that this pejorative and incorrect paragraph is removed from the guidelines.	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	5.2.3 Page 98	9-15	BABCP suggest that this paragraph be amended to incorporate recommendations about Mental Health Support Teams and, in particular, to note that Educational Mental Health Practitioners working in schools are able to support the whole school approach and a stepped care model	Thank you. The committee decided not to make direct reference to mental health support teams as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. Mental health support teams are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	5.2.3 Page 97	23-26	BABCP warmly agree that school staff need to be properly supported and trained. However, BABCP do not agree that 'relational approaches' (whatever they are) and 'trauma-informed practice (ditto) are necessary cornerstones of CPD for teachers. BABCP would strongly recommend that staff training is based on clearly defined constructs that have been	Thank you. Relational approaches are defined in the 'terms used in this guideline' section of the guideline. Trauma informed approaches have now also been defined in the same section. Recommendation 1.1.8 gives some examples, which have been amended since the consultation version.

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				demonstrated to be relevant to child and adolescent well-being There are some excellent, practical and evidence- based training packages that are available for teachers (see below) and BABCP recommend that staff and headteachers are signposted towards those. https://www.annafreud.org/schools-and-colleges/5-steps-to-mental-health-and-wellbeing/supporting-staff/provide-training-for-staff-with-responsibilities-for-mental-health-and-wellbeing/ https://www.minded.org.uk https://charliewaller.org/what-we-do/for-educators	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	5.2.3. Page 95	17-19	BABCP were concerned that most of the research included in the review did not involve students or young people in the research itself or in the interventions that were evaluated. BABCP agrees with the committee that this is a serious limitation of the evidence and suggest that this important point is incorporated into the research recommendations.	Thank you. The committee did not make a research recommendation about this because they agreed that much of it could be extrapolated from broader qualitative literature, because they had data from the focus groups with children and young people to draw on, and because they recommended that schools evaluate and monitor the whole school approach, which includes asking children and young people about it.
British Association of Behaviou	Evidence	5.2.3 Page 96	30-32	BABCP is unable to understand why opinion from one headteacher is given greater weight than peer reviewed research. This decision appears to be contrary to the	The published evidence is one part of the evidence that committees take into account when they are making recommendations, and as you yourselves note it is limited in this particular case. The role of an expert committee is to layer

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ral and Cognitive Psychotherapies	review A			principles and procedures of evidence-based decision making. BABCP suggests that the committee review their use of this testimony and on the weight they placed on it relative to the peer reviewed evidence.	their experience and expertise, their knowledge of practice and the policy context and the views of expert stakeholders and witnesses to create recommendations. In addition to evidence from the published literature, the committee were aware of the policy drivers supporting implementation of whole school approaches, and the promising evidence from practice that these are a good thing to do.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	5.2.3 Page 96	45-47	BABCP strongly welcomes the statement "*Additionally, they identified a need to consider varied opportunities to engage, discuss and reflect upon values in a whole school approach and how they link into actions and daily life for promoting wellbeing"* The concept of values is integrated into many cognitive and behavioural approaches to mental health and well-being (contrary to the suggestion that behavioural approaches are 'very limited' as stated above). Currently a behavioural treatment for depression in adolescents (Brief BA: Pass & Reynolds, 2021) is used by Educational Mental Health Practitioners in schools and colleges across England.	Thank you for your support. The committee reconsidered the evidence on mindfulness-based approaches and cognitive behavioural approaches and discussed the evidence at length. They agreed that there was evidence to support cognitive behavioural approaches and modified recommendation 1.2.6 to account for this.

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				Pass L & Reynolds S (2021) Brief Behavioural Activation: A treatment manual and clinicians guide: Jessica Kingley This approach is also used by schools in Berkshire as part of a whole school approach to mental health supported by the Charlie Waller Trust and the Titcomb Foundation.	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	5.2.3 Page 94	46-47	BABCP are intrigued at this reference to 'expert witnesses' and were not able to find any list of their names, qualifications, or experience and therefore was not able to assess their credibility or account for any biases they may bring to their testimony. Given how much weight was given to the testimony of unnamed experts compared to the weight given to the peer reviewed research evidence, BABCP strongly advise that more information is provided about the experts (qualifications, experience, conflicts of interest), the criteria used to select them, and the methods used to solicit their evidence e.g. in writing, in person, in response to specific questions etc. BABCP would also welcome further information about	Thank you. All expert witness statements are published in appendices to the reviews. We agree that in this guideline that makes them difficult to find and we have removed them from the reviews and compiled them into a separate document (evidence review K). Please see the webpage for this guideline for details. All expert witnesses provide a full declaration of interest to NICE. For further information about the use of expert testimony by NICE see the Developing NICE guidelines: the manual. The manual is currently being updated and future versions will contain more detail about this.

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				the rationale for using evidence from experts – was the committee unable to provide expert opinion on some areas and if so which areas? How were experts identified? What selection process was used to invite experts?	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	5.2.3 Page 96	23-24	As noted above, this evidence review identified a small number of studies of the effectiveness of whole school approaches to children's emotional, social, and mental well-being. Most studies were of 'low' or 'very low' quality. The effects observed were small, and often not significant. Only interventions for bullying reported consistent benefits (albeit small effect sizes). Given those points BABCP cannot follow the rationale of the committee (line 23-24) to make a 'strong' recommendation that all schools take a whole school approach. BABCP suggest that this recommendation is modified and qualified.	The published evidence is one part of the evidence that committees take into account when they are making recommendations. The role of an expert committee is to layer their experience and expertise, their knowledge of practice and the policy context and the views of expert stakeholders and witnesses to create recommendations. In addition to evidence from the published literature, the committee were aware of the policy drivers supporting implementation of whole school approaches, and the promising evidence from practice that these are a good thing to do. Under the section 'The committee's discussion and interpretation of the evidence' within evidence review A, it states that 'the committee stated that whole-school approaches were the current standard for best practice'. Additionally, expert testimony around relational approaches highlighted the importance of a whole-school approach for successful implementation. Full details of expert testimonies can be found in evidence review K.
British Association of	Evidence	5.2.4	22	BABCP is concerned that this section of the review has been written without any consideration of the new Mental Health Support Teams	Thank you. The committee decided not to make direct reference to mental health support teams as a resource. The committee noted that several different services and

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Behavioural and Cognitive Psychotherapies	review A	Page 99-100		As the committee observe (line 22) 'very minor changes in context or circumstance can dramatically impact the findings." BABCP suggest that the introduction of 5000 Educational Mental Health Practitioners into schools and colleges constitutes very much more than a minor change and thus must be carefully considered and that as a result many parts of the guidance may need to be revised.	occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. Mental health support teams are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	pages 36-38	2.1.5 Table 6	BABCP note the very wide range of different intervention types that are included in these studies. The descriptions of these interventions are often vague. It is difficult not to conclude that this table is comparing and evaluating widely disparate interventions. It is not clear how these interventions were classified or sub-divided. The content of interventions is often obscured. This is relevant to the guidelines (page N, note x) which recommend 'relational' whole school approaches. BABCP suggest that greater clarity is needed so that readers understand exactly what a 'relational' approach is and how to identify one.	Thank you. The interventions were all whole school approaches to social, emotional and mental wellbeing and met all of the inclusion criteria set out in the review protocol in appendix A. The interventions were pooled by outcome with close attention paid to heterogeneity in the meta-analysis and confidence in the findings downgrade should the heterogeneity be of concern (see the methods document for details). The content of the interventions is abbreviated in the body of the text rather than obscured, but full evidence tables that give details of the intervention are included in appendix D. Full links are also provided to all of the papers should you wish to check them. Relational approaches are defined in the terms used in this guideline section of the guideline.

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				BABCP also suggest that studies that took a 'relational approach' are clearly identified in the tables. BABCP note also that most of these studies identify outcomes related to bullying and/or victimisation. Outcomes related to emotional, social, or mental well-being are less often reported. BABCP were surprised that no intervention studies targeting 'healthy habits" e.g. sleep, diet, or activity level were identified in the literature review. These are plausible targets for 'whole school interventions' that have been evaluated (e.g. School breakfast clubs) and that have impacts on children's emotional, social and mental well-being (as well as other relevant outcomes e.g. cognition and academic performance). BABCP are concerned that the search criteria may have been unnecessarily restrictive and/or that studies that target these outcomes were excluded at the screening stage. BABCP suggest that this omission is reviewed and that both the search criteria and the screening and exclusion of studies are re-examined so that robust evidence that	The review protocol for this review (see appendix A of the review or the PICO summary on p.7) included observed behavioural outcomes, including conduct problems (bullying). Papers also measured wellbeing at school, school connectedness, co-operation, classroom climate and other outcomes. All of these outcomes relate directly to poor social, emotional and mental wellbeing. No studies targeting sleep or diet were identified because they were not searched for. The review question for this review is "What principles or combination of principles of whole-school approaches to promote social, emotional and mental wellbeing in children in primary education are effective and cost-effective?". Sleep and diet are not components of whole school approaches (although education about them might form part of the universal curriculum) and these interventions would have been found by the searches used for this review. For the purposes of this review, whole school approaches was limited to interventions delivered during the school day and did not cover extra-curricular activities such as breakfast clubs.

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				examines whole school approaches to 'healthy habits' is included.	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	Pages 46-	Table 8	Table 8 shows the components of 'whole school approaches' that each intervention study targeted. In Appendix J the Whole school approach is defined as *The whole-school approach is an integrated approach that includes and goes beyond teaching and learning in the classroom to all aspects of the life of a school including culture, ethos and environment, as well as partnerships with parents or carers and families, outside agencies, and the wider community.* It is notable that most of the studies included in this table focused on only one or two components and therefore do not adequately represent a 'whole school approach'. Only one study (Ferrer-Cascales 2019) involved parents/carers, students, staff ,and leaders/managers. BABCP suggest that because only one study evaluated the effectiveness of a 'whole school approach' that	Thank you. Appendix J is a list of excluded studies and does not define a whole school approach. The studies listed in table 8 meet the inclusion criteria as whole school approaches for this review. The full protocol in appendix A details the inclusion and exclusion criteria. The purpose of table 8 is to break down the interventions to show which parts of the intervention map onto the core elements of a whole school approach. Most of the interventions map onto most of the core components of the whole school approach and the committee were content that they were adequate, alongside their expertise and experience to support their decisions.

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				results are not adequate to inform guidance on this area of practice.	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review A	81	15-16	BABCP are concerned that the results presented here, from only 4 studies, which relate to four different interventions, are insufficiently broad or relevant to make policy recommendations or guidelines.	Thank you. The 4 studies here are for one section of this 4-part mixed methods review. In total 28 studies reported in 45 papers contributed to the evidence base for the whole school approach recommendations. The published evidence is just one part of the evidence that committees take into account when they are making recommendations. The role of an expert committee is to layer their experience and expertise, their knowledge of practice and the policy context and the views of expert stakeholders and witnesses to create recommendations. In addition to evidence from the published literature, the committee were aware of the policy drivers supporting implementation of whole school approaches, and the promising evidence from practice that these are a good thing to do.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	1.1.12.1 Page 101	7-9	BABCP note with interest the committee's reasons for prioritising outcomes and suggests that to identify "The outcomes that matter most' it is essential to clarify the subject – matter most to whom? BABCP suggest that outcomes that matter most to children and young people, and to their parents and carers should be prioritised in any evaluation of school-based interventions to improve well-being.	Thank you. The outcomes that matter most are based on core outcome sets where these are available. For this review, no core outcome sets were identified and so the committee agreed the critical and important outcomes as part of the protocol development process. These are the ones extracted from the literature that is reviewed. These are based on internationally agreed core outcome sets where these are available, and where they are not the outcomes are selected by topic experts during the scoping process and agreed by the committee as part of protocol sign off.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	1.1.12.13 Page 103	3-5	BABCP agree that all new interventions present opportunity costs.	Thank you for your agreement.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	1.1.3 Page 6	7-11	BABCP welcome the priority given to reports from the child / young person when assessing the impact of interventions on their social, emotional, or mental well-being. Evidence suggests that parents and teachers do not observe or report internalising problems that are experienced and reported by children and young people	Thank you for your support.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	1.1.12.2 Page 101	42-43	It is illogical to downgrade studies based on self-report data when the committee previously stated that children's self-report data was prioritised (see note 44). BABCP suggest that this contradiction is resolved so that self-report data is not both prioritised and then down-graded. BABCP suggest that the most valid way to assess emotional, psychological, or mental well-being is to ask the individual to self-report on their experience. BABCP	Thank you. For the purposes of critically appraising primary studies it is usual to downgrade self-reported outcomes for risk of bias. This is particularly the case when the trial is unable to blind participants as to whether they are in the intervention group or the control group. In these cases participants (and especially children and young people) are more likely to say what they think the researcher (often an authority figure) wants to hear. This is known as response bias. Objectively

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				is unsure what NICE would consider a more valid method and suggests that NICE clarify their reasoning.	measurable outcomes do not usually have this bias and therefore are not downgraded. Because of this, even though the committee prioritised self-report data as the most important, they also acknowledged that it was potentially biased.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	1.1.12.2 Page 102	19-20	BABCP agree with the committee's view that effectiveness studies are more informative than efficacy studies and that they should be given greater weight in developing guidance. To enhance transparency of decision making BABCP suggest that the effectiveness and efficacy studies are clearly identified so that readers can see which studies were given greater weight.	Thank you. The distinction was not a formal splitting of the evidence but rather a tool the committee used when they were discussing the evidence. We have amended the text to make this clearer.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	1.1.4 Page 6	24-25	BABCP suggest that it would be helpful to summarise the key reasons for excluding 410 references (e.g. no data reported, not trials, no follow up data etc). This would be useful to understand why other systematic reviews were not included – some recent examples are listed below Mackenzie, K., & Williams, C. (2018). Universal, school-based interventions to promote mental and emotional well-being: What is being done in the UK and does it work? A systematic review. *BMJ open*, *8*(9), e022560.	Thank you. It is standard NICE practice to outline reasons for exclusion in the appendix of the evidence review (Appendix J). The most common reasons for excluding studies at full text in evidence review B were not being randomised study, not containing usable outcome data and the study being conducted before 2007. The references in this comment were checked and none met the inclusion criteria for any of the evidence reviews (as outlined in the review protocols in appendix A of each of the reviews).

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				Chua, J. Y. X., Tam, W., & Shorey, S. (2020). Research Review: Effectiveness of universal eating disorder prevention interventions in improving body image among children: a systematic review and meta-analysis. *Journal of Child Psychology and Psychiatry*, *61*(5), 522-535. Pandey, A., Hale, D., Das, S., Goddings, A. L., Blakemore, S. J., & Viner, R. M. (2018). Effectiveness of universal self-regulation–based interventions in children and adolescents: A systematic review and meta-analysis. *JAMA pediatrics*, *172*(6), 566-575. Andermo, S., Hallgren, M., Jonsson, S., Petersen, S., Friberg, M., Romqvist, A., ... & Elinder, L. S. (2020). School-related physical activity interventions and mental health among children: a systematic review and meta-analysis. *Sports medicine-open*, *6*(1), 1-27.	Mackenzie et al. 2018 was excluded as only SLRs of RCTs and cRCTs were included. SLRs containing non-randomised studies were excluded. Chua et al. 2020 focussed universal eating disorder prevention interventions, which were out of scope. The included studies in the SLR by Pandey et al. 2018 were checked and all were either already captured in the evidence review or out of scope. Andermo et al. 2020 focussed on physical activity interventions, which were out of scope.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	1.1.12.3 Page 102	43-44	BABCP strongly object to the following statement and consider it to be untrue and misleading *'….they acknowledged that there are contra-indications against the use of cognitive-*	Thank you. We have amended the text as you suggest.

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				behavioural therapy in people who have suffered trauma' Cognitive behavioural therapy is the NICE recommended treatment for people (children and adults) who have suffered trauma and have PTSD. The committee provided no evidence that supports this statement so it presumably is based on their opinion. BABCP consider that the statement is incorrect, and it is therefore unreasonable it to be included. BABCP request that this statement is removed, and the paragraph amended. BABCP suggest that it might be appropriate for the committee instead to comment about the potential harms associated with **all** interventions, including mindfulness, and to encourage all adults working with children and young people that their primary responsibility is to mitigate harm. Any intervention that is introduced into a school or college should be carefully assessed and reviewed.	

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British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	1.1.649Page 21-22	Table	'Bullying' – the data in this part of the table appears to be taken from a systematic review by Fraguas (2020) – it is not clear if the data in column 2 (labelled 'Illustrative comparative risks') have been taken directly from the Fraguas review paper or if the data have been recalculated by NICE? BABCP suggest that the methods used to derive the data presented in this table should be described so that readers can follow (and if desired – replicate) the analysis. If data were taken directly from the review paper BABCP is concerned that other review papers have been excluded for reasons that are not described. Examples of other relevant reviews include: Mackenzie, K., & Williams, C. (2018). Universal, school-based interventions to promote mental and emotional well-being: What is being done in the UK and does it work? A systematic review. *BMJ open*, *8*(9), e022560. Chua, J. Y. X., Tam, W., & Shorey, S. (2020). Research Review: Effectiveness of universal eating disorder prevention interventions in improving body image among children: a systematic review and meta-analysis. *Journal of Child Psychology and Psychiatry*, *61*(5), 522-535.	Thank you. The illustrative comparative risks are calculated based on the pooled data by a piece of Cochrane software called RevMan. In this case, as you say, the attributable risks come from a single study so the mean differences are those reported by Fraguas. The summary tables are abbreviated versions of the full GRADE tables for each outcome that are provided in appendix F of the review. These GRADE tables are in turn summaries of the data from individual studies reported in the forest plots in appendix E of the review. The references in this comment were checked and none met the inclusion criteria for any of the evidence reviews (as outlined in the review protocols in appendix A of each of the reviews). The reasons for why the cited references do not meet our inclusion criteria are as follows: Mackenzie et al. 2018 was excluded as only SLRs of RCTs and cRCTs were included. SLRs containing non-randomised studies were excluded. Chua et al. 2020 focussed universal eating disorder prevention interventions, which were out of scope. The included studies in the SLR by Pandey et al. 2018 were checked and all were either already captured in the evidence review or out of scope.

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				Pandey, A., Hale, D., Das, S., Goddings, A. L., Blakemore, S. J., & Viner, R. M. (2018). Effectiveness of universal self-regulation–based interventions in children and adolescents: A systematic review and meta-analysis. *JAMA pediatrics*, *172*(6), 566-575. Andermo, S., Hallgren, M., Jonsson, S., Petersen, S., Friberg, M., Romqvist, A., ... & Elinder, L. S. (2020). School-related physical activity interventions and mental health among children: a systematic review and meta-analysis. *Sports medicine-open*, *6*(1), 1-27. BABCP suggest that the reasons for excluding relevant systematic reviews and meta-analyses on this topic are provided so that the rational is clear and transparent. However, BABCP suggests that the guidance would be strengthened if more relevant studies were included. We therefore request that the literature search methods are revised and that the search and evidence appraisal is updated to better reflect the available evidence.	Andermo et al. 2020 focussed on physical activity interventions, which were out of scope.
British Association of Behavioural and	Evidence Review B	1.1.6 Page 22-23	Table	'You can do it!' – it is not clear what this sub-title relates to; is this the name of an intervention programme?	You can do it! Is the intervention that was assessed by Ashdown 2012 as detailed in section 1.1.5. Please see also the evidence table for Ashdown 2012 in appendix D which

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Cognitive Psychotherapies				'…compared to usual practice for SEW" – Please note the acronym SEW and explain what it means – presumably this refers to Social and Emotional Well-being? Column 1 refers to Ashdown (2012) – is this data taken from a single paper as this implies, or from 4 independent studies as implied in column 4. Or does a single study have just 4 participants? If the latter BABCP suggest that this study is underpowered and should not be included in this literature review. The note (superscript 1) at the bottom of the table indicates that the quality of the study was downgraded for a number of reasons. One of these listed is 'assessments carried out by self-report'. This contradicts a previous statement (page 6, lines 7-11) about the priority given to young people's self-report for social, emotional, and well-being outcomes – logically a method of assessment cannot both be prioritised by NICE and also used to downgrade an assessment of quality. BABCP suggest that this contradiction is addressed and corrected	gives more detail on the intervention and on what is meant by 'usual practice' in that study. We have filled out the abbreviation SEW to make it clear that it refers to social, emotional and mental wellbeing. The table summarises outcomes from a single study with 4 participants, which as you say is very likely to be underpowered and the committee took this into account. You will also note that the study was downgraded several times in its GRADE assessment as a result of this and other methodological limitations. For the purposes of critically appraising primary studies it is usual to downgrade self-reported outcomes for risk of bias. This is particularly the case when the trial is unable to blind participants as to whether they are in the intervention group or the control group. In these cases participants (and especially children and young people) are more likely to say what they think the researcher (often an authority figure) wants to hear. This is known as response bias. Objectively measurable outcomes do not usually have this bias and therefore are not downgraded.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	1.1.6 Page 24	Table	Jovenes Fuertes SEL – BABCP suggests that some explanation of this is provided – presumably it is the name of an intervention programme?	Jovenes Fuertes is an adaptation of the strong teens programme to make it culturally relevant. It is listed in the table of included studies in section 1.1.5 and the evidence table for Castro-Olivo 2014 in appendix D gives further details of the intervention.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	1.1.6 Pages 38-41	Table	Mindfulness – BABCP note with interest that a maximum of 6 studies and 1587 participants provided data related to the effectiveness of universal mindfulness interventions on children's well-being.	Thank you. That is correct.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	Page 21-78	1.1.6	BABCP found these tables extremely difficult to navigate and to understand and suggests that the committee consider using funnel plots and other visual devices to present effectiveness data. Column 1 lists Outcomes and references a single study; some are primary research and others meta-analyses – for example line 1, page 21 refers to 'Overall bullying' – endpoint (Fraguas, 2020) – presumably this is a meta-analysis? BABCP suggest that this is made explicit.	Thank you. This is a normal method of communicating effectiveness evidence for systematic reviews at NICE This format is widely used and understood. Other ways of presenting data are simpler but lack the detail that forest plots and GRADE tables provide, for example harvest plots that simply indicate the direction of travel of pooled effect estimates. Funnel plots are not a normal method of communication effectiveness evidence. They are normally used in systematic reviews to assess publication bias. Throughout the GRADE summary tables in section 1.1.6 the column titled number of participants (studies) reports how many studies were included in the analysis of that outcome. In

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				BABCP note that much of this table presents data from one or two studies that assessed a specific intervention programme with small numbers of participants. BABCP suggests that these studies are seriously underpowered and that therefore their results are not reliable and unsuited to drawing national recommendations. BABCP therefore recommend that where only one or two studies have assessed a specific intervention that this programme is further classified, based on the theoretical approach (e.g. interpersonal, cognitive, behavioural etc) and the content of the intervention and that where, effectiveness of studies is examined in a meta-analysis. BABCP also observes that the method of analysis used by NICE does not seem to incorporate weighting for sample size (except confidence intervals) and notes that this may lead to misleading comparisons of SMDs and reliance on underpowered studies.	this review, in many cases, it is a single study. In those cases no meta-analysis is possible and the data reported are those from the single study. The published evidence is one part of the evidence that committees take into account when they are making recommendations. The role of an expert committee is to layer their experience and expertise, their knowledge of practice and the policy context and the views of expert stakeholders and witnesses to create recommendations. It is incorrect to say that the method of analysis does not incorporate weighting for sample size. Any meta-analysis undertaken uses a weighting system to attribute weights to the studies included in the meta-analysis and this is reported in all of the forest plots where you can see the weight given to each study. Furthermore, when an outcome is assessed against the GRADE criteria, it is penalised for having wide confidence intervals (which as you note tend to be smaller studies) and the confidence in the finding is downgraded accordingly.
British Association of	Evidence	1.1.12.5	8-11	BABCP suggest that the committee include the role of School Mental Health Teams into this paragraph – these	Thank you. The committee decided not to make direct reference to Mental Health Support Teams as a resource. They noted that these services were not yet in place in all

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Behavioural and Cognitive Psychotherapies	Review B	Page 107		teams and their staff now have extensive experience of delivering interventions on-line during the COVID-19 pandemic.	areas and would not be until 2025 at the earliest. Until more is known about the effectiveness of MHST, the committee agreed they were just one of several different services and occupations that might be involved in CYP's social, emotional and mental wellbeing and did not want single them out at this time. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation about compiling a directory of the local offer directory and keeping it up to date (recommendation 1.1.20).
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	1.1.7 Page 79	17-18	BABCP note that 56 documents were excluded and suggests that a summary of the reasons for their exclusion is added to enhance transparency.	Thank you. It is standard NICE practice to outline reasons for exclusion in the appendix of the evidence review (Appendix J). The most common reasons for excluding studies at full-text in evidence review B were not being randomised study, not containing usable outcome data and the study being conducted before 2007.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	6	12-13	BABCP agree that teacher reported outcomes are the optimal way to assess behavioural (i.e. observable) outcomes but note that this is only relevant for behaviours that are exhibited in the classroom. Teachers may not be able to report on playground behaviours or covert behaviours (e.g. bullying) and alternative methods should be used to assess these.	Thank you. We agree this is the case, and for that reason include not only teacher reported outcomes but also child/young person reported outcomes and parent reported outcomes.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B Universal curriculum approaches	1.1.1 page 5	20 1 PICO table	Intervention: As this evidence review includes both mental health / well-being promotion and prevention BABCP note that very different timescales and study sizes would be needed to assess these aims adequately. The effects of interventions to *promote* mental health / well-being can be assessed in the relatively short term as well as longer term. The evaluation of interventions to *prevent* poor well-being/mental health in an unselected population (i.e. not at elevated risk) requires RCTs with very large sample sizes, and with lengthy follow up. BABCP suggest that interventions that aim to *prevent* undesirable outcomes should have a follow up of a minimum of 1 year and that 5 years would be preferred. BABCP also found the search strategy rather limited – were terms that would capture universal interventions related to physical activity, diet, and sleep included? There is evidence that interventions to target each of these areas are effective in improving the specific target, i.e. sleep, diet, physical exercise, and on other aspects of social, emotional and mental well-being – for example: Hosker, D. K., Elkins, R. M., & Potter, M. P. (2019). Promoting mental health and wellness in youth through	Thank you. Unfortunately NICE cannot set the timescales that primary studies use for follow-up. The committee noted the difficulties with follow-up times in the committee discussion of the evidence section. However, the committee also agreed that no study showed a negative outcome in the shorter-term and they concluded that this was an important consideration given the potential for the long-term impact of these interventions. For this reason, the committee were not minded to make a research recommendation regarding long-term effectiveness of universal curriculum approaches. The search strategy would capture universal interventions related to physical activity, diet and sleep. The studies you cite here did not meet the inclusion criteria specified in the review protocol in appendix A of the review. The review is about the effectiveness of universal classroom-based interventions, not about interventions that could be delivered in schools, therefore the narrowness of the protocol is appropriate. The reasons for why the cited references do not meet our inclusion criteria are as follows: Hosker et al. 2019 is not an RCT. Åslund et al. 2018 the interventions captured in the SLR were not necessarily school-based and the outcomes focused on

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				physical activity, nutrition, and sleep. *Child and Adolescent Psychiatric Clinics*, *28*(2), 171-193. Åslund, L., Arnberg, F., Kanstrup, M., & Lekander, M. (2018). Cognitive and behavioral interventions to improve sleep in school-age children and adolescents: a systematic review and meta-analysis. *Journal of Clinical Sleep Medicine*, *14*(11), 1937-1947. Adolphus, K., Hoyland, A., Walton, J., Quadt, F., Lawton, C. L., & Dye, L. (2021). Ready-to-eat cereal and milk for breakfast compared with no breakfast has a positive acute effect on cognitive function and subjective state in 11–13-year-olds: a school-based, randomised, controlled, parallel groups trial. *European Journal of Nutrition*, *60*(6), 3325-3342. BABCP recognises that not all of these studies focus on delivery of interventions in school – however, until recently there were very few qualified mental health clinicians routinely working in schools. BABCP suggests that the selection criteria for this review are too narrowly focused on studies conducted in schools and therefore ignore many potentially effective interventions that could be delivered in schools.	measured of sleep rather than social, emotional and mental wellbeing. Adolphus et al. 2021 focused on a cereal and milk intervention and outcomes of cognitive function, which were both out of scope.

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				Outcomes: BABCP are concerned that the time point at which outcomes are assessed for prevention studies has not been pre-specified and suggest that primary prevention studies (i.e. evaluate universal interventions) that are underpowered and/or do not follow up participants for a minimum of one year do not offer useful data and that their results should not be used to inform this guideline	
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	101	22-24	BABCP agree that self-report outcomes by children and young people should be given greater weight than outcomes reported by teachers and parents. However, BABCP observe that in the evidence review, self-report data resulted in down-grading of the quality of studies and notes that this is contradictory and unsuited to assessing children's well-being.	Thank you. The committee prioritised outcomes reported by the child, however for the purposes of methodological assessment of the studies, it is appropriate to downgrade confidence in the outcome where there is a risk of response bias (a self-reported outcome). Confidence in the outcome does not equate to importance of the outcome.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	102	21-22	BABCP agree with the committee that scores on self-report scales of symptoms cannot be used alone to identify children and young people with 'depression', or indeed 'anxiety'. BABCP agree that the language used to describe children experiences is important and that in the context of universal interventions it is not helpful to imply that children have a mental health diagnosis when no such conclusion can be reasonably drawn.	Thank you for your support.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	102	27-28	*"The committee acknowledged that interventions based on CBT principles appeared to have an effect but questioned the feasibility of recommending these therapies, due to the need for facilitator training. CBT based interventions require an element of training to understand the core principles and methods."* BABCP had a number of concerns about this paragraph. 1. BABCP agree with the committee that interventions based on CBT principles have an effect – this has been demonstrated in many other systematic reviews and meta-analysis. However, in a universal intervention targeted at a non-clinical population, effects of any intervention on well-being will be very small. As noted above, studies that assess prevention require large samples and long follow ups and most studies included in the evidence review did not have these features.	Thank you. The committee discussed this and agreed with you. They have removed this paragraph from the evidence review.

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				2. BABCP do not agree with the concern about feasibility of recommending CBT interventions in schools and colleges. The introduction and expansion of School Mental Health teams across England and the employment of Educational Mental Health Professionals provides a workforce who have been trained to deliver CBT based interventions and to support school staff as well as students. Thus, CBT based interventions are feasible to deliver in an increasing number of primary and secondary schools. 3. BABCP would also point out that the safe delivery of mindfulness interventions, which the committee chose to recommend, also require facilitator training, supervision, and ongoing personal mindfulness practice, and thus place an even greater demand on schools' resources. Therefore, the specific concern expressed in relation to CBT is more appropriately targeted at mindfulness training in schools.	
British Association of	Evidence	102	30-31	BABCP strongly objects to the following statement:	Thank you. The committee discussed this and agreed with you. They have removed this paragraph from the evidence review.

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Behavioural and Cognitive Psychotherapies	Review B			*'Additionally, it was raised that CBT in traumatised children and young people can lead to harm due to fear of failure experienced by the participants'* No supporting evidence was presented for this statement. BABCP believes this statement to be misleading, harmful, and biased. It is not reasonable to single out CBT interventions as potentially harmful - **all** potent interventions (including mindfulness) have the potential for harms as well as benefits and it is essential that harm is monitored and reported. The evidence review stated that there was ***no evidence*** of harm reported. BABCP suggests that the committee consider the fact that CBT is the NICE recommended treatment for Post-Traumatic Stress Disorder (PTSD) in children and adolescents, as well as a range of other disorders. BABCP expects the committee to withdraw this pejorative statement and to amend the guidelines accordingly - especially as the evidence review indicates that CBT universal interventions were effective, and the committee agreed.	They also amended recommendation 1.2.7 to include cognitive behavioural approaches.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	103	12-13	BABCP agree that resources should be considered in any decision to offer universal interventions in schools. BABCP also suggest that the role of Educational Well-Being Practitioners (EMHPs) in schools provides an important new resource for schools in delivering these interventions and that this should be reflected in the guidelines. BABCP suggest that the role of EMHPs is explicitly mentioned in this paragraph	Thank you. The committee decided not to make direct reference to Educational Well-Being Practitioners as a resource. They agreed they were just one of several different services and occupations that might be involved in CYP's social, emotional and mental wellbeing and did not want to single them out at this time. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation about compiling a directory of the local offer directory and keeping it up to date (recommendation 1.1.20).
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	103	34-35	BABCP suggest that the committee review the accuracy of this statement. The results of the evidence review and the committees' opinion indicated that CBT interventions are effective and this should be reflected in the guidelines.	Thank you. The committee discussed this and agreed with you. They have removed this paragraph from the evidence review. Additionally, the committee agreed that there was evidence to support cognitive behavioural approaches and modified recommendation 1.2.6 to account for this.
British Association of Behavioural and Cognitive	Evidence Review B	104	23-33	BABCP is puzzled by the reasoning presented in this paragraph. The committee appear to be saying that interventions that did not demonstrate effectiveness in relation to their chosen outcome variables may still be successful in terms of their 'aims'.	We assume this refers to p.105 line 23-33. The committee were discussing whether the interventions might have effects beyond what was measured by the study, and agreed that even though the interventions were not shown to be effective, they could have had an impact on the lives of

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Psychotherapies				BABCP suggests that if outcomes do not relate to the 'aims' of the intervention or if studies are not designed in a way that can assess those aims that these studies are poorly designed and should not contribute to the evidence that the committee use to develop guidelines. .	the children and young people who received them, and on the broader school culture.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	104	17-22	BABCP scrutinised the evidence review for studies that demonstrated that 'regular rhythmic movement' had benefits for children and young people in managing their well-being and was unable to find any. One study of physical activity was included in the evidence review (Christiansen, 2018); this examined physical activity generally and did not show evidence of effects on well-being. BABCP is concerned that the committee is placing such weight on 'expert testimony' to inform practice. In BABCP's judgement expert testimony alone is insufficient to warrant even a 'weak recommendation' and suggest that this is removed from the guidance.	Thank you. You are correct that this recommendation is based on expert testimony alongside the committees experience and expertise. For this reason it is framed as a 'Consider' recommendation, which means that it is something for schools to think about doing. For further information on the way NICE use words in recommendations please see Making decisions using NICE guidelines.
British Association of Behavioural and	Evidence Review B	104	12-15	BABCP scrutinised the data presented about mindfulness interventions in schools.	The committee considered the pooled effect estimates which showed an effect for mindfulness on social emotional skills, depression, anxiety and depression and academic outcomes.

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Cognitive Psychotherapies				BABCP noted with interest that a maximum of 6 studies and 1587 participants provided data related to the effectiveness of universal mindfulness interventions on children's well-being. These participants included primary and secondary pupils, boys and girls. BABCP suggest that the analysis presented is underpowered to examine any sub-group effects (e.g. effects for boys or girls) and that therefore these analyses are not valid. BABCP also noted that of the 16 separate outcomes presented in the evidence review, confidence intervals for only 1 outcome did not cross zero. There was one significant effect – on anxiety/depression (Ghiroldi, 2020) but, given the number of comparisons presented and not corrected, BABCP is of the view that there is a high likelihood that this result can be attributed to Type II error. Therefore, mindfulness as a universal intervention is highly likely to have had no significant effect on children's social, emotional, or mental well-being, or on the behavioural outcomes presented. Therefore the statement *"The committee noted that mindfulness showed a positive improvement for some outcomes,*	None of these pooled estimates crossed the line of no effect. Therefore the committees comment is correct. The committee agreed that the evidence was not convincing enough to recommend that it is introduced into all schools, so instead made a recommendation to 'consider' it. For further information on the way NICE use words in recommendations please see Making decisions using NICE guidelines

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				including academic outcomes, and emotional distress" is not supported by the data provided in the evidence review even though the committee considered that it, '…*matched with evidence they heard from expert testimony (see evidence review A) and with their own experience and expertise."* BABCP suggests that the committee has not characterised the nature of the evidence about mindfulness correctly (or that the evidence reported is not accurate?) and that this should be reflected in the text here and in the guidelines. BABCP considers that the evidence for universal mindfulness interventions is not adequate to form the basis of recommendations that they are introduced into schools and colleges.	

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British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	104	8-9	BABCP could not find a definition of 'relational' whole school approaches and suggest that these are clearly defined so that schools are able to understand the concept. BABCP also suggest that if evidence supports a 'relational' approach that this is clearly presented in Evidence Review A.	Thank you. A definition for relational approaches is provided in the "Terms used in this guideline" section of the guideline. The evidence for relational approaches was provided primarily through expert testimony and committee consensus.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	105	11-16	BABCP share the concern raised here about the lack of clarity about potential costs that the educational sector would bear and noted that in the cost effectiveness review different levels of QALY were reported. BABCP also remind the committee that School Mental Health Teams and their staff, who are engaged to deliver interventions to improve well-being in schools and colleges, are primarily funded by the Department of Health. Therefore, a significant proportion of the costs incurred would not fall on the education sector. BABCP strongly recommend that the evidence review and guidelines are revised so that they consider and incorporate School Mental Health Teams and Educational Mental Health Practitioners.	Thank you. The committee decided not to make direct reference to mental health support teams or educational mental health practitioners as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. Mental health support teams and educational mental health practitioners are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	107	16-20	There is ample published and peer reviewed evidence on these topics – BABCP suggest that the committee refer to this rather than to their own expertise. For example, please provide a source for this statement; *'COVID-19 was also seen to exacerbate pre-existing mental health conditions in young people (16–25 years). '*	Thank you. This section of the evidence review is intended to detail how the committee moved from the evidence to the recommendations that they made. The expert testimony that the committee received abut COVID-19 and its impact on young people alongside their own experiences work in or alongside schools led them to this conclusion.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	107	27-30	Please provide references for statements about differences between primary and secondary school children. BABCP is concerned that the 'expert' opinion diverges from the published evidence, which should be referred to in preference to 'expert opinion'. Where 'expert' testimony is the only available source of evidence and the issue is critically important, BABCP suggests that expert testimony should be recorded and available as part of the evidence review, and that all experts invited to contribute should be required to provide details about possible conflicts of interest and evidence to support their 'expert' status.	Thank you. We do not have the references you suggest because as you note this information came from expert testimony. Experts are required to submit declarations of interest to NICE and their testimony is written up in an appendix to the relevant evidence review. We agree that in this guideline that makes them difficult to find and we have removed them from the reviews and compiled them into a separate document. Please see the webpage for this guideline for details. All expert witnesses provide a full declaration of interest to NICE.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	107	12-13	BABCP is very concerned about the reliance of the committee on 'external experts' and this is increased when they are anonymous, and their testimony is not public - and therefore cannot be examined and challenged. There has been a great deal of peer reviewed evidence relating to the impact of COVID-19 on children and young people, for example: Creswell, C., Shum, A., Pearcey, S., Skripkauskaite, S., Patalay, P., & Waite, P. (2021). Young people's mental health during the COVID-19 pandemic. *The Lancet Child & Adolescent Health*, *5*(8), 535-537. Waite, P., Pearcey, S., Shum, A., Raw, J. A., Patalay, P., & Creswell, C. (2021). How did the mental health symptoms of children and adolescents change over early lockdown during the COVID-19 pandemic in the UK?. *JCPP advances*, *1*(1), e12009. Raw, J. A., Waite, P., Pearcey, S., Shum, A., Patalay, P., & Creswell, C. (2021). Examining changes in parent-reported child and adolescent mental health throughout the UK's first COVID-19 national lockdown. *Journal of Child Psychology and Psychiatry*, *62*(12), 1391-1401.	Thank you. All expert witness statements are published in appendices to the reviews. We agree that in this guideline that makes them difficult to find and we have removed them from the reviews and compiled them into a separate document. Please see the webpage for this guideline for details. All expert witnesses provide a full declaration of interest to NICE. For further information about the use of expert testimony by NICE see the Developing NICE guidelines: the manual. The manual is currently being updated and future versions will contain more detail about this. The studies you cite did not meet the inclusion criteria specified in the review protocol in appendix A of the review. The reasons for why the cited references do not meet our inclusion criteria are as follows: Creswell 2021 is a commentary piece, which is out of scope. Raw et al. 2021 fall outside the date range of our final literature searches. We will flag this study for surveillance, who will consider it when this guideline is due to be updated. Waite et al. 2021 was excluded at title and abstract screening as no abstract was available and the title alone did not meet the threshold to progress to full-text screening.

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				BABCP therefore suggest that the committee refer to this body of evidence, rather than 'expert review' - on this topic and on others where peer reviewed evidence is available. Where 'expert' testimony is the only available source of evidence and the issue is critically important, BABCP suggests that expert testimony should be recorded and available as part of the evidence review, and that all experts invited to contribute should be required to declare possible conflicts of interest and provide evidence of their 'expert' status and its limits. BABCP suggest that NICE consider their own guidance on the recruitment and use of 'experts' and the status given to their testimony relative to peer reviewed research evidence.	Additionally, Creswell, who is an author for all of these references, provided expert testimony for the committee. Therefore, it is likely that committee considered the overall findings for these publications.
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	108	3-4	BABCP suggests that the role of School Mental Health teams is incorporated into this sentence given that their role is to deliver interventions to support students' mental well-being and to support schools in implanting whole school approaches.	Thank you. The committee decided not to make direct reference to Mental Health Support Teams as a resource. They noted that these services were not yet in place in all areas and would not be until 2025 at the earliest. Until more is known about the effectiveness of MHST, the committee agreed they were just one of several different services and occupations that might be involved in CYP's social, emotional and mental wellbeing and did not want to single them out at

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					this time. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation about compiling a directory of the local offer directory and keeping it up to date (recommendation 1.1.20).
British Association of Behavioural and Cognitive Psychotherapies	Evidence Review B	108	5-6	This comment is current national policy in England with extensive training and support for identified mental health leads - see https://www.gov.uk/guidance/senior-mental-health-lead-training BABCP therefore suggest that this text is edited to reflect the current position and resources available to schools and colleges.	Thank you. It is not the role of NICE guidelines to repeat national policy. As the committee did not discuss the current position and resources available to schools and colleges, it cannot be added to the committee discussion section of this review. The committee discussed the mental health leads programme and reflected on it in the rationale and impact section of the guideline for whole school approaches.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review C			Unfortunately, BABCP did not have sufficient time to review this document.	Thank you for this information.
British Associati	Evidence	1.1.5	Table	BABCP has a few suggestions about the contents of Table 1.1.5.	Thank you. We agree that prospective cohort studies are the best way to explore this review question, however the

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on of Behavioural and Cognitive Psychotherapies	review D	Page 7		Cross sectional studies should be removed from this table of evidence as they provide no useful information about prognosis or risk. This is not mitigated by controlling for possible confounds in a regression analysis or by any other statistical method. Cross sectional data can identify associations between variables but not causal relationships. Where longitudinal studies are cited the length of follow up and the age of the children and young people at each assessment point should be given to help interpretation of the findings. The table should indicate who reports on the risk factors and outcomes at each time point (parent, teacher, child etc), and if the reporter of both risk and outcomes is the same person (or not). Methods to reduce negative affectivity, common method variance, and bias should be assessed.	committee agreed that it was unlikely that there would be enough data from cohort studies to cover all of the risk factors they were interested in, therefore they agreed that cross sectional studies would be useful in those cases. This is set out in the review protocol in appendix A of the review. The further details you suggest would make the table unmanageable and these data are reported in the evidence tables in Appendix D of the review.
British Association of Behavioural and	Evidence review D	1.1.4.16	14-20	BABCP note that a very large proportion of the references identified were discarded.	Thank you. A large proportion of the references are always discarded when conducting a systematic review. This is

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Cognitive Psychotherapies				BABCP suggests that the committee provide a summary of the reasons for this (Appendix J is not sufficient for transparency). BABCP also noted with concern that 24 studies were excluded because they did not contain risk factors 'of interest to the committee'. This potentially introduced uncontrolled bias into the evidence review. BABCP suggests that these 24 studies and the risk factors they identified are noted so that readers can assess the judgement of the committee to exclude these BABCP notes that some important risk factors were omitted in this review (e.g., domestic violence) and is concerned that this may have been available but ignored. BABCP received feedback from members and service users about the corrosive and adverse effects of domestic violence on children and young people and about the role of schools in supporting children and parents. Several examples suggested that schools would benefit from more explicit guidance and training in this area. For example.	because we err on the side of sensitivity in the searches to ensure we do not miss important studies. Domestic violence as a risk factor was not excluded and data are presented on child maltreatment, sexual, physical and emotional abuse and conflict between parents. Studies that were excluded because they did not contain risk factors 'of interest to the committee' were exclusively cross-sectional in design. Cross-sectional studies were used to supplement the evidence base where there was an absence of data for specific risk factors highlighted by the committee.

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				"My child had almost a year of hardly attending school when staying at his dads half of the week. School knew he was left at the house all alone with me being unable to call and house locks changed so I couldn't go. School wouldn't do a welfare check despite requesting this. Eventually after approximately 8 months, they did a welfare check but as there was no answer they phoned my child's father (the abuser) and they were happy with his response. . 12 months on and just received a letter to say they are setting a hearing date at which each of us separately have to go and present our case for my child being off school' Schools can also have a very positive impact on children and young people who are exposed to domestic violence – for example, one mother told us: *"When my marriage broke down, the first thing I did was have a meeting with the schools Head of pastoral care. I was very honest about our situation, and shared any documentation allowed with them, showing evidence of the issues. Non-molestation orders, police liaison officer details, domestic abuse support contact*	

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				information…anything really to reassure the school that our situation was genuine & needed to be taken seriously. The school then made a point of speaking to both kids to get their opinion on how they would like the situation handled. For example; my kids don't want their father coming to or near the school without their written permission first. The school has 100 percent complied with this. They also had meetings with the kids to work out an emergency strategy of what they should do if he did turn up at the school." BABCP suggests that the committee should consult with children, young people, and parents to identify relevant risk factors and that these are included in the literature search strategy.	
British Association of Behavioural and Cognitive	Evidence review D	1.1.7 Page 32	1	BABCP suggests that this narrative synthesis of the evidence incorporates a statement about the low quality of the evidence that has been reviewed. BABCP particularly note concerns that the limitations about correlational designs and the impossibility of inferring risk or protective factors from correlations	Thank you. Each of the evidence statements in section 1.1.9 includes a statement about the risk of bias of the study. The committee discussion of the evidence section 1.1.10.2 'the quality of the evidence' discusses the decision to add cross sectional studies for risk factors where no cohort study was found.

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Psychotherapies				between variables measured at the same point in time should be recognised.	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review D	4 Page 24	Table 4	BABCP suggests that the classification of ACES as an individual characteristic of the child is misleading and potentially stigmatising and pejorative. Events that are captured in measurements of ACEs are typically external not internal. BABCP suggests that ACES should be classified as part of the child's environment (i.e. Table 2 or Table 3)	Thank you. The designation of the table is to indicate that the risks/protective factors in the table were at an individual level rather than a broader family, school or environmental level. Compare with tables 2 and 3 which address factors at those levels. This includes specific ACEs such as parental drug / alcohol use.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review D	6	25-27	The information suggests that 21 studies were cross-sectional designs. BABCP does not understand how a cross-sectional study can provide valid information about 'risk' factors. The design of a cross sectional study only allows observation of co-existing factors/variables – no inference can be made about causal direction and therefore it is not possible to determine if one variable increases or decreases the risk of another. Statistical methods, however sophisticated they are, cannot overcome the intrinsic limitations of cross-sectional study designs.	Thank you. The committee discussion of the evidence section 1.1.10.2 'the quality of the evidence' discusses the decision to add cross sectional studies for risk factors where no cohort study was found.

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				There is also a problem with confounding of 'risk factors' and 'outcomes'. For example, taking the first reference in the table 1.1.5 (page 7); the table shows that high self-esteem is correlated with mental health concerns. This is not surprising as low self-esteem is a characteristic (not a symptom) of many common mental health problems and is an indicator of low well-being (not a risk factor for it). The fact that these two variables are correlated says nothing useful about prognosis or risk. In BABCP's opinion cross sectional studies do not provide valid evidence of 'risk' factors and should not be used as the basis for recommendations or policy. BABCP request that cross-sectional studies are not used to identify risks. However, if the committee does not wish to respond to this request BABCP asks that the reasoning of the committee to include cross-sectional studies in this evidence review is explained and, if the evidence review is not amended, that the limitations of this evidence are clearly acknowledged.	

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British Association of Behavioural and Cognitive Psychotherapies	Evidence review D	Page 25	Table 4	BABCP notes that symptoms of depression and anxiety are included in the table, within individual rows, as both a risk factor and an outcome – this is tautological given that depression and anxiety symptoms are mental health concerns. BABCP suggests that the committee scrutinise this table, identify and remove all tautologies	Thank you. Anxiety and depressive symptoms were identified as potential exposures (risk factors) in the protocol that could lead to poor social, emotional and mental wellbeing. As anxiety and depressive symptoms are also examples of poor social, emotional and mental wellbeing, they were also included as an outcome (under mental health concerns).
British Association of Behavioural and Cognitive Psychotherapies	Evidence review D	Page 28	Table 4	'Need for professional services e.g. counselling' is positively associated with 'mental health concerns' one year later This is hardly surprising given that children's mental health difficulties tend to persist. Whilst not directly tautological, BABCP suggest that this kind of association is of little value to policy makers and that the committee consider how they define 'risk' or 'protective' factors and discriminate between these and 'outcomes'.	Thank you. This outcome was reported by some studies that were included in the review. The technical staff do not make any subjective judgment of the usefulness of the evidence. The purpose of a systematic review is to provide evidence to the committee upon which they can base their decisions and recommendations. The committee agreed that the outcome was not useful and did not base recommendations on it.
British Association of	Evidence	Page 29	Table 4	The table suggests that high self-esteem is associated with mental health concerns. This is not surprising as low self-esteem is a characteristic (not a symptom) of	Thank you. The contents of a systematic review are pre-specified in the review protocol and not subject to change once the protocol has been published. The committee agreed that the identification of risk and protective factors was complex

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Behavioural and Cognitive Psychotherapies	review D			many common mental health problems. The fact that these two variables are correlated says nothing useful about prognosis or risk. BABCP suggests that overlapping constructs that relate to well-being are carefully classified so that risk factors and outcome are distinct constructs. BABCP suggests that the committee consider a more nuanced classification of variables currently all labelled as 'risk factors' and that this discriminates between • Adverse experiences and events that increase the risk that children will develop difficulties in social or emotional well-being, or mental health • genetics, developmental, or temperamental factors that are associated with increased vulnerability or risk; and • early signs or symptoms of distress and mental health problems. These are not equivalent or similar factors and it is not helpful to suggest that they are similar or should be considered equivalent.	and following concerns raised in this consultation have deleted the risk factors examples that they had included in the guideline and replaced it with a link to DfEs mental health in schools guidance.

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				BABCP suggests that Evidence Review D is revised and that the results of a more limited number of high-quality cohort and longitudinal studies are used to inform this recommendation.	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review D	32	19-24	BABCP is surprised and concerned that domestic violence is not a variable that was identified as a risk factor for children's well-being. Given that many studies were excluded for reasons that are not explicit, BABCP suggest that the committee should review the excluded studies to check that studies on domestic violence were not omitted. BABCP also suggest that considering this significant omission from the literature review that the search strategy used to identify relevant data is examined carefully and, if the term 'domestic violence' and relevant synonyms were not included, that the search is re-run with this term included.	Thank you. Domestic violence as a risk factor was not excluded and data are presented on child maltreatment, sexual, physical and emotional abuse and conflict between parents. The initial draft of the search strategy for the risk factors elements included a long list of specified risk factors, including domestic violence. However it was felt that however long the list was, it would always exclude some issues which could be considered a risk factor. The search strategy was further developed to take a broad, overarching view of the literature and included terms for risk, risk factors, vulnerable children etc. Any specific factor that would lead to a child being seen as at risk, for example domestic violence, would be covered by this. Specific named interventions that are delivered in schools to reach children impacted by domestic violence may also have been found in the searches for other evidence reviews and would already have been considered for inclusion.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence review D	33	10-14	ACES are not an individual characteristic of the child or young person. ACES reflect adverse environments that the child experiences and is raised in – thus ACES should be re-classified to reflect either family, or wider environment factors.	Thank you. ACEs can be individual or broader, the decision to include them in the individual table was a pragmatic one and has no impact on any analysis since they were not included in any meta-analysis. The decision reflects tha fact that for many children and young people there are 'clusters' of ACEs in individual children or young people.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review D	34	5-6	BABCP welcome the committee's expression of surprise about potential risk factors that were omitted from the evidence review. BABCP suggest that this observation raises concerns about the adequacy of the search strategy used to identify relevant evidence. BABCP suggests that the committee review and revise the search strategy so that a wider range of potential risk factors are included.	Thank you. Through development of the search strategy it was agreed that creating a full list of all possible risk factors, along with all potential related terms for each, was not feasible. The strategy was developed instead to take an overarching view of the concept of risk within the context of social & emotional wellbeing. The committee were offered the opportunity to view and have input into the strategy before it was run and were comfortable with this approach.
British Association of Behavioural and	Evidence review D	47 48	45-47 1	BABCP note the absence of domestic violence in this list and strongly suggests that it is included. This list also suggests potential shortcomings in the literature search strategy and therefore BABCP suggests that the committee revise the search strategy to include these	The search took a broad overarching approach using concept for risk, risk factors etc rather than listing specific risk factors. The search results did return several hundred articles with terms relating to family violence, partner violence, violence exposure, child abuse, family abuse and other similar concepts

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Cognitive Psychotherapies				terms and their synonyms, and then re-run the literature search.	in the titles. This demonstrates domestic abuse was not excluded by the search strategy however there are a number of reasons why the articles were not subsequently considered appropriate for inclusion, for example that they do not relate to a school-based intervention.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review D	49	21-23	BABCP agree that it is difficult for parents and teachers to identify internalising difficulties in children and young people and note that there is substantial evidence that this is the case. BABCP welcomes the recommendation that research is required in this area.	Thank you for your support.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review D	49	51-53	BABCP is delighted to see this reference to the role of school mental health support teams and educational mental health practitioners (EMHPSs). BABCP suggest that the role of these new teams and clinicians is inserted throughout the documents (evidence reviews and guidance) and that their role in supporting whole school approaches, universal approaches and indicated approaches is recognised.	Thank you. The committee decided not to make direct reference to Educational Well-Being Practitioners as a resource. They agreed they were just one of several different services and occupations that might be involved in CYP's social, emotional and mental wellbeing and did not want to single them out at this time. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation about compiling a directory of the local offer directory and keeping it up to date (recommendation 1.1.20).
British Association of	Evidence	50	4-6	BABCP would like the committee to be aware of the funded training for School Mental Health Leads that will	Thank you for this information.

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Behavioural and Cognitive Psychotherapies	review D			support the development of their skills in identifying children and young people who are at risk	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review D	50	9-10	BABCP is very pleased to see the committee reference the important role of sleep in predicting mental health difficulties and well-being in children and young people. There is extensive high-quality evidence on this relationship and BABCP were surprised not to find this evidence in the literature review tables. For example, this study shows that sleep problems in adolescents predicted increased symptoms of depression and anxiety. Orchard, F., Gregory, A. M., Gradisar, M., & Reynolds, S. (2020). Self-reported sleep patterns and quality amongst adolescents: cross-sectional and prospective associations with anxiety and depression. *Journal of Child Psychology and Psychiatry*, *61*(10), 1126-1137. BABCP suggests that this is another area where the literature search failed to find highly relevant and high-quality evidence and thus another reason to review and revise the search criteria.	Thank you. The search strategy did not specifically list sleep as a named risk factor however as with domestic violence the concept was not excluded. The search results identified a number of papers relating to the impact of sleep on children and adolescents, demonstrating that the strategy was able to identify papers on this topic. Regarding the publication, anxiety and depression diagnoses do not appear to be measured in CYP in education and therefore this study would be excluded from the evidence review. The decision to limit interventions to those which can be delivered in schools was made because the guideline is aimed at schools and the staff working in them.

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				BABCP agree that teachers are ill placed to observe children's sleep habits or problems. However, this is an area of low stigma in which children and young people can self-report easily. There are also a range of low intensity interventions for sleep problems in children and young people that could be offered to young people who self-identify with sleep problems. This is thus a prime area of intervention, and one which was overlooked in the evidence reviews conducted for this guideline. BABCP suggests that limiting the evidence reviews to interventions that have previously been delivered in schools and colleges has been an unhelpful decision given the changing provision of mental health services for children and adolescents, especially the introduction of School Mental Health Support teams.	
British Association of Behavioural and Cognitive	Evidence review D	50	30-31	BABCP welcome the committee's recognition of the EMHPs role and School Mental Health teams. BABCP suggest that the impact of these teams across England, during the lifetime of this guideline is acknowledged and integrated into the guidelines rather than being hidden in the evidence review	Thank you. The committee decided not to make direct reference to Educational Well-Being Practitioners as a resource. They agreed they were just one of several different services and occupations that might be involved in CYP's social, emotional and mental wellbeing and did not want single them out at this time. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new

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Psychotherapies					recommendation about compiling a directory of the local offer directory and keeping it up to date (recommendation 1.1.20).
British Association of Behavioural and Cognitive Psychotherapies	Evidence review D	50	33 and 46	BABCP welcome the inclusion of Appendix L outlining the role and testimony of experts, which was previously missing and should be routinely included in all evidence reviews. BABCP remains extremely concerned that, rather than referencing the published peer reviewed evidence, the committee relied on the testimony of selected experts. This raises multiple opportunities for unconscious bias to influence the committee's deliberations and conclusions and thus is a major threat to the validity of the guidelines that have been developed. BABCP suggest that NICE consider their own guidance on the recruitment and use of 'experts' and the status given to their testimony relative to peer reviewed research evidence.	Thank you. We note your concerns that the expert testimony is difficult to find and have removed all of the expert witness statements from individual reviews and compiled them into a single document. We hope that this makes them easier to find. NICEs process for the use of expert testimony is regularly reviewed as part of ongoing methodological development. Full details of NICEs methods and process for guideline production can be found in Developing NICE guidelines: the manual.
British Association of Behavioural and Cognitiv	Evidence review E			Unfortunately, BABCP did not have sufficient time to review this document. However, BABCP suggest that qualitative studies are not designed to provide generalisable data and are not suitable as a method to identify potential risk or protective factors. Qualitative research may identify participants' beliefs, attitudes,	Thank you. Evidence review E aimed to identify barriers and facilitators to implementing assessment tools designed to identify social and emotional difficulties for children and young people and identifying factors associated with poor social, emotional and mental wellbeing. Evidence identified in this review was intended to be used in conjunction with evidence from reviews D and F.

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e Psychotherapies				understanding or experience of potential risk and protective factors but these data are not appropriate to make broader interpretations about causal relationships between variables.	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review F			Unfortunately, BABCP did not have sufficient time to review this document in any detail. BABCP were surprised that the evidence review identified only one relevant study and suggests that this may indicate problems with the search strategy used and how it was conducted. Multiple studies have assessed the validity and sensitivity of screening tools in child and adolescent mental health and related to mental well-being and BABCP cannot understand why these were not identified in the search. BABCP suggest that the committee provide an explanation for this limited literature search and review the search strategy that was used so that the guidelines are able to provide evidence-based recommendations for measures that schools and School Mental Health Teams can use. BABCP also note that the committee chose to exclude studies for a variety of reasons that may not have been	Thank you. The search strategy used for this evidence review was an overarching search for risk factors that covered multiple reviews. It does not specifically search for screening tools but looks instead at the impact of risk overall. As with specific named risk factors the concept of screening tools was not excluded from the search and there were records in the search results that included phrases such as screening tools, demonstrating that such papers were able to be found by the strategy. The committee agreed that a sensible filter for inclusion into this review was to determine the validation status of tools by their inclusion on the SPECTRUM database, which they agreed was one of the most comprehensive databases of tools in the UK. The committee were interested in tools to assess children who had been identified as being at risk of poor social, emotional and mental wellbeing. This means that studies conducted in unselected populations (screening tools) would not have been a useful addition to this review.

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				helpful. For example, studies that recruited an unselected population and were conducted outside the UK were all excluded. We were not able to identify any rationale for this decision. Screening an unselected population e.g., in classrooms is a routine method of identifying children and young people who may be at risk of developing future problems. Studies conducted in many other countries have findings that can easily be generalisable to the UK. BABCP does not agree that UK children and adolescents would be fundamentally different from children and adolescents in e.g., Australia, USA, Canada. BABCP is of the view that screening instruments developed in those countries are very useful in the UK (and many are widely used in community and clinical settings). The decision to exclude non-UK studies is also at odds with other literature searches in this guideline development which included non-UK studies.	

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				BABCP suggests that studies that recruited an unselected population and those conducted outside the UK could provide very useful evidence to inform these guidelines. The exclusion of studies that were published before 2007 is questionable and some of these studies may have been extremely relevant and potentially useful. BABCP suggest that reviewing the psychometric qualities of measures to identify social, emotional, and mental well-being needs for children and young people may not have been within the expertise of committee. BABCP find it hard to understand why the committee chose not to invite experts to help develop the literature search and appraise the literature, and why experts were not consulted when the results of the literature search were known. In BABCP's view this would have helped the committee and its advisors to develop a search strategy that was better suited to identifying literature in this area of practice.	

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British Association of Behavioural and Cognitive Psychotherapies	Evidence review F	Page 51	Appendix J	Some references in Appendix J have the notation 'Can't confirm if the tool is UK validated'. BABCP suggest that this indicates lack of attention to detail. BABCP looked further and discovered that some of these measures are UK validated. For example, the reference, Reardon, Spence, Hess, Jorden et al., (2018) has a UK first author Tessa Reardon, (PhD supervised by Professor Cathy Creswell, University of Oxford and one of the invited experts), and was conducted at the University of Reading, Berkshire UK. Participants were recruited in Berkshire. This was therefore a UK validated measure and has been incorrectly excluded from this review. BABCP therefore request that this list of studies is examined with greater care so that potentially useful measures are identified.	Thank you. As detailed in the protocol, validation status was determined by examining the SPECTRUM database. The tool featured in Reardon 2018 (Spence Children's Anxiety Scale) was not found on the SPECTRUM database, hence the reason for exclusion was 'Can't confirm if the tool is UK validated'.
British Association of Behavioural and Cognitiv	Evidence review G	Page 16-20	Summary Table	BABCP could not understand the rationale for grouping studies in this table only based on their delivery by school staff or external specialists. BABCP suggests that the effectiveness of targeted	Thank you. The committee agreed that one of the key drivers for selecting targeted interventions was whether they could be delivered as part of the school offer or whether external specialists need to be involved. We agree that the data could have been split by intervention, but this would have made any meta-analysis impossible and there is value to undertaking appropriate meta-analysis over and above the data in

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e Psychotherapies				interventions is also examined according to the theoretical basis and content of the interventions.	individual studies. Table 6 details the individual interventions, and their effects can be easily visualised in the forest plots in appendix E.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	Summary table Pages 34-36	Table	BABCP could not understand the rationale for grouping studies in this table only based on their delivery by school staff, external specialists, or unknown providers. BABCP suggests that the effectiveness of targeted interventions is also examined according to the theoretical basis and content of the interventions.	Thank you. The committee agreed that one of the key drivers for selecting targeted interventions was whether they could be delivered as part of the school offer or whether external specialists need to be involved. We agree that the data could have been split by intervention, but this would have made any meta-analysis impossible and there is value to undertaking appropriate meta-analysis over and above the data in individual studies. Table 6 details the individual interventions, and their effects can be easily visualised in the forest plots in appendix E.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	1.1.26	PICO 12	Study type: BABCP is surprised and concerned to see that non-randomised studies were included in this review and suggests that the committee explain their reason for including these studies, acknowledge the significant risk of bias that these studies introduce and describe how they will mitigate this risk.	Thank you. Study types included in the evidence reviews are decided in collaboration with the committee prior to conducting the systematic review. The committee discussed this and decided to include non-randomised studies to increase the size of the potential evidence base. Risk of bias of non-randomised studies is taken into account when determining the quality of evidence.
British Association of Behavioural and	Evidence review G	1.1.3 Page 7	2-5	BABCP welcome the priority given to reports from the child / young person when assessing the impact of interventions on their social, emotional, or mental well-being. Evidence suggests that parents and teachers do	Thank you for your support.

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Cognitive Psychotherapies				not observe or report internalising problems that are experienced and reported by children and young people	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	2.1.2 Page 26	PICO 14 4	Study type: BABCP is surprised and concerned to see that non-randomised studies were included in this review and suggests that the committee explain their reason for including these studies, acknowledge the significant risk of bias that these studies introduce, and describe how they will mitigate this risk.	Thank you. Study types included in the evidence reviews are decided in collaboration with the committee**.** No non-randomised studies were included in this part of the review which included 6 RCTs and 1 cluster RCT.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	2.1.3 Page 27	8-9	What does the committee mean by 'The most common timepoint for each outcome was used'? Most commonly answered, most commonly administered, or most commonly something else? BABCP suggests that the committee clarify the meaning of this sentence and indicates which timepoints were prioritised as outcomes. For example, many studies report outcomes at 3 months, 6 months, and 12 months. Which of these different timepoints would the committee give most weight to? How would studies with a short follow up e.g., 3 months be rated in terms of quality?	Thank you. The most commonly reported timepoint for each outcome was used. We have clarified this in the review.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	3.1.4 Page 40	14-15	BABCP is surprised that only 4 studies were included in this review and notes that 54 studies were excluded. BABCP suggests that to increase transparency the reasons for excluding those studies are noted.	Thank you. A list of excluded studies along with reasons for exclusion is included in appendix J. The most common reasons for excluding studies at full-text in evidence review G and H were not using usual education (treatment as usual) as a comparator and focussing on a universal intervention (rather than a targeted).
British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	4.1.4 Page 50	8	BABCP is surprised that only 3 studies were included in this review and notes that 55 studies were excluded. BABCP suggests that to increase transparency the reasons for excluding those studies are noted.	Thank you. A list of excluded studies along with reasons for exclusion is included in appendix J. The most common reasons for excluding studies at full-text in evidence review G and H were not using usual education (treatment as usual) as a comparator and focussing on a universal intervention (rather than a targeted).
British Association of Behavioural and Cognitive	Evidence review G	5.2.2 Page 56	37-38	BABCP is very concerned that the evidence review identified so few studies. The validity of conclusions is further weakened by the inclusion of non-randomised studies that are at high risk of bias. BABCP suggest that a revised literature search is	Thank you. The evidence was drawn from 20 studies. The size of the systematic review did not raise undue concern with the committee who were able to supplement the evidence base with their own expertise and experience. The inclusion of non-randomised studies is a common strategy when evidence is

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Psychotherapies				conducted, that RCTs are prioritised, and that experts in this area are consulted to ensure that appropriate inclusion and exclusion criteria are established, and comprehensive search terms developed.	thin. There would be fewer studies if the searches were limited to RCTs only. All NICE literature searches are constructed by information specialists and quality assured by senior members of the team to ensure they gather the correct literature.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	7	7-8	BABCP agree that teacher reported outcomes are the optimal way to assess behavioural (i.e., observable) outcomes but note that this is only relevant for behaviours that are exhibited in the classroom. Teachers may not be able to report on playground behaviours or covert behaviours (e.g., bullying) and alternative methods should be used to assess these.	Thank you. We agree this is the case, and for that reason include not only teacher reported outcomes but also child/young person reported outcomes and parent reported outcomes.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	7	18-19	BABCP note the large number of studies that were excluded and in the interests of transparency request that the committee provide a summary table outlining the reasons for excluding studies and the number of studies excluded for each reason.	Thank you. It is standard NICE practice to outline reasons for exclusion in the appendix of the evidence review (Appendix J). The most common reasons for excluding studies at full-text in evidence review G and H were not using usual education (treatment as usual) as a comparator and focussing on a universal intervention (rather than a targeted).
British Association of	Evidence	7	20-21	BABCP also note with surprise that of the 58 references included only 9 were relevant to primary education.	Thank you. The 58 references also include studies from evidence review H, which focuses on targeted mental health

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Behavioural and Cognitive Psychotherapies	review G			Could the committee please clarify if the other 49 references were targeted at secondary education	support. This is demonstrated in the PRISMA diagram in appendix C of this evidence review.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	7	22	BABCP is concerned that non-randomised trials are the majority of studies in this review. BABCP believes that this increases the chance of bias in the reporting of results. BABCP therefore suggest that the committee make it clear that the results of these non-randomised studies were given significantly less weight than the results of randomised studies.	Thank you. Study types included in the evidence reviews are decided in collaboration with the committee prior to conducting the systematic review. The committee discussed this and decided to include non-randomised studies to increase the size of the potential evidence base. Risk of bias of non-randomised studies is taken into account when determining the quality of evidence.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	27	11-15	BABCP welcome the priority given to reports from the child / young person when assessing the impact of interventions on their social, emotional, or mental well-being. Evidence suggests that parents and teachers do not observe or report internalising problems that are experienced and reported by children and young people	Thank you for your support.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	27	30-32	BABCP is extremely concerned to note that only 6 randomised trials were included in this evidence review.	Thank you. Fortunately within the context of the wider review and their own expertise and experience the committee were able to contextualise the evidence to make recommendations.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	27	16-17	BABCP agree that teacher reported outcomes are the optimal way to assess behavioural (i.e. observable) outcomes but note that this is only relevant for behaviours that are exhibited in the classroom. Teachers may not be able to report on playground behaviours or covert behaviours (e.g., bullying) and alternative methods should be used to assess these.	Thank you. We agree this is the case, and for that reason include not only teacher reported outcomes but also child/young person reported outcomes and parent reported outcomes.
British Association of Behavioural and Cognitive	Evidence review G	27	28-29	BABCP note the large number of studies that were excluded. BABCP suggests that in the interests of transparency that the committee provide a summary table outlining the reasons for excluding studies and the number of studies excluded for each reason.	Thank you. It is standard NICE practice to outline reasons for exclusion in the appendix of the evidence review (Appendix J). The most common reasons for excluding studies at full-text in evidence review G and H were not using usual education (treatment as usual) as a comparator and focussing on a universal intervention (rather than a targeted).

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Psychotherapies					
British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	56	40-41	BABCP agree that a follow-up duration of 3 months is not adequate to assess the effectiveness of an indicated intervention.	Thank you for your support.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review G	57	29-34	BABCP welcomes the committees' awareness of Mental Health Support Teams in schools.	Thank you for your support.
British Association of Behavioural and Cognitiv	Evidence review G	58	14-15	BABCP agree that follow up of 1 week is too short. BABCP suggest that follow data at 6 months and 12 months should be the minimum duration of interest.	Thank you. The committee took the length of follow up into account as described. If they had restricted their consideration to follow up of longer than 6 months then no studies would have been included in the review.

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e Psychotherapies					
British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	Summary table Pages 12-16	Table	BABCP could not understand the rationale for grouping studies in this table only based on their delivery by school staff, external specialists, or unknown providers. BABCP suggests that the effectiveness of targeted interventions is also examined according to the theoretical basis and content of the interventions.	Thank you. The committee agreed that one of the key drivers for selecting targeted interventions was whether they could be delivered as part of the school offer or whether external specialists need to be involved. We agree that the data could have been split by intervention, but this would have made any meta-analysis impossible and there is value to undertaking appropriate meta-analysis over and above the data in individual studies. Table 3 details the individual interventions, and their effects can be easily visualised in the forest plots in appendix E.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	Page 7	3-4	What does the committee mean by 'The most common timepoint for each outcome was used'? Most commonly answered, most commonly administered, or most commonly something else? BABCP suggests that the committee clarify the meaning of this sentence and indicate which timepoints were prioritised as outcomes. For example, many studies report outcomes at 3 months, 6 months, and/or 12 months. Which of these different timepoints would the committee give most weight to? How would studies with a short follow up e.g., 3 months be rated in terms of quality?	Thank you. This means the timepoint most commonly reported by the included studies for that outcome. We have clarified this in the review.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	2.1.3 Page 24	9-10	What does the committee mean by 'The most common timepoint for each outcome was used'? Most commonly answered, most commonly administered, or most commonly something else? BABCP suggests that the committee clarify the meaning of this sentence and indicates which timepoints were prioritised as outcomes. For example, many studies report outcomes at 3 months, 6 months, and 12 months. Which of these different timepoints would the committee give most weight to? How would studies with a short follow up e.g., 3 months be rated in terms of quality?	Thank you. This means the timepoint most commonly reported by the included studies for that outcome. We have clarified this in the review.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	2.1.5 Pages 40-45	Table	BABCP found these tables to be difficult to understand. What was the rationale for grouping studies together? and were alternative classifications considered – for example, interventions based on CBT compared to those based on other theories? Why did the analysis not consider a main meta-analysis with subsequent sub-group analyses? The tables suggest that these interventions are effective but offer little or no information about what the interventions are.	Thank you. The committee agreed that one of the key drivers for selecting targeted interventions was whether they could be delivered as part of the school offer or whether external specialists need to be involved. We agree that the data could have been split by intervention, but this would have made most meta-analysis impossible since few of the interventions were evaluated by more than 1 study. A summary of the interventions is given in table 6 and further detail is given in the evidence tables in appendix D The authors of the papers that reported the outcome are all listed in the summary of findings table, and this can be matched with table 6 to find the intervention. We agree this is

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				Interpretation of the data presented here is very problematic. For example, on page 40, what was the group intervention delivered by specialists? What was the individual intervention delivered by external specialists? BABCP suggest that consideration is given by the committee to describing and justifying the way in which these tables have been constructed. In addition, as the tables do not identify the types of interventions delivered, BABCP recommend that a different method of classifying studies together is used and that this should map onto distinct theoretical models or methods of practice.	cumbersome, but there is no way to include all of the information in a single table.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	2.1.4.4 6 Page 33-39	Table	BABCP notes that 17 different interventions are listed in Table 6. Fourteen are based on CBT principles BABCP suggests that classifying interventions according to their theoretical basis would help schools determine which interventions are more likely to be helpful	Thank you. The levels of heterogeneity, especially of outcomes, among the CBT informed studies would have precluded such an analysis being useful to the committee. The theoretical underpinnings of each intervention are reported in appendix D in the table row 'Rationale/theory/Goal'.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	3.1.4.3. Table 8 Pages 52-53	Table	BABCP note that of the 9 qualitative studies listed in this table the majority examined the acceptability of school counselling and only one focused on a CBT intervention and one on a behavioural intervention for depression. As the effectiveness studies reviewed in Table 6 were almost all CBT in orientation the results of these qualitative studies cannot be assumed to apply to the acceptability of CBT interventions. BABCP suggest that this limitation is noted in the committee's comments and interpretation.	Thank you. We have added this in the committee discussion section.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	5.1 Page 73	15-17	BABCP note that the statement below is not correct. *'The qualitative studies did not report any themes that specifically related to the acceptability of using these techniques or whether they were perceived to be effective'.* Lewis-Smith (2020), which is cited in the evidence review specifically discusses the acceptability of Brief Behavioural Activation for depression in schools with young people and presented explicit evidence from young people on this topic.	Thank you. We have clarified this in the review.

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British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	7	6-10	BABCP welcome the priority given to reports from the child / young person when assessing the impact of interventions on their social, emotional, or mental well-being. Evidence suggests that parents and teachers do not observe or report internalising problems that are experienced and reported by children and young people	Thank you for the support.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	7	27-30	BABCP note the large number of studies that were excluded and in the interests of transparency that the committee provide a summary table outlining the reasons for excluding studies and the number of studies excluded for each reason.	Thank you. It is standard NICE practice to outline reasons for exclusion in the appendix of the evidence review (Appendix J). The most common reasons for excluding studies at full-text in evidence reviews G and H were not using usual education (treatment as usual) as a comparator and focussing on a universal intervention (rather than a targeted).
British Association of Behavioural and Cognitive	Evidence review H	7	11-12	BABCP agree that teacher reported outcomes are the optimal way to assess behavioural (i.e., observable) outcomes but note that this is only relevant for behaviours that are exhibited in the classroom. Teachers may not be able to report on playground behaviours or covert behaviours (e.g., bullying) and alternative methods should be used to assess these.	Thank you. We agree this is the case, and for that reason include not only teacher reported outcomes but also child/young person reported outcomes and parent reported outcomes.

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Psychotherapies					
British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	7	31-32	BABCP were surprised to see that only 6 effectiveness studies in primary education had been included the evidence review and suggest that the committee might consider a research recommendation in this specific area.	Thank you. The committee discussed this but agreed that it was not a research priority since there were studies in this area.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	24	12-16	BABCP welcome the priority given to reports from the child / young person when assessing the impact of interventions on their social, emotional, or mental well-being. Evidence suggests that parents and teachers do not observe or report internalising problems that are experienced and reported by children and young people	Thank you for the support.
British Association of Behavioural and Cognitiv	Evidence review H	24	33-35	BABCP suggest that to increase transparency that reasons for excluding 189 references are summarised.	Thank you. It is standard NICE practice to outline reasons for exclusion in the appendix of the evidence review (Appendix J). The most common reasons for excluding studies at full-text in evidence reviews G and H were not using usual education (treatment as usual) as a comparator and focussing on a universal intervention (rather than a targeted).

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e Psychotherapies					
British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	24	17-18	BABCP agree that teacher reported outcomes are the optimal way to assess behavioural (i.e. observable) outcomes but note that this is only relevant for behaviours that are exhibited in the classroom. Teachers may not be able to report on playground behaviours or covert behaviours (e.g., bullying) and alternative methods should be used to assess these.	Thank you. We agree this is the case, and for that reason include not only teacher reported outcomes but also child/young person reported outcomes and parent reported outcomes.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	24	36	BABCP are very pleased that 24 studies were identified and included. BABCP also note that these are all RCTs or cRCTs.	Thank you for your support.
British Association of Behavioural and	Evidence review H	Page 74	13-14	Primary education BABCP agrees that the large majority of interventions followed a CBT based approach.	Thank you. The purpose of this section of the review is to explore the links between the qualitative and quantitative components of the review rather than to comment on the evidence.

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Cognitive Psychotherapies				BABCP suggest that, in the interests of clarity, committee should acknowledge that most evidence suggested that a CBT approach was effective. This will provide much clearer and more helpful guidance to schools and School Mental Health Teams.	
British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	Page 76	13-22	BABCP welcome the explicit acknowledgement of School Mental Health Teams and their role in providing indicated interventions such as those included in the evidence review.	Thank you for the support.
British Association of Behavioural and Cognitive Psychotherapies	Evidence review H	Page 76	3-4	Secondary education BABCP suggest that this sentence be amended to indicate that the vast majority of interventions that were included in the effectiveness review were CBT based. This is important information that will help schools choose effective interventions.	Thank you. The purpose of this section of the review is to explore the links between the qualitative and quantitative components of the review rather than to comment on the evidence.
British Associat	Evidence	Page 77	7-9	BABCP were surprised to note the following comment:	Thank you. Gee 2020 was captured by our searches but excluded as outcome data from systematic literature reviews were not included in evidence review H.

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ion of Behavioural and Cognitive Psychotherapies	review H			*The committee noted that there was a lack of evidence to compare the relative effectiveness of group vs. individual interventions.* Gee et al. (2020) compared individual and group intervention and found that whilst both were effective, there was a significantly larger effect for individual interventions (d = -.67) than for group interventions (d= -.31). This difference has obvious implications for acceptability of interventions to young people as well for costs, and it is therefore very important in practice. BABCP suggest that NICE re-examine the evidence obtained on this issue, including reviewing the search criteria they used to identify relevant studies.	
British Association of Behavioural and Cognitive	General			Thank you for inviting comments on this important guidance – we hope that BABCP's comments, suggestions, and requests are helpful and look forward to seeing revised guidelines in due course.	Thank you for your engagement with this guideline.

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Psychotherapies					
British Association of Behavioural and Cognitive Psychotherapies	General			This response has been prepared by BABCP – the British Association of Behavioural and Cognitive Psychotherapies. BABCP is the lead organisation for CBT in the UK and Ireland. BABCP promotes, improves, and upholds standards of CBT practice, supervision, and training. BABCP accredits CBT training programmes in the UK and Ireland and publishes Minimum Training Standards (i.e. a national curriculum) for training CBT therapists. BABCP is a multi-disciplinary professional organisation operating a highly respected voluntary register for accredited cognitive behavioural psychotherapists. We also operate a voluntary register for Psychological Well-being Practitioners (PWPs) and other low intensity clinicians including Educational Mental Health Practitioners (EMHPs). EMHPs are a newly created role of clinicians with specialist training in low intensity (i.e. brief) evidence based psychological interventions, who work in schools and colleges in England. Currently (Feb 2022) there are 400 School Mental Health Teams in England made up of	Thank you for responding to this consultation.

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				EMHPs and more senior clinicians who supervise EMHPs and manage the service. By 2024/25 School Mental Health Teams are expected to cover 47% of England. Members of BABCP work clinically with children, young people, and parents in a range of settings and conduct clinical research, including RCTs, related to child and adolescent well-being and mental health and psychological interventions. Many members of BABCP are international experts in child and adolescent mental health and at least one (Professor Cathy Creswell) provided expert advice to the committee. BABCP members and our service user representatives were invited to contribute to this response. BABCP is therefore very well placed to offer expert opinion on the quality and credibility of these guidelines.	
British Association of Behavioural and Cognitive Psychotherapies	General			BABCP welcome the publication of guidance on this topic particularly in light of current investment in child and adolescent mental health services in England. This investment includes recruitment, training, and deployment of Mental Health Support Teams in Schools. Given this new and growing body of mental health professionals working with, and in, schools and colleges	Thank you for this information

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				this is an important time to issue guidance that has the potential to inform practice for the next 5 to 10 years. Educational Mental Health Practitioners (EMHPs) work in Mental Health Support Teams and deliver brief (low intensity) evidence-based interventions, support a whole school approach, and offer universal interventions to children and young people in schools and colleges. The training of EMHPs (HEIs fees and salary) is funded by Health Education England. Qualified EMHPs are employed and funded by the NHS. Information about the EMHP role is available here https://www.healthcareers.nhs.uk/explore-roles/psychological-therapies/roles-psychological-therapies/education-mental-health-practitioner Here is the national curriculum for EMHPs https://www.hee.nhs.uk/sites/default/files/documents/EMHP%20training%20curriculum.pdf This national curriculum was developed collaboratively by experts in clinical psychology, child and adolescent mental health, education, and training. It highlights evidence-based and evidence-informed knowledge and	

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				skills related to working with children and young people, parents, teachers, and the wider school system and offering assessment, brief interventions, and consultation.	
British Association of Behavioural and Cognitive Psychotherapies	General			Our response to this guidance considers each document in turn, starting with the Evidence Reviews. We appreciate that the process of identifying, appraising, and integrating the evidence is challenging and complex especially in topics where there are large areas of uncertainty. We also note that the committee was made up of experts in some relevant fields, including public health, but lacked experts in child and adolescent mental health, psychometrics, and psychological interventions, all of which were highly relevant in the development of these guidelines. Many of our concerns about the guidance are based on a methodological critique of the Evidence Reviews. We also draw on peer reviewed research in places to provide contrasting (sometimes directly conflicting) evidence and we have aimed to cite only high-quality studies. BABCP members have contributed to some of the evidence reviewed by the committee and also to peer	Thank you. The formation of the committee was agreed during the scoping process for the guideline and involved the broadest range of relevant experts possible. Where the committee lacked the expertise to make judgments they invited expert testimony to plug those gaps. We have addressed your points as they are raised, but thank you for summarising them here.

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				reviewed and relevant evidence that the committee failed to consider. Across the different evidence reviews BABCP noted many concerns about the selection and appraisal of evidence and how this was interpreted by the panel. These are listed in relation to individual points in the Evidence Reviews and Guidance. Our major concerns include; 1. There is an over-reliance on 'expert' testimony and on the opinions of the committee. Expert testimony is not transparent and cannot be appraised, may reflect unconscious bias, and should not be given greater weight than peer reviewed evidence. 2. There were examples of bias in the committee's references to 'behavioural approaches' and a pervasive tendency for the committee to underplay or ignore the effectiveness of CBT approaches. 3. Evidence syntheses ignored different types of intervention and thus failed to examine or identify differences in effectiveness between them	

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				4. Some interventions were recommended where evidence was absent (regular rhythmic movement) or where the evidence suggested that the intervention was not effective (universal mindfulness). 5. The evidence reviews were based on unreasonably narrow and restrictive searches of the literature. Important areas of evidence were omitted and BABCP provided examples of several areas where high quality evidence exists but was excluded. 6. The committee's recommendations often did not reflect important recent developments in funding and training programmes for mental health staff working with children and young people in schools 7. The perspectives of children, young people and families were not apparent in the evidence reviews and there was no evidence that children and young people had been consulted or involved in the development of the guidelines. In addition to these concerns BABCP also considers that the overall content of the guidance lacks specificity and	

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				that therefore it will not be possible for the guidance to be implemented in a way that is consistent with the evidence.	
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.1.105	18-19	BABCP agree that protected time for supervision and CPD is extremely important. This recommendation would be strengthened if the committee made more explicit recommendations about the frequency of supervision and the number of hours of CPD that would be expected for staff.	Thank you. The committee discussed this but decided not to make explicit recommendations about the frequency of supervision and the number of hours of CPD. They felt that this would be too specific considering that school processes will vary widely across the country.
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.1.115	20	BABCP also support the idea of peer supervision for professionals. Peer supervision can have several different functions and BABCP suggest that this recommendation would be more useful if the committee described the intended purpose of peer supervision. BABCP also suggest that the frequency and style of peer supervision could be outlined (e.g. how many staff, how often, how managed etc?)	Thank you. The committee have changed the wording of this recommendation to "peer support or supervision". They decided not to make explicit recommendations about the frequency of supervision. They felt that this would be too specific considering that school processes will vary widely across the country.
British Association of	Guideline	1.1.14	3-4	BABCP tentatively support the recommendation that schools adopt a 'whole school approach' to support well-being in education.	Thank you. The published evidence is one part of the evidence that committees take into account when they are making recommendations. The role of an expert committee is to layer their experience and expertise, their knowledge of practice and

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Behavioural and Cognitive Psychotherapies				However, we are aware that this recommendation is not well supported by the evidence (see notes 10, 11, 22, 23, 34 above). Few studies were identified, appraisal suggests that they were of low quality, and for almost every study, on almost every outcome, there was no significant difference between the intervention group and the control group. BABCP suggest that these striking methodological concerns and the limited availability of data are acknowledged in the guidance – readers of NICE guidance will expect that recommendations are based on evidence of reasonable quality and quantity. The current recommendation reflects the opinions of the committee, and perhaps professional consensus and general principles, but is not based on valid research data. Because the evidence relating to the effectiveness of a 'whole school approach' is limited and of low quality BABCP does not agree that this should be a strong recommendation. For these reasons BABCP suggest that this is, at best, a weak and qualified recommendation.	the policy context and the views of expert stakeholders and witnesses to create recommendations. In addition to evidence from the published literature, the committee were aware of the policy drivers supporting implementation of whole school approaches, and the promising evidence from practice that these are a good thing to do. NICE has a specific layout for guidelines which are web-based. Whole school approach is in the terms used in the guideline section and will be hyperlinked from the recommendations when it occurs.

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				In addition, because this term is not well understood BABCP suggest that the definition of a 'whole school approach' (page 14, lines 14-22) is included in the main text of the guidance. This will highlight that taking a 'whole school approach' involves the entire system (child, classroom, staff, school, family, community etc) in and around the provision of primary and secondary education.	
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.1.146	2-3	BABCP agree that parents and carers are an essential part of the 'whole school approach' and agree that they should be encouraged to help design and implement the 'whole school approach'. BABCP also note that this recommendation is not based on the evidence review as parents and carers were involved in only one of the 9 studies that were included in the evidence review.	Thank you for your support. The committee develop recommendations based on the evidence base, expert testimony and their own experience. The reasoning for making recommendations can be found in the rationale and impact section of the guideline.
British Association of Behavioural and Cognitiv	Guideline	1.1.156	4-7	BABCP welcome the recommendation that children and young people are involved in the 'whole school approach'. However, it is important to acknowledge that this is not based on evidence of effectiveness but reflects the ideological model of the 'whole school	Thank you. The committee agreed that student engagement and involvement is an important part of the whole school approach and recognised that being involved in the design and implementation was important for all age groups so did not consider it necessary to specify this for secondary school students. They acknowledged that the phrasing of 'tell students

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e Psychotherapies				approach' and the value based on student engagement and involvement. BABCP suggest that the recommendation could be strengthened for secondary school students, who could be involved in the 'design and implementation' of the whole school approach. BABCP also note that to 'tell' students about decisions is not compatible with the whole school approach, in which students should be involved collaboratively.	about decisions…' was not compatible with a relational or child centred approach so amended the wording to "communicate with…".
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.1.166	9-12	BABCP agree that there should be a lead in each school for the 'whole school approach'. BABCP suggests that this usually should be the Designated School Mental Health (DSMH) Lead, which every school should have in place by 2025 and for which funded training is available https://www.headteacher-update.com/best-practice-article/designated-mental-health-leads-what-should-this-new-role-look-like-wellbeing-pastoral-pandemic/237076/ https://www.gov.uk/guidance/senior-mental-health-lead-training	Thank you. The committee were mindful of the need for caution over using specific terms which are current now but later may not be, so did not want to specify that the lead person should be the DSMH lead in the recommendation. However, they agreed to reference the DSMH lead in the rationale and impact section, which states "[The committee] agreed that leadership was key was also key to embedding this approach and that the leadership needed to come from a senior person. They discussed that this might fit well with the role of the designated school mental health lead, but since this is a developing role they agreed it would be premature to specify this".

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				https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/995681/Learning_outcomes_for_senior_mental_health_leads_in_schools_and_colleges.pdf BABCP suggests that this recommendation could be strengthened by referencing the role of the DSMH) and their training in the guidance. Educational Mental Health Practitioners also have a key role in helping to implement the whole school approach and BABCP suggest that specific reference to this group of clinicians should also be made in this recommendation. https://www.prospects.ac.uk/job-profiles/education-mental-health-practitioner	
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.1.186	18-20	BABCP agree that a stepped care model 'step up- step down' is likely to be appropriate as an approach. However, the evidence review did not provide any support for this model and it would be more transparent to make the lack of evidence clear.	Thank you for your support. The committee develop recommendations based on the evidence base, expert testimony and their own experience. The reasoning for making recommendations can be found in the rationale and impact section of the guideline.

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British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.1.24	5-6	BABCP note with concern the recommendation to use 'Relational' Whole School Approaches'. In reviewing the evidence underpinning this recommendation (Evidence Review A), and as noted in points 9 and 21 above, no evidence was presented to support this recommendation. Only 9 studies were reviewed and none of them described relational approaches or evaluated a 'whole school approach' It therefore seems that this recommendation is made purely based on the opinion of the committee and a single 'expert' who was consulted. BABCP suggest therefore that this recommendation is removed on the basis that it is not evidence based and cannot therefore be justified. If the committee hold a clear view of what a 'relational' approach is and consider that there is evidence that supports the effectiveness of this type of work BABCP suggest that this is described and made explicit so that the reasoning used by the committee is transparent.	Thank you. The published evidence is one part of the evidence that committees take into account when they are making recommendations. The role of an expert committee is to layer their experience and expertise, their knowledge of practice and the policy context and the views of expert stakeholders and witnesses to create recommendations. In addition to evidence from the published literature, the committee were aware of the policy drivers supporting implementation of whole school approaches, and the promising evidence from practice that these are a good thing to do.
British Association of Behavio	Guideline	1.2.17	8	BABCP notes the recommendations made in this section of the guidelines are very limited. We carefully scrutinised Evidence Review B and noted that interventions to improve sleep, diet and physical activity	Thank you. The evidence review aimed to identify universal curriculum content interventions that aim to improve social, emotional and mental wellbeing. Interventions that aim to improve sleep, diet and physical activity were therefore out of

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ural and Cognitive Psychotherapies				were absent. This is unfortunate as there is evidence that targeting each of these areas improves the target itself and has other positive effects on well-being. Andermo, S., Hallgren, M., Jonsson, S., Petersen, S., Friberg, M., Romqvist, A., ... & Elinder, L. S. (2020). School-related physical activity interventions and mental health among children: a systematic review and meta-analysis. *Sports medicine-open*, *6*(1), 1-27. BABCP recommends that the search strategy used in Evidence Review B is reviewed and revised to include studies looking at these targets. BABCP suggests that this would result in additional universal interventions being identified as effective (and cost effective)	scope. The review protocols that detail the inclusion and exclusion criteria for each review can be found in appendix A of each review document.
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.410	10	Targeted support: BABCP have many concerns about the appraisal of the evidence reviewed in this part of the guidance. Evidence review G excluded many studies but the reasons for these exclusions were not clear. As mentioned previously only 6 randomised trials were included in the evidence review and this is significantly fewer than recently published meta-analyses. For example, Gee et al., 2020 identified 45 relevant RCTs of school based targeted interventions for anxiety and depression.	Thank you. Each study that was examined at full text is either included or is listed in appendix J of the evidence review along with a reason for its exclusion. Risk of bias is taken into account for all studies that are included in a review and GRADE is used to determine the confidence we can have in any finding or outcome. We have updated the review to acknowledge that most of the interventions are based on cognitive behavioural approaches.

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				Gee, B., Reynolds, S., Carroll, B., Orchard, F., Clarke, T., Martin, D., ... & Pass, L. (2020). Practitioner Review: Effectiveness of indicated school-based interventions for adolescent depression and anxiety–a meta-analytic review. *Journal of Child Psychology and Psychiatry*, *61*(7), 739-756 BABCP were also very surprised and concerned to see that non-randomised studies were included because this leads to a high risk of bias. The majority of targeted interventions in schools are based on cognitive behavioural approaches. This is not acknowledged in the guidance. Many relevant studies were not included in the evidence review, which was poorly designed and limited in scope. The evidence review classified studies along random criteria that did not reflect the content or type of intervention and thus failed to identify the type of interventions that are likely to help children and young people with mental health symptoms, distress, or low levels of well-being. BABCP suggests that to understand what types of targeted intervention are effective in schools all the	The evidence review was conducted using standard NICE methods, which are almost identical to methods used by other international systematic reviewing organisations like Cochrane. The included references in Gee 2020 were checked against our own inclusion criteria for evidence reviews G and H. The majority of studies were captured by our searches and either included in the evidence reviews or excluded based on the PICOS criteria. Any studies that were not captured by our searches did not meet the inclusion criteria for these reviews. The difference in number of studies included in the cited reference is likely due to differences in inclusion and exclusion criteria and date ranges of search strategies. The review protocols that detail the inclusion and exclusion criteria for each review can be found in appendix A of each review document.

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				relevant studies need first to be identified, and then to be described and classified in meaningful ways that can inform practice.	
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.1.34	9-10	The reference to 'relational approaches' is not supported by the evidence presented in Evidence Review A (see points 9 and 21 above) and therefore should not be included in the guidance. BABCP suggest an alternative form of words "Review policies and procedures regularly to make sure they are consistent with the culture and ethics of the school, reinforce positive relationships and behaviours, the value of each individual, and the importance of psychological safety."	Thank you. The published evidence is one part of the evidence that committees take into account when they are making recommendations. The role of an expert committee is to layer their experience and expertise, their knowledge of practice and the policy context and the views of expert stakeholders and witnesses to create recommendations. In addition to evidence from the published literature, the committee were aware of the policy drivers supporting implementation of whole school approaches, and the promising evidence from practice that these are a good thing to do. The committee discussed the wording of recommendation 1.1.3 and decided on the following: "Review policies and procedures regularly to make sure that they promote social, emotional and mental wellbeing positively and consistently. This should include making sure that they are consistent with relational approaches to social, emotional and mental wellbeing".

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British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.1.4	12-13	The statement refers to 'the value of trauma-informed' approaches. What does the committee mean by this? What are trauma informed approaches? BABCP notes that no studies that evaluated a 'trauma-informed' approach were included in the evidence review and the committee's interpretation of the evidence did not refer to additional evidence, or define 'trauma-informed' approaches. It appears that this recommendation is based on the views of the committee but not on any evidence. If so, this is insufficient to form the basis of a recommendation. BABCP suggests that the use of this phrase, without explanation or specificity is unhelpful. It does not help identify specific actions that schools or individual staff can or should take. BABCP recommend that this phrase is justified by the evidence and defined, or that it is removed.	Thank you. Although the committee believed the term to be widely understood in education they added a definition to the terms used in this guideline section.

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British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.3.2 Box 19	6	BABCP agrees that these are important risk factors and that schools may need to be aware of them. BABCP also had some questions about the selection of these risk factors, related to their scrutiny of Evidence Review D. BABCP had a number of methodological criticisms of Review D, particularly the use of cross-sectional data to infer causal relationships and the confounding of 'risks' and 'outcomes'. The problem of confounding is repeated in Box 1. Behavioural difficulties, low mood, self-harm/suicidal ideation, and an inability to concentrate or pay attention are symptoms of child and adolescent mental health problems (conduct problems and depression) and should therefore not be classified as 'risk' factors. This kind of muddled thinking is pervasive in the evidence review and committee's interpretation of the research evidence. BABCP suggests that the committee consider a more nuanced classification of variables currently all labelled as 'risk factors' and that this discriminates between • Adverse experiences and events that put children at risk;	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline. Prospective and retrospective cohort studies were the preferred study type for this evidence review. Cross-sectional studies were used to supplement the evidence base where there was an absence of data for specific risk factors highlighted by the committee. The search results did return several hundred articles with terms relating to family violence, partner violence, violence exposure, child abuse, family abuse and other similar concepts in the titles. This demonstrates domestic abuse was not excluded by the search strategy however there are a number of reasons why the articles were not subsequently considered appropriate for inclusion, for example that they do not relate to a school-based intervention.

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				• genetics, developmental, or temperamental factors that are associated with vulnerability / risk; and • early signs or symptoms of distress and mental health problems. These are not equivalent or similar factors, and it is not helpful to suggest that they are similar or should be considered equivalent. BABCP suggests that Evidence Review D is revised and that the results of a more limited number of high-quality cohort and longitudinal studies are used to inform this recommendation. The committee might benefit from consulting subject experts in revising the literature search and in appraising and interpreting the evidence. BABCP members also noted that the list of risks excluded important factors including domestic violence and suggest that this may indicate an important limitation of the search strategy used in Evidence Review D.	

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British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.4.1 10	10-11	BABCP agree that having clear guidance on how to identify children and young people for targeted support would be helpful. BABCP suggests that the committee should provide that guidance. As highlighted above (point 160) there are a range of well validated measurement tools that are suitable for use in schools to assess wellbeing in children and young people. BABCP refers again to the need to conduct a comprehensive literature search, to establish relevant and appropriate criteria to include and exclude studies, and to seek expert advice where this is not available amongst the committee members. It is extremely concerning that this incomplete guidance has been drafted and BABCP strongly recommends that it is revised following a new literature search and appraisal.	Thank you. A comprehensive litwerature search was undertaken for this review. Details of the literature search can be found in appendix B of the relevant review document. The committee agreed that different schools had different approaches to supporting children and young people and therefore it would be unhelpful to be too specific in the recommendation. They agreed that schools should be able to determine their own criteria and select the tools that best matched what they were trying to achieve and their school community.
British Association of Behaviou	Guideline	1.4.2 10	16-17	BABCP endorse the recommendation to use trained and experienced practitioners to deliver targeted interventions and this position is based on an	Thank you. The committee decided not to make direct reference to mental health support teams as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and

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ral and Cognitive Psychoth erapies				independent review of the literature (Gee et al.., 2020) that showed that interventions delivered by school staff were not as effective as those delivered by external 'experts'. The qualitative review conducted for these guidelines also suggest that external staff are preferred by young people. BABCP therefore suggest that the recommendation could be expanded to refer to Mental Health Support Teams and Educational Mental Health Practitioners, who are trained to deliver targeted, evidence based psychological interventions in schools and colleges. In line with the evidence, the interventions they deliver are primarily based on cognitive and behavioural principles. The committee did not categories targeted interventions by the mode or techniques used although the data presented by the Evidence review suggests that cognitive and behavioural interventions were helpful. BABCP suggests that the recommendation should acknowledge that the effectiveness of CBT based interventions is supported by the evidence review. This will mean that children and young people receive the most effective interventions, and importantly will help	mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. Mental health support teams are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline. The committee reconsidered the evidence on mindfulness-based approaches and cognitive behavioural approaches and discussed the evidence at length. They agreed that there was evidence to support cognitive behavioural approaches and modified recommendation 1.2.6 to account for this. They also reworded the guideline to remove negative references to behavioural approaches. The committee's intention had been to communicate that punitive behavioural approaches alone were not helpful in the context of whole-school approaches, but this had not come across in the guideline in the way they intended.

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				prevent them receiving ineffective, or harmful interventions.	
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.1.5 4	14-15	BABCP agree that regular monitoring of any approach is generally to be welcomed. However, this recommendation alone is not sufficiently specific to be useful. How should schools monitor 'the whole school' approach. • Does this refer to assessing the fidelity with which the intervention is being delivered across all parts of the school system? That seems like a good idea. • Does it refer to assessing attitudes of teachers, students, parents, and other relevant people towards the whole school approach? Similarly, BABCP agree that evaluation is an excellent idea and that schools should be encouraged to do this. But how should schools evaluate the whole school approach?	Thank you. The committee decided not to provide examples of how to monitor and evaluate whole-school approaches. They were mindful that different schools will have their own systems and there is no one correct way to conduct monitoring and evaluation. The committee also decided to amend recommendation 1.1.5 to clarify that schools / colleges should consider monitoring and evaluating the impact and effectiveness of the whole-school approaches.

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				• Should schools assess the impact of the whole school approach on specific behaviours e.g. bullying, absence from school, behaviour in lessons and in the playground? • Or does the committee think that the approach should be evaluated in relation to measures of emotional, social and mental well-being? • If so, what measures should schools use?	
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.3.39	8-10	BABCP agrees that monitoring children who may have experienced risk and adverse events is important but feel that this guidance is too limited. Where children or young people are exhibiting symptoms of distress and/or mental health problems, including self-harm or suicidal ideation, BABCP strongly suggest that school staff be given clear recommendations about how to support the child or young person, simple methods that may help reduce the distress or symptoms, and clear advice on when and where to get additional help. School staff also need guidance on how and when to involve parents and carers and when and how to invoke safeguarding procedures.	Thank you. The committee agreed that there are many validated measures that might be useful in different contexts so they recommended that schools select tools based on that context. Repositories of validated tools exist online, for example the SPECTRUM database. If a child or young person is identified as having mental ill health rather than poor mental wellbeing then referral pathways will already be in place in all schools. The committee recommended that these are kept up to date (recommendation 1.1.20). The committee chose not to cross reference to other guidelines because in general they were not relevant to the school setting, but instead were aimed at clinical services.

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				The committee should consider cross-referencing the NICE guidance on self-harm, depression, and other relevant guidance. BABCP agree that brief and valid assessment measures may help school staff assess children or young people's well-being. BABCP is extremely concerned that the committee did not identify any validated measures of mental, emotional, or social well-being and finds this very disappointing and unhelpful. BABCP disagrees with the committee's conclusions and understanding of the evidence base and is disappointed that the committee members failed to take expert advice on this topic. There are a range of well-validated measures that schools could find useful including the very well validated and widely used Strengths and Difficulties Questionnaire (SDQ), which has many versions in multiple languages and is therefore very well suited for use in schools.	

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				Evidence Review F includes a systematic search of the literature but failed to identify relevant studies and validated measures. BABCP found some of the judgements made to exclude measures hard to understand and found no justification for the decisions taken. Some excluded studies were excluded incorrectly. BABCP has no confidence in the validity of this recommendation. BABCP request that this part of the guidance is revised and rewritten and that subject experts are approached to help develop the search strategy and appraise the evidence. There are well validated measures that schools could use to assess general well-being, anxiety, depression, behaviour problems, pro-social behaviours.	
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.4.310	18	BABCP agrees that informing parents about targeted support is important. BABCP reminds the committee that it is legally necessary to obtain informed consent from parents /carers before delivering any targeted intervention to children and young people who do not have capacity to give consent.	Thank you. The committee decided to add to recommendation 1.4.3 that parent's and carer's agreement should be sought when offering support to children and young people. The committee also noted that obtaining informed consent when offering interventions is standard practice and therefore does not need to be explicitly stated in the guideline.

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				Therefore, BABCP strongly suggests that this recommendation is amended to incorporate the concepts and requirements to obtain informed consent and assess capacity	
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.1.64	17	BABCP agree that schools should engage the wider community and external groups in their 'whole school approach'. BABCP suggests that this recommendation should explicitly refer to School Mental Health Teams who will be rolled out in introduced into English schools and colleges during the lifetime of this guidance. Educational Mental Health Practitioners, who form the major part of the School Mental Health Support Teams, have a responsibility to support their schools in a 'whole school approach'. BABCP suggest that these staff are specifically referred to in this recommendation. https://www.prospects.ac.uk/job-profiles/education-mental-health-practitioner	Thank you. The committee discussed this but decided not to make direct reference to Mental Health Support Teams as a resource. They noted that these services were not yet in place in all areas and would not be until 2025 at the earliest. Until more is known about the effectiveness of MHST, the committee agreed they were just one of several different services and occupations that might be involved in CYP's social, emotional and mental wellbeing and did not want single them out at this time. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation about compiling a directory of the local offer directory and keeping it up to date (recommendation 1.1.20).

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				https://www.healthcareers.nhs.uk/explore-roles/psychological-therapies/roles-psychological-therapies/education-mental-health-practitioner	
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.4.4 11	1	BABCP agree that it is necessary to involve children and young people in decisions about any interventions that are offered to them. BABCP also remind the committee that it is essential to obtain informed consent for any treatment or intervention and that children and young people must be given the opportunity to refuse treatments or interventions. BABCP suggest that the guidance provides appropriate guidance on informed consent and assent. In addition to the legal requirement to obtain informed consent BABCP reminds the committee of the ethical duties and codes of conduct that professionals who deliver targeted interventions must adhere to. It would be extremely helpful to acknowledge these in the guidelines so that school staff are aware of their obligations and responsibilities, as well as those of other professionals.	Thank you. The committee decided to add to recommendation 1.4.4 that children and young people's agreement should be sought when offering them support. The committee also noted that obtaining informed consent when offering interventions is standard practice and therefore does not need to be explicitly stated in the guideline.

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British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.2.68	3-5	BABCP is very concerned to see that mindfulness has been included here as a universal intervention. We carefully examined the evidence presented for Mindfulness interventions in Evidence Review B This evidence is very limited and very weak. Data from a maximum of 6 studies and 1587 participants provided data related to effectiveness. These participants included primary and secondary pupils, boys and girls. BABCP suggest that the analysis presented is underpowered to examine any sub-group effects (e.g., effects for boys or girls). BABCP also note with interest that of the 16 separate outcomes presented, confidence intervals for only 1 outcome did not cross zero. Therefore, based on this analysis, mindfulness as a universal intervention has no effect on children's social, emotional, or mental well-being, or on the behavioural outcomes presented. These data are also shown on page 796; for primary schools the evidence is more favourable than for secondary schools – but both forest plots show that the confidence intervals cross zero.	Thank you. The committee reconsidered the evidence on mindfulness-based approaches and cognitive behavioural approaches and discussed the evidence at length. They agreed that there was evidence to support cognitive behavioural approaches and modified recommendation 1.2.6 to account for this. They also reworded the guideline to remove negative references to behavioural approaches. The committee's intention had been to communicate that punitive behavioural approaches alone were not helpful in the context of whole-school approaches, but this had not come across in the guideline in the way they intended.

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				There was one significant effect – on anxiety/depression (Ghiroldi, 2020) but, given the number of comparisons presented and not corrected, BABCP is of the view that there is a high likelihood that this result can be attributed to Type II error. In addition to the absence of any evidence that mindfulness interventions are effective BABCP has other concerns about this recommendation related to feasibility and safety. <u>Safety and harms</u>: Mindfulness is an active psychological intervention, and, like all potentially effective interventions, it has the potential to cause harm as well as to help. Mindfulness practice requires participants to allow their thoughts and images to enter consciousness and to learn to ignore them or 'let them go'. BABCP suggests that there is a high risk of harm to traumatised children who are exposed to mindfulness interventions delivered by under qualified schoolteachers. Children who have experienced trauma are highly likely to experience intrusive, frightening, and distressing images and thoughts of that trauma or	

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				related to that trauma, which they and their teachers are unlikely to be able to manage in a classroom setting. BABCP therefore does not approach mindfulness as a benign intervention but as a potentially potent intervention with associated benefits and risks. BABCP members wanted to draw attention to the potential adverse effects of mindfulness interventions – see the following for relevant research – these data are taken from research with adults where mindfulness practice has been longer established. There is no reason to imagine that these results would not generalise to children and young people. • Shapiro (1992) identified potential adverse effects including physical pain, disorientation, addiction to meditation, suicidal ideation and destructive behaviour • Shonin et al., (2014) review found mindfulness and other forms of meditation can induce psychotic episodes. Six studies (n = 12) reported that meditation-induced psychotic-like symptoms. However, although some patients had practiced mindfulness-based exercises, others had received training in other forms of meditation.	

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				• Lomas et al. (2015) although some positive outcomes were identified, 25% of the participants' narratives related to problems arising from their practice. More specifically, the qualitative analysis identified problems including troubling experiences of self, exacerbation of mental health issues and reality being challenged. Feasibility: Because of the potential risk, mindfulness interventions should always be delivered by trained and supervised mindfulness practitioners who have their own mindfulness practice. Teachers can be trained to deliver mindfulness interventions, but this is a significant commitment of personal and professional time that few schools are likely to be able to resource. For example, in the ongoing MYRIAD RCT of mindfulness in schools (Funded by the Wellcome Trust and run by Professor Willem Kuyken, Oxford University) teachers complete a personal eight-week face to face mindfulness course in their own time (i.e., after school), followed by 4 days of training to deliver mindfulness to pupils. They then complete supervised practice delivering mindfulness training for 3 months before	

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				being allocated as mindfulness teachers. Whilst offering mindfulness training they are required to maintain their personal practice and access regular supervision. https://myriadproject.org/schools/teachers-in-study/ Guidance on training of mindfulness teachers can also be found here Good Practice Guidelines for Teaching Mindfulness-Based Courses. https://bamba.org.uk/wp-content/uploads/2020/01/GPG-for-Teaching-Mindfulness-Based-Courses-BAMBA.pdf BABCP note that the MYRIAD trial is not complete – the aim of the trial is to evaluate the effectiveness and cost-effectiveness of a mindfulness training programme to enhance mental health, well-being, and social-emotional functioning in adolescence. This will recruit 5700 students and follow them up for 2 years. BABCP suggest that the recommendation to offer universal mindfulness interventions in schools is premature and lacks adequate evidence of effectiveness.	

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				At such time as there is sufficient evidence to recommend universal mindfulness interventions in schools BABCP request that recommendations include the necessity of using properly trained and supervised mindfulness teachers.	
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.3.6 10	3-83	BABCP suggest that the guidance given on how to select a measure is too vague to be useful. Specific, freely available, measures suitable for primary and secondary age children should be identified.	Thank you. The committee discussed this but decided not to recommend specific tools due to the lack of evidence identified in the review. This is highlighted in the rationale and impact section of the guideline.
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.1.8 5	11-14	BABCP warmly agree that staff should receive high quality CPD to support their own well-being and that of their students. However, BABCP is concerned that this recommendation repeats several of the same imprecise constructs highlighted in note 145 above. No evidence has been presented to support the specific recommendation that training is related to 'relational' approaches and this term is unhelpfully vague.	Thank you. The committee clarified that the examples given were intended to be just examples and have clarified this in the guideline. Relational approaches are defined in the terms used in this guideline section of the guideline.

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				BABCP suggests that the recommendation is reworded to reflect evidence and that the absence of evidence is explicitly mentioned. For example "Ensure that staff have continuing professional development to support their well-being and the implementation of the school's approach to well-being. There is no specific evidence to guide the targets of this training, but the committee suggests that this should reflect the ethos and values of the school and the importance of providing positive reinforcement for valued behaviours".	
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.2.78	6-8	BABCP was baffled by this recommendation, for which it could find no evidence in Evidence Review B. None of the included studies appeared to evaluate 'regular rhythmic physical activity'. BABCP requests that the rationale for this recommendation is reviewed by the committee. If there is evidence to support it please include it in the Evidence Review and if there is no evidence to support it please remove this recommendation.	Thank you. This recommendation was based on evidence from expert testimony. For clarity, a definition of rhythmic physical activity has been added to the glossary of terms.
British Associat	Guideline	1.2.8	9-10	BABCP could not identify any data or studies in Evidence Review B that related to this recommendation.	Thank you. This recommendation was based on evidence from expert testimony and from committee consensus. The committee agreed that each child having a relationship with a

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ion of Behavioural and Cognitive Psychotherapies				BABCP also did not understand what these interventions are or would include or be delivered. BABCP requests that the evidence to support 'peer to-peer support' as an intervention, and 'peer-to-trusted-adult support' is provided or that the recommendation is removed. If there is evidence to support this recommendation BABCP also suggest that the committee provide more information about these interventions so that schools and colleges can understand and implement the recommendation.	key trusted adult was the most important parts of the relational approach. The committee recognised that the wording of 'peer-to-trusted-adult' could be confusing so amended this to 'child-to-trusted-adult'.
British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.4.611	7	BABCP cannot find any evidence that supports this recommendation in the Evidence Review. It is unclear what the committee mean when they refer to 'peer to peer support' or if this is an intervention or just normal everyday interactions between children and young people. BABCP requests that the committee provide evidence to support this recommendation and provide a clear description of what this intervention is and how it is delivered and supported in schools and colleges.	The published evidence is one part of the evidence that committees take into account when they are making recommendations. The role of an expert committee is to layer their experience and expertise, their knowledge of practice and the policy context and the views of expert stakeholders and witnesses to create recommendations. In addition to evidence from the published literature, the committee were aware of the policy drivers supporting implementation of whole school approaches, and the promising evidence from practice that these are a good thing to do. Peer-to-peer support refers to helping children and young people to be active listeners so that they can support their classmates.

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British Association of Behavioural and Cognitive Psychotherapies	Guideline	1.4.7 11	9	BABCP agrees with the ethical principle of minimising harms. However, we do not understand how targeted interventions can be delivered to children and young people without identifying them – i.e. '*singling people out for support*'. This is an undeliverable recommendation and thus BABCP request that it is removed. A more realistic recommendation would be around managing the way in which targeted interventions are provided, considering how these may be promoted in a positive way to young people, and providing practical and emotional support to young people who accept an offer of targeted interventions.	Thank you. The committee were concerned that removing children from classes or offering interventions during break times may risk singling some children out. The committee agreed that targeted interventions should be promoted in a positive way and added "proactively normalise seeking support" to recommendation 1.4.7.
British Association of Behavioural and Cognitive Psychotherapies	Guideline	4	7-8	In the same paragraph BABCP also note the comment *'Take into account that purely behavioural approaches used in isolation have limited impact'.* It is not clear what the committee is basing this comment on, or why behavioural approaches have been singled out for specific negative attention.	Thank you. The committee discussed this and agreed to remove this sentence from the recommendation. The committee also decided to amend recommendation 1.1.2 to the following: Ensure that the school has a culture, ethos and practice that strengthens relational approaches and inclusion, and that recognises the importance of psychological safety.

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				BABCP reviewed the evidence presented in Evidence Review A and found no basis for this comment. Several studies (of the 9 identified) used 'positive behaviour support' and other behavioural approaches or techniques. These resulted in a mixture of outcomes with some evidence that they improved specific outcomes. There was no evidence that these interventions were less effective than other approaches, and no evidence that 'relational' approaches were in any way more effective. BABCP therefore suggest that either the committee remove the statement or that they provide clearer justification for the comment and that this is backed up by evidence and presented in Evidence Review A. BABCP suggest that this whole paragraph is reworded in a way that reflects the evidence (and the absence of evidence) accurately and fairly. For example: 'Ensure that the school has a culture and ethics that reinforces positive relationships and behaviours, the	

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				value of each individual and the importance of psychological safety'. There is insufficient evidence to recommend any specific approach or techniques, but it is important to involve all members of the school system including pupils/students, parents, staff, and the local community.	
Childhood Bereavement Network				**What would help users overcome any challenges?** We know that staff in schools that have experienced a death in their community often wish they had been better prepared. Despite the availability of excellent training and resources from child bereavement services across the country, there is a barrier to tackling this difficult topic. Our free *Growing in Grief Awareness* audit tool helps schools develop an action plan for a whole school approach to bereavement including targeted support for bereaved pupils, partnerships with local services, staff training and support, and curriculum development to help pupils learn about coping with bereavement. https://childhoodbereavementnetwork.org.uk/if-you-need-help-around-death/schools/growing-grief-awareness	Thank you for this example of good practice. Unfortunately, NICE no longer maintains its shared learning database due to lack of resources and therefore is unable to add this training to it
Childhood Bereave				**The COVID-19 context** More pupils than usual have been bereaved during COVID-19, often in very distressing circumstances	Thank you for this information. Unfortunately NICE has no control over what is prioritised in the curriculum at a school level.

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ment Network				where they were unable to spend time with or say goodbye to the person and prevented from getting together with other family members to share memories and support. Anxiety about the health of surviving family members is common among bereaved children and can make them very worried about being separated during the school day, impacting on attendance. This has been compounded by fear about transmitting infection to family members. The COVID-19 context has made bereaved pupils even more vulnerable to poor social and emotional well-being. As well as those who have been directly bereaved, all children have been exposed to a period of mass anxiety and discussion about death and dying. These changes make it even more important that coping with loss and bereavement is incorporated into the curriculum so that pupils can understand ways of supporting one another and themselves through this experience.	
Childhood Bereavement Network		31	25	We welcome the committee's inclusion of bereavement as a form of life transition in which the school plays a key role. 70% of primary schools have a recently bereaved child on roll, and all schools need to be prepared for a death in the school community, whether sudden or expected.	Thank you for your support.

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Childhood Bereavement Network	Guideline	9	6	We recommend that bereavement is included in the list of some key risk factors for poor social, emotional and mental well-being, perhaps as an example of an adverse childhood experience, (along with one or two other examples). As bereavement was not included in the Center For Disease Control questionnaire that initiated research on ACEs, it remains an under-researched experience in childhood. However, we do know from longitudinal research that 'family bereavement had continuous, cumulative effects on children's emotional and social well-being, long after the event happened. (Jones, E., Gutman, L. and Platt, L. (2013) Family stressors and children's outcomes, London: Childhood Well-being Research Centre. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/219639/DFE-RR254.pdf). Including bereavement here would serve to remind users of the significance of this experience.	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. Death and loss (in the family) is included in the table. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Childhood Bereavement Network	Guideline	13	7	We recommend that the definition of Adverse childhood experiences includes a clarification that these experiences are not limited to the ten experiences listed in the Center for Disease Control research questionnaire. The death of a parent is not included in this questionnaire, and this has led to	Thank you. The definition makes no reference to ten experiences listed by the CDC, not is this mentioned anywhere in the guideline.

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14/01/22 – 25/02/22

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				bereavement being under-researched as a facet of adverse experiences in childhood. We recommend that bereavement is included as an example in this definition.	
Childhood Bereavement Network	Guideline	25	25	We agree with the committee's rationale that while the presence of 1 or 2 adverse childhood events should not be seen as a pre-determined risk, it is a sign that assessment is needed.	Thank you for your support.
Compass	Recommendation		General	The main body of the guidance, it might be worth guidance on how those schools who have not taken up the option of becoming a MHST school to see the benefits of doing so.	Thank you. You raise an important point, however, it is outside the remit of this guideline.
Compass	Recommendation		General	The guidance is light on the role of schools and school based mental health services on the role of mental health awareness raising and mental health promotion for parents/families/carers. It would be good to see recommendations for schools to provide / arrange this as part of the wider community engagement. The guidance could strengthen the role of school based mental health support by specifying the commitments necessary from schools to support Whole school approach.	Thank you. You raise an important point, however, it is outside the scope of this guideline. Please see the scope document on the NICE website.

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Compass	Recommendation 1	5	19	Clinical supervision appears to be a new concept to school staff and therefore further explanation will be needed to support understanding and implementation.	Thank you. Clinical supervision is not referred to in the guideline.
Compass	Recommendation 1.3.2	9	6	In the box 'Some key risk factors for poor social, emotional and mental wellbeing'- Could specific reference be made to young people from the LGBTQ+ community, and children who are Looked After?	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Compass	Recommendation 1.3.6	10	2	There appears to be no input from parents/carers.	Thank you. The committee discussed this but decided not to specifically mention parents and carers in recommendation 1.3.6. They agreed parents and carers should be involved in children and young people's social and emotional wellbeing but thought explicitly mentioning them in this recommendation would make it appear like an exception. Parent and carer involvement has been highlighted in other recommendations, such as 1.1.6, 1.1.14, 1.4.3 and 1.5.7. Additionally, parent and carer input falls under "information from a variety of sources" in recommendation 1.3.2.
Compass	Recommendation 1.4.1	10	11	It would be good to provide schools with a validated group work programme/manual in order to standardise quality.	Thank you. Unfortunately no validated programme/manual exists to our knowledge.

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Compass	Recommendation 1.4.2	10	17	It is unclear what being 'quality assured' means or how it is qualified or measured.	Thank you. The committee agreed this was vague and removed it.
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust		General	General	Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. • Increasing links with parents, carer, local authorities, communities, primary, secondary health and other agencies to wrap care around the child whilst in the school environment will have the biggest impact. This will prevent contrary messages and duplication. Having the best person (in terms of availability, time and training) working with the child, agreed on an individual basis means that staff do not need to be experts in all aspects but can draw on a team to support them. • All the additional responsibilities these recommendations place on pastoral staff is going to the most challenging to implement. The pastoral staff are already balancing multiple responsibilities towards the children. If the plan is to add in protected time for training and supervision, there would not be sufficient staff time available to pick up	Thank you. The committee discussed the impact of training and protected time. They agreed that protected time for training was important even though it would have an impact on staff time, but also agreed that most staff undergo training already but this could be more focussed on social, emotional and mental wellbeing.

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				the requirements to a high standard or consistency to have the desired outcomes.	
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust		General	General	Would implementation of any of the draft recommendations have significant cost implications? • Requirement for more pastoral staff / Mental Health support. 2 Additional leadership roles for whole school approach implementation and Universal curriculum implementation	Thank you. The NICE resource impact team considered the costs of this and produced a resource impact statement that can be found on the NICE webpage for this guideline.
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust		General	General	What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) • Review the different roles and expectations of leadership team / pastoral team, to ensure no duplication or wasted time and energy.	Thank you. The roles of different members of the school leadership team are for individual schools to determine. The guideline refers to engaging with local health systems and resources, for example in recommendations 1.1.19 to 1.1.22. Engaging with local community groups and voluntary groups is covered in recommendation 1.1.6 which encourages schools to engage with local community and voluntary organisations.

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				• Use health resources where possible, right person doing the right role for training and delivery of target responses. Consider what other local community / voluntary sector groups can offer	
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust		General	General	*This guideline was commissioned before the coronavirus pandemic and therefore the original review questions have not taken into account the impact of COVID-19 on the current school environment. NICE have completed additional searches to identify evidence relating to issues caused by COVID-19 on schools and expert witnesses have been brought in to discuss its impact. However, there is currently limited evidence in this area.* *Please tell us if there are any particular issues or evidence relating to COVID-19 that we should take into account when finalising the guideline for publication.* The probability of increasing numbers of children with mental health and neurological disorders	Thank you. The committee heard expert testimony about this topic and used it to inform their formulation of the recommendations. It is hoped that improving social, mental and emotional wellbeing may help prevent exacerbations of mental ill-health.
Cumbria, Northumberland, Tyne and		General	General	NICE have published a health economic tool to inform the impact of interventions on a range of student outcomes in relation to social, emotional and mental wellbeing in primary and secondary education. The tool aims to calculate the number of students who would be impacted by an intervention and the cost per outcome	Thank you for your comments. Regarding small size font the model, since built in excel, allows the model user to zoom in and out of the sheets to adjust to the preferred size. The base case cell uses data from the NICE evidence reviews and updates depending on the approach, intervention and

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Wear NHS Foundation Trust				case. The tool includes an explanatory video. Please tell us if you have any comments on the tool, its usability or its content. • It would have helped to have a link to the tool and video in the question as it took some time to find it. • Liked standardised font and no block capitals, although 10 font is small, for some reason font on drop down for perspective is different • If there is a formula field just protect the cell so they cannot alter it by mistake, I do not think red text is enough of a deterrent. • Cell J14, difficult to read needs to be white font • Do not underline, creates unnecessary confusion when users may think it is a link. Bold should be sufficient but should also not be overused as can confuse and overwhelm a reader. • No idea what is needed in Base Case, or user defined fields. Simple and easy to use and navigate	outcome selected for analysis. The user defined cell allows the user of the model to input their own data/values into the model if, for some reason, they do not want to use the data from the NICE evidence reviews. The title sheet explains that the cells with a blue and orange background can be typed over, while cells with a white background and red text cannot. The model has been updated and some cells have been locked down to prevent users altering them by mistake.
Cumbria, Northumberland, Tyne		6	28	This is a global comment on all guidelines (and indeed upon clinical activity) I feel the word 'risk' is **always** unhelpful as it is pejorative. The word used should always be **safety**.	Thank you. The committee discussed this but did not agree that the term risk was pejorative. The language of risk and protective factors is common in the literature and the committee saw no reason not to use those terms.

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and Wear NHS Foundation Trust					
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust		7	20	1.2.5 – This section lacks something about personal drivers to the person – 'What is (most) important to the person'. It is key to understand, and help the person understand this, as this is what is going to motivate the person into change. Also on a technical point, although 'non-judgemental' has been a nice buzz word for some time, this is not possible. The person has been 'judged' to need the support; the person's responses are being 'judged' throughout the work otherwise no informed decisions can be made. I would advise simply losing the phrase.	Thank you. The committee did not see any evidence about the value of personal drivers in this context. The use of non-judgmental here refers to not stigmatising children and young people for the choices they have made. This is different from assessing someone's need for support.
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	NICE Draft Guideline	General	General	These recommendations mention the Whole School approach then do not use the 8 principles as the basis for them, so it looks like a separate initiative rather that part of the whole. I would suggest reorganising them to align with the 8 Principles • Leadership and Management • Ethos and Environment • Curriculum and Learning • Student Voice	Thank you. The recommendations in the whole-school approaches section of the guideline could not easily be mapped to the 8 principles set out by Public Health England. Therefore, it was deemed more appropriate to organise the recommendations under our own headings.

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				• Staff development, health and wellbeing • Identifying need and monitoring impact • Working with parents, families and carers, Targeted support and appropriate referrals	
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	NICE Draft Guideline	General	General	Whole School approach does not include the integration with partners, so should be added as an additional section in the guideline	Thank you. We believe that integration with partners is adequately covered by recommendations 1.1.19 and 1.1.21
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	NICE Draft Guideline	4/5	1.1.6 1.5.5	Some of these recommendations falls short of giving guidance on how they should / could address them, where with others it is clear. I understand the recommendations do not want to be too prescriptive but without any clearer guidance, I think the schools would struggle to understand how to even start. Although in the point 1.1.6 having shared principles for engagement between education and mental health services, for example agreeing referral pathways is much clearer	Thank you. It is not possible to be too prescriptive when making recommendations due to differences between schools and how they operate.

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Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	NICE Draft Guideline	4/5	1.1.6	This should be a whole school approach lead person to determine what is needed to successfully implement a whole school approach, they should be responsible for keeping the Governors and leadership team appraised and the developments on track. The original 1.1.6 should move to section 1.2 Universal curriculum	Thank you. The committee discussed implementing the whole school approach and agreed this was the best place for it in the guideline, as planning universal curriculum approaches are part of this approach. The committee did not think there should be a specific person identified in this guideline since the appropriate person changes depending on school factors. The committee decided to clarify that this should be someone in a leadership post.
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	NICE Draft Guideline	4 4 12	1.1.3 1.1.4 1.5.5	How often is "regularly" or "ongoing"	Thank you. It is not possible to specify this due to differences between schools and how they operate.
Cumbria, Northumberland, Tyne and	NICE Draft Guideline	4	1.1.4	Presumes that they have an accessibility plan and approach to understanding behaviour, should it include have or develop an accessibility plan and approach to understanding behaviour and review on regular (annual???) basis.	Thank you. It is a statutory requirement for schools to have an accessibility plan. The frequency for reviewing the accessibility plan has not been specified due to differences in school operating procedures across the country.

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Wear NHS Foundation Trust					
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	NICE Draft Guideline	488	1.1.5 1.2.6 1.2.7	Is this optional as the word consider suggests, I would have thought it was an essential part of the implementation of the Whole School approach	Thank you. NICE uses words such as consider to reflect the strength of a recommendation. This is based on the committee's interpretation of the evidence base and their own experience. Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations.
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	NICE Draft Guideline	677	1.1.19 1.1.21 1.2.4	Some of the recommendations are unclear, how you would show / prove that they have met them.	Thank you. NICE recommendations outline good practice. NICE does not require organisations to show they have met them.

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Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	NICE Draft Guideline	6 7	1.1.19 1.2.21	The responsibility for some of the recommendations cannot lie with the schools to implement. It needs to be clearer who will be responsible	Thank you. It is not always possible or appropriate to identify who should be responsible to carry out the recommendations due to variety in how schools / colleges operate across the country.
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	NICE Draft Guideline	7	1.2	Moved from 1.1.6 Designate a lead person to determine what is needed to successfully implement universal curriculum interventions. The lead should also be the go-to person for advice on the latest educational resources for any intervention	Thank you. The committee discussed implementing the whole school approach and agreed this was the best place for it in the guideline, as planning universal curriculum approaches are part of this approach. The committee did not think there should be a specific person identified in this guideline since the appropriate person changes depending on school factors. The committee decided to clarify that this should be someone in a leadership post.
Cumbria, Northumberland, Tyne and	NICE Draft Guideline	7	1.1.21	This is presupposing an integrated care system (ICS) is in place and fully operational. However, this main mean the semi-official collaboration of services in a locality. The more formal NHS ICS's are due to start at the earliest in July 2022 but there is a lot of work to do to make this fully integrated. Without a	Thank you for this information.

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Wear NHS Foundation Trust				clear definition of what is meant by ICS with an agreed governance and communication structure in place schools would not meet this recommendation.	
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	NICE Draft Guideline	8	1.1.7	Suggest split into 2 points as separate actions. Ensure that school governance structures support the whole-school approach and that school leadership is actively involved. Make the responsibility for social, emotional and mental wellbeing curriculum content part of the remit of school leadership (including governance).	Thank you. The committee believed these points closely enough linked to be combined in one recommendation.
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	NICE Draft Guideline	9	1.3.2	Is identification not a process of assessment? should assess be in here not in 1.3.2. Who is responsible and when should this happen. Is it at start of year and then at times of significant life changes	Thank you. Identification of children and young people at risk of poor social, emotional and mental wellbeing is initially based on soft intelligence. Those identified as being at risk are subsequently more formally assessed.
Cumbria,	NICE Draft	9	1.3.3	Remove assess (see above 15) and change to, based on assessed risk decide whether to monitor	Thank you. Identification of children and young people at risk of poor social, emotional and mental wellbeing is initially based

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Northumberland, Tyne and Wear NHS Foundation Trust	Guideline			them or not. Need to add who is responsible for deciding whether to monitor is there a criteria or risk level which triggers it automatically and who is responsible for monitoring	on soft intelligence. Those identified as being at risk are subsequently more formally assessed.
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	NICE Draft Guideline	10	1.4	Additional point needed, ensure that all targeted support is delivered collaboratively with other external agencies / services and support that the child is receiving.	Thank you. The committee agreed to add the additional recommendation: Ensure that all targeted support is delivered collaboratively with any other external agencies or services and support that the child or young person is receiving.
Cumbria, Northumberland, Tyne and Wear NHS	NICE Draft Guideline	10	1.4.2	Need clarification if the experience practitioners are from within the school or outside agencies or both	Thank you. Practitioners could be internal or external.

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Foundation Trust					
Health Conditions in Schools Alliance	Guideline	General	General	The Health Conditions in Schools Alliance broadly welcomes these guidelines and their intention to promote good social, emotional and psychological health to protect children and young people against behavioural and health problems. We are a voluntary alliance made of over 30 organisations, including charities, professional associations and trade unions who work collaboratively to ensure children with health conditions get the care they need in school. It is vital that all children, regardless of background or circumstance, are given the opportunity to flourish in education. For children with health conditions, the extra considerations that managing their conditions bring can be a major barrier to getting the most out of their education and in many cases they are excluded from getting the quality of education they deserve. Maintained schools have a legal duty to make arrangements to support pupils with medical conditions (both mental and physical), under section 100 of the Children and Families Act 2014. The Department for Education (DfE) statutory guidance 'Supporting pupils at school with medical conditions' outlines the framework	Thank you for this information. The medical conditions policy is covered in recommendation 1.1.4.

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				of support that should be in place for pupils with health conditions to achieve this: • Pupils at school with medical conditions should be properly supported so that they have full access to education • Governing bodies must ensure that arrangements are in place in schools to support pupils at school with medical conditions – this includes a medical conditions policy • Governing bodies should ensure that school leaders consult health and social care professionals, pupils and parents to ensure that the needs of children with medical conditions are properly understood and effectively supported. This should be led by a medical conditions policy, a document that schools in England are required to have by law that sets out how they will support any children with medical conditions, the procedures for getting the right support and training in place, and who is responsible for making sure the policy is implemented.	

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				Every pupil with a medical condition in school should also have an Individual Health Plan (IHP), an agreement between parents/ carers and the school (with the input of healthcare professionals) about what support a child needs and how it will be delivered. IHPs should include key information such as what to do in an emergency as well as support for the child's educational, social and emotional needs, The guidance advises that headteachers, school governors and responsible bodies should ensure that their school's policy covers the role of individual healthcare plans, and who is responsible for their development. They should also ensure that plans are reviewed at least annually, or earlier if evidence is presented that the child's needs have changed. Reference: Supporting pupils with medical conditions at school - GOV.UK (www.gov.uk) http://www.medicalconditionsatschool.org.uk/ **Error! Hyperlink reference not valid.**	
Health Conditions in Schools Alliance	Guideline	General	General	We wish to highlight the increased emotional and mental health risks that children with health conditions face, as made clear in the DfE guidance 'Supporting pupils at school with medical conditions' (2015):	Thank you. Medical conditions policy has now been included in recommendation 1.1.4.

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				"**In addition to the educational impacts, there are social and emotional implications associated with medical conditions.** Children may be self-conscious about their condition and some may be bullied or develop emotional disorders such as anxiety or depression around their medical condition. **In particular, long-term absences due to health problems affect children's educational attainment, impact on their ability to integrate with their peers and affect their general wellbeing and emotional health.** Reintegration back into school should be properly supported so that children with medical conditions fully engage with learning and do not fall behind when they are unable to attend. Short-term and frequent absences, including those for appointments connected with a pupil's medical condition (which can often be lengthy), also **need to be effectively managed and appropriate support put in place to limit the impact on the child's educational attainment and emotional and general wellbeing."** Whilst the guidelines acknowledge the impact of complex and long term health conditions on social, emotional and mental wellbeing we feel that they should go further in addressing this association throughout the guidance. We feel that references to medical conditions	

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				should be strengthened and referenced throughout the guidelines, in alignment with the current recommendations for those with special educational needs and disabilities. Reference: **Error! Hyperlink reference not valid.**	
Health Conditions in Schools Alliance	Guideline	4	11	Rec 1.1.4 – The guideline should recommend that the school's medical conditions policy should be regularly reviewed alongside the accessibility plan. Schools in England are required to have a medical conditions policy by law and this is vital to ensuring that children with health conditions (both physical and mental) are properly supported to have positive social, emotional and mental wellbeing in school. The DfE guidance states that this policy statement should be developed with pupils, parents, school nurses, school staff, governors, the school employer and relevant local health services. This would further support co-production with parents, a whole school approach and an outward facing approach to the community but	Thank you. Medical conditions policy has now been included in recommendation 1.1.4.

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				also crucially involve children and young people, who should be at the centre of these discussions. Reference: Supporting pupils with medical conditions at school - GOV.UK (www.gov.uk)	
Health Conditions in Schools Alliance	Guideline	5	1-9	The shared principles of engagement should have regard to the DfE guidance 'Supporting pupils at school with medical conditions' (2015) and be clear on the role of school leadership in establishing support arrangements for children with physical and mental health conditions.	Thank you. The school medical conditions policy has now been mentioned in recommendation 1.1.4.
Health Conditions in Schools Alliance	Guideline	6	4-7	Rec 1.1.15 – We welcome the commitment to involve children and young people in discussing and agreeing whole-school approaches but would want to see this expanded upon. We feel the commitment should be strengthened with specific mechanisms to include children and young people in conversations and co-production of school decision making. At present, this point is not robust	Thank you. The committee decided not to add specific mechanisms as there are multiple mechanisms that could be used.

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				enough and it is unclear how schools can undertake meaningful participation.	
Health Conditions in Schools Alliance	Guideline	7	12-13	Rec 1.2.2 – We welcome the reference to this guidance when developing universal curriculum content. This guidance is unequivocal on making the connection between physical and mental health, advising that primary school pupils should be taught to "understand that good physical health contributes to good mental wellbeing, and vice versa" and education should "include factual information about the prevalence and characteristics of more serious mental and physical health conditions" for secondary school pupils. Reference: Relationships and sex education (RSE) and health education – GOV.UK (www.gov.uk)	Thank you for the support.
Health Conditions in Schools Alliance	Guideline	8	15-23	1.3.1 – We re-iterate our point that "long term conditions" should be explicitly mentioned here after "special educational needs or disabilities". Though the two are not are not always related , it is vital to consider the additional needs of children with long term health conditions and how these fit within broader special education needs support.	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was

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				The DfE guidance is clear that some children with medical conditions may be considered disabled under the definition established in the Equality Act 2010 and have special educational needs that may require additional support and an Education and Health Care plan (EHCP). Reference: **Error! Hyperlink reference not valid.**	published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Health Conditions in Schools Alliance	Guideline	8	3-8	We feel it is important to note that mindfulness and rhythmic physical activity are not universal tools, and whilst very helpful and effective in many cases, they can create added anxiety and stress among other issues. Mental health and wellbeing interventions need to be flexible and depend on the individual. Our suggestion here would be to add the caveat that for any intervention, the medical conditions of the child or young person be taken into account, and that	Thank you. Both of these recommendations are weak recommendations which say that schools should 'consider' doing these things. Please see Making decisions using NICE guidelines. This explains how we use words to show the strength (or certainty) of our recommendations.

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				child or young person be included in the discussion on which interventions may work for them.	
Health Conditions in Schools Alliance	Guideline	8	1-2	It is important to be aware where children with health conditions may already have issues with self-worth, skills and resilience due to their ongoing medical condition and adapt accordingly.	Thank you for this information.
Health Conditions in Schools Alliance	Guideline	9	6	Whilst we appreciate this list is not intended to be exhaustive, we feel it may cause confusion as it combines risk factors such as adverse childhood experiences with warning signs or things for people to look out for such as self-harm or suicidal ideation. We would suggest reviewing this list and potentially splitting these risk factors into categories would make it easier for the guidelines to be understood and implemented. We also strongly suggest a change of wording from "Chronic illness or poor general health" to "complex or long term health condition" to be clearer and avoid stigmatisation.	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Health Conditions in Schools Alliance	Guideline	10	18-20	1.4.3 – We feel reference should be made to how an Individual Healthcare Plan can aid these discussions and support measures should be included within them. This will make the recommendation easier to apply in practice. Individual Healthcare Plans can be	Thank you. The committee discussed Individual Healthcare Plans and acknowledged that these would not be necessary for every child requiring support. They agreed that schools would likely already have a system in place for logging and tracking the kinds of things included in an Individual Healthcare Plan, in case they should need to access future support.

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				developed to support pupils with mental and/or physical health conditions and also reflect how long term conditions can change over time and require different types of support.	
Health Conditions in Schools Alliance	Guideline	11	14	We wish to highlight how transitions and life changes impact children and young people with health conditions and express that being diagnosed with or managing a health condition is a major life change in itself as the guidelines are largely limited to considering transition between schools at present. We would welcome any further consideration in these guidelines for transitions from school into other education settings, employment or unemployment, with support around forward planning and advice, particularly for those with health conditions that need particularly specialised services. Absence is of particular concern for pupils with medical conditions who have missed a lot of school or have had school at home or in hospital. They may face multiple periods of absence due to regular medical appointment, illness and go through transition periods to feel part of the whole school upon return. Currently, many face stigma due to their absence, especially when not properly understood	Thank you for the information. It is a statutory requirement for schools to develop individual healthcare plans and therefore does not need to be reiterated in this guideline.

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				by staff, or appropriately explained to classmates. Staff need the guidelines and tools to be able to holistically support students when discussing the need for absence, taking absence, and requirements when returning like helping them catch up with work and settle back in with friendship groups. This care also needs to extended to awareness and knowledge around how staff should communicate medical conditions in a way that would not negatively affect a pupil e.g. a school staff member telling a potential employer/college/university member that a pupil's condition made them "difficult" to support . There is an important role that Individual Healthcare Plans can play in establishing support and easing transitions. These should detail the support needed related to a child's health condition, including their educational, emotional and social needs. IHPs should be regularly reviewed and updated to ensure continued holistic support for children with medical conditions when things change.	

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Health Conditions in Schools Alliance	Guideline	26	2-9	There is further evidence on the interface between mental and physical health in the Children and Young People's Mental Health Taskforce's 'The Future of Mind' report including findings that the presence of a chronic condition increases the risk of mental health problems by two to six times in children and young people. Reference: Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing - GOV.UK (www.gov.uk)	Thank you for this information.
Health Conditions in Schools Alliance	Guideline	32	11	We think that these guidelines should have a greater focus on extra-curricular activity and where this fits in with supporting wellbeing in children and young people than they do at present. These activities are important for social and emotional wellbeing because they exist outside of the structured and more monitored school experience, and are where pupils will start building a community, having fun together, exploring different areas and gaining different skills together. It allows them to talk and learn about each other outside of a formalised setting which can sometimes be restrictive on what can be discussed.	Thank you. The guideline only considered interventions within school hours. Extra-curricular activity would be considered beyond the remit of this guideline.

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Imperial College London Self-Care Academic Research Unit	Evidence Reviews & B			There is no mention of interventions or education / campaigns to raise awareness about domestic violence & abuse in the whole school approach, and universal curriculum approaches. We recommend inclusion of structured education & support to raise awareness about signs fo abuse and	Thank you. Raising awareness about these things would be part of the universal curriculum offer, but no studies were found evaluating this.
Imperial College London Self-Care Academic Research Unit	Evidence Reviews C, D, H & I			There is no mention of structured education to promote individual self-care capability from a young age. Changing behaviours once they have set in is generally hard. Supporting school children (& their parents) during these formative years to promote the sustained adopting of good health-seeking self-care behaviours is crucial. See our submission to the House of Lord Select Committee which makes the case for more structured approaches to promoting health literacy and self-care: • https://figshare.com/articles/conference_contribution/Submission_to_the_Select_Committee_on_Science_Technology_Ageing_Science_Technology_Healthy_Living/12581414/1 Also consider this paper form BMJ: https://www.bmj.com/content/368/bmj.m999	Thank you. None of the studies identified for this guideline evaluated the effectiveness of structured education on social, emotional and mental wellbeing. The BMJ article you cite is a news report rather than a report of a primary study and therefore would not be eligible for inclusion.

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Institute of Education, Department of Psychology and Human Development, Mental Health and Wellbeing Network				1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. These guidelines will present a set of challenges to staff who have great intentions but are not trained and supported in a value based frame that promotes collaborative thinking and holistic approaches beyond narrow behavioural protocols. Lots of useful comments to further contextualise proposed guidelines and support our thinking on problem solving can be found here: https://www.bera.ac.uk/media/president-roundtable-seminar-series-wellbeing-schools-and-pupil-mental-health-do-we-fix-the-child-or-do-we-fix-the-school These guidelines could have a positive impact on students and staff if a relational and experience sensitive approach is practiced. This requires a mindset that allows collaborative practice, seeing families, students and school staff as equal experts about decisions that affect their lives. Our working group would like to emphasise the need for child centred and family centred practice as this is something that is coming up a lot in different working groups and research advisory groups currently. Mothers, fathers and CYP need to be in consultation and working groups so that whole school strategies can be realistic,	Thank you. . Your comment matches closely with the committees approach to writing this guideline, which focused on relational whole school approaches (see recommendations 1.1.1, 1.1.2, 1.1.3), engagement with pupils and parents (1.1.14, 1.1.15) and an outward facing approach to the local community (1.1.6).

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				tailored and effective. There are endless possibilities to enrich staff perspective through collaborative practice. Finally, it is important that discussions and actions about mental health are not affecting healthy populations. Schools would benefit from having a policy for Tier 1 and 2 approaches to mental health. The evidence is beginning to suggest that this should include evidence-informed approaches for SEL and WSAs to support the development of consistent sustainable structures with a good fit to the school. At the same time, a relational approach to mental health should proactively de-medicalise the needs of healthy students who face strong emotions in current context. Staff will need support in not interpreting milder or more transient experiences as mental health problems or disorders, things that wouldn't previously have received that label, and perhaps shouldn't. Schools should offer a safe space for students and staff to express and admit distress without creating the impression of mental health disorders for health people who might situationally struggle.	
Institute of Education,				2. Would implementation of any of the draft recommendations have significant cost implications? A relational and trauma informed approach is cost effective as it can promote mental health and prevent	Thank you. . Recommendations 1.1.8 to 1.1.13 address these issues and reinforce the need to support and train staff so that they can better support children and young people, including neurodiverse children and young people.

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Department of Psychology and Human Development, Mental Health and Wellbeing Network				need for reactive support. It is a value based approach that does not need specific training, it requires however space for reflection and proactive planning and time for staff to rehearse ways of being with each other and students. Neurodiversity training is essential in the light if current statistics that showcase high levels of seclusion, exclusion and traumatising practice. This needs to be sensitively designed with neurodivergent people who need to be paid as equal collaborators. Delivery of trainings will have cost implications, additional train the trainer sessions might be useful along with mentoring schemes and working groups with incentives in order to monitor progress	
Institute of Education, Department of Psychology and Human Development, Mental				3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) The first is to encourage schools to review what they already do in terms of practices and policies and their implications for the mental health and wellbeing of children and young people as well as school staff WITH students and staff. In the guidelines, there is an over-emphasis on how schools can introduce or 'bolt on' additional things that could serve to resolve and support social and emotional wellbeing in schools once problems appear. It is likely	Thank you. Recommendations 1.1.3, 1.1.4 and 1.1.5 address reviewing policies regularly to ensure they promote social, emotional and mental wellbeing consistently, and rather than being approached as a 'bolt on', this guideline very deliberately positions whole school relational approaches as the key to its success and this is reflected in the rationale and impact section of the guideline.. Recommendations 1.1.8 to 1.1.13 reinforce the need to support and train staff so that they can better support children and young people, including neurodiverse children and young people.

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Health and Wellbeing Network				that the greatest benefits and implications for wellbeing result from the activities, ethos and messages the take place in schools on a day-to-day basis and there may be some 'quick wins' that schools can take advantage of. For example, in terms of a review of current behavioural policies and structures appropriate and whether these are helpful in addressing the social relational and emotional wellbeing needs of pupils? Can schools be encouraged to think about how they can improve what they already do? This may seem to be going beyond the remit of the guidelines, but greater success is likely to come from mental health and wellbeing strategies that start with what schools do on a day-to-day basis rather than what they can do in addition to what they are already often overstretched in trying to do. Next, teachers should receive support to address the mental health of their students. This support should include opportunities for developing knowledge and skills, but also acknowledgement of the emotional labour involved and clear structures for any proposed school-wide changes. Neurodiversity training, training on LGBTQ+, training on carers' needs should be coproduced and codelivered with experts by experience. Working groups should include family members, students, staff and leadership teams working together with curiosity on best ways to implement best practice.	The committee agree that a constant stream of new initiatives being implemented in schools may not be the most useful approach and were careful not to recommend that. Thank you for the information about neurodiversity training. Unfortunately, NICE no longer maintains its shared learning database due to lack of resources and therefore is unable to add this training to it.

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				Finally, the emphasis on 'new' initiatives and interventions may exacerbate a continuous problem within schools. There is an ongoing conveyor belt, year-on-year, of 'new' interventions that are selected by schools for a period and then dropped in favour of the next 'new' thing. This does not help overstretched staff in very busy schools. It also appears that once dropped the important lessons or practices associated with these interventions are rarely assimilated into school systems or the school knowledge base. This approach of encouraging schools to go for the latest intervention is not part of a sustained developmental approach to whole school system improvement. Strong emphasis should be placed on a value based approach that is sensitive to the experiences of students and staff and is inviting all to create a synergetic mindset, examining their impressions and co-defining in day to day to practice key values. There is a national initiative to coestablish and codelivery neurodiversity training that is supporting teams to create effective reflective working groups within schools in collaboration with emotional wellbeing teams- for more information you may contact georgia.pavlopoulou@ucl.ac.uk	

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Institute of Education, Department of Psychology and Human Development, Mental Health and Wellbeing Network				4. This guideline was commissioned before the coronavirus pandemic and therefore the original review questions have not taken into account the impact of COVID-19 on the current school environment. NICE have completed additional searches to identify evidence relating to issues caused by COVID-19 on schools and expert witnesses have been brought in to discuss its impact. However, there is currently limited evidence in this area. Please tell us if there are any particular issues or evidence relating to COVID-19 that we should take into account when finalising the guideline for publication. A new guidance for schools and families supporting pupils with SEND in response to Covid 19 https://discovery.ucl.ac.uk/id/eprint/10118958/ New evidence on needs of siblings https://www.ucl.ac.uk/ioe/news/2021/apr/disabled-childrens-siblings-provided-more-care-lockdown New evidence of autistic students and their families Briefing summary: The experiences of autistic young people and their parents of lockdown and the reopening of schools Full report: The experiences of autistic young people & their parents of lockdown & the reopening of schools	Thank you for highlighting these reports. They provide useful context and match the committees understanding of some of the difficulties children and young people with SEND faced during lockdown. The committee heard expert testimony about how the lockdown had very different impacts on different children and young people with SEND. For more detail on the content of the expert testimony see the guideline webpage. The studies themselves are not eligible for inclusion in any of the reviews because none of the reviews looked at the needs of siblings or families.
Institute of		4	14	1.1.5 We welcome this recommendation and we would like to emphasis the importance of proposing inclusive	Thank you for this information. This is consistent with the whole school approach that the committee are recommending.

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Education, Department of Psychology and Human Development, Mental Health and Wellbeing Network				evaluation models that welcome the voice of young people, their families and school staff to identify wha works and potential barriers to whole school approaches. This is important for both speaking and non speaking students all ages and abilities. There is research on how to best use talking mats and creative methods that are low cost, although it can be time consuming. For enthusiastic and experience students, collaborative elicitation techniques will be easy to implement as natural part of how they communicate with their students outside consultation times.	
Institute of Education, Department of Psychology and Human Development,		5	6	1.1.7 This guideline will be effective if school staff who are responsible to deliver need to be consulted and included in discussions with leadership teams. If people are not included and are simply instructed to comply with new guidelines, there is no guarantee for commitment.	Thank you. The committee was clear that the social, emotional and mental wellbeing of staff is also key to the implementation of a successful whole school relational approach and made recommendations to support and involve staff and ensure their psychological safety (see recommendations 1.1.1, 1.1.2, 1.1.3, 1.1.8, 1.1.10, 1.1.11,1.1.17).

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Mental Health and Wellbeing Network					
Institute of Education, Department of Psychology and Human Development, Mental Health and Wellbeing Network		5	11	1.1.8 Young people and families could and should codeliver and coproduced training material in order to create meaningful and memorable training opportunities. Neurodiversity training should be led by neurodivergent people, otherwise there is a chance we repeat a damaging narrative that is proving to seclude and exclude autistic students. Trauma informed training for all school staff is crucial in order not to re-traumatise CYP and to replace camouflaging and challenging behaviours. Emphasis needs to be placed on how staff can plan for their behaviour and self awareness to be in control of their emotional regulation when addressing behaviours of concern of students.	Thank you. Recommendation 1.1.8 is about supporting staff. The committee did not consider any evidence about what the best ways to do this were.
Institute of Educatio		6	2	1.1.14 There is an emphasis on collaborative practice which is extremely useful but this is not defined- how can it look like for schools to coproduce policy that	Thank you for your support. The committee was aware that the social contexts in which schools operate, as well as the way the school itself works varies greatly between schools and areas. Additionally, the committee noted that production of

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n, Department of Psychology and Human Development, Mental Health and Wellbeing Network				makes sense to those who are affected by these policies. School staff will need training in codelivery and coproduction of strategies and cofacilitation skills. We strongly agree with creating opportunities for mothers and fathers to be involved in working groups.	policy is an operational matter and therefore a decision for the school. As a result, the committee felt unable to specify how individual schools would do this because it would be done in ways that are responsive to local context.
Institute of Education, Department of Psychology and Human Development, Mental		6	4	1.1.15 The voice of young carers, siblings of disabled children and neurodivergent students must be considered as these groups often remain excluded. Esp young carers and siblings who are at risk of loneliness and social exclusion, but they don't fit under any diagnostic umbrella.	Thank you. The recommendation has been modified to say that the opinions of all members of the school community should be taken into account and that appropriate adjustments should be made for neurodiversity and communication needs.

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Health and Wellbeing Network					
Institute of Education, Department of Psychology and Human Development, Mental Health and Wellbeing Network		6	9	1.1.16 Additionally to mental health leads, in line with above comments, a working group of dedicated school staff to work alongside. This working party can have access to an educational psychologist or educational consultant who will facilitate the inclusion of all voices. The working party must include CYP too, those whose voice remains marginalised.	Thank you. This recommendation came from a recognition by the committee that there needs to be a focal point for universal curriculum interventions to ensure that implementation is equitable across the school. The amount of support that person needs or how they fulfil the role is a decision for individual schools.
Institute of Education,		7	Whole page	Need to stress the fragile nature of involving school staff. For WSAs lessons can be learnt by implementation science. BERA presidential paper by Hurry et al, 2021 can be useful to consider here.	Thank you. We are unsure what your comment refers to. None of the recommendations on page 7 refer to involving staff. We assume the reference in this comment refers to the BERA presidential roundtable report titled 'The role of schools in the

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Department of Psychology and Human Development, Mental Health and Wellbeing Network					mental health and children and young people'. Roundtable reports were not included in any of the evidence reviews and would be excluded on the basis of study design.
Institute of Education, Department of Psychology and Human Development, Mental Health		7	20	1.2.5 When discussing resilience concepts, we need to be have a comprehensive and tailored approach to emotional regulation of ADHD and autistic students to avoid camouflaging responses and minimise behaviours of concern. School staff need to be sensitised on the role of focused/special interests in learning and regulating in the class.	Thank you. Neurodiversity is taken into account in recommendations throughout the guideline (for example, 1.1.1, 1.1.8, 1.1.15 and 1.4.2).

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and Wellbeing Network					
Institute of Education, Department of Psychology and Human Development, Mental Health and Wellbeing Network		7	20	A strengths based approach could be rephrased as an experience based approach. While it is important to build on streghs it is also important to recognise how CYP make sense of their struggles, what meaning they give to their experiences and personal journeys, sense of sensory comfort, sense of belonging etc. Important to have ongoing risk and strengths assessment ongoing as well as career support for at risk populations. Need to emphasise that one meeting with career mentors/teachers is often not enough and sustained support should be encouraged.	Thank you. The committee discussed this, and while they agreed that the term experience-based approach was also useful, the decided to keep the term 'strengths-based approach' as they believed this was more in keeping with the preventative approach they were promoting.
Institute of Education, Departm		8	3	1.2.6 There are neurodivergent members of school staff and students who might struggle with still mindfulness exercises or any mindfulness body scan etc.	Thank you. The wording of this recommendation has changed to include cognitive behavioural approaches as well. This creates a broader opportunity for people who might struggle with one of the approaches.

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ent of Psychology and Human Development, Mental Health and Wellbeing Network					
Institute of Education, Department of Psychology and Human Development, Mental Health and	Guideline	4	5	1.1.2 This recommendation can effectively reduce exclusion and seclusion in schools. Emphasis on relational approach is crucial and it can reform current reactive behavioural approaches that are traumatising for staff and students. We welcome this recommendation and we believe that all school staff will need training to rethink relationships as the foundation of mental health. To best achieve that it will be important to be able to promote relational practices beyond the promotion of social emotional and mental wellbeing through the curriculum and pastoral periods (e.g. assembly, collective worship) and emphasise the important contribution of other parts of the school day such as breaktimes, mealtimes and after-school or	Thank you. Your support is appreciated. The committee agreed that there are likely to be training and support needs for school staff and were emphatic that the social, emotional and mental wellbeing of staff was part of the whole school approach that they supported. The recommendations 1.1.8 – 1.1.13 refer to additional support and training that staff might need. Whilst the committee agreed that self-chosen and out of curriculum activities were important, they did not form a part of the evidence base for this guideline, hence there are not recommendations for break, lunch, after school activities etc.

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Wellbeing Network				enrichment activities. 'Open' settings like break and lunch times, where children have more autonomy to undertake enjoyable 'self-chosen' activities and to develop relationships with friends and peers, have a significant contribution to make to the social, emotional and mental wellbeing of both children and young people. They can also make an important contribution to children's sense of being part of the school community. Yet these times are often seriously overlooked and undervalued by school staff. Breaks are often withheld as a consequence for poor behaviour, without careful consideration for the effect that this practice might have on children's wellbeing. There are significant gains to be had by building in consultations with young people about these times and making the most of the positive contributions that they can have for everyday relationships and wellbeing of pupils as well as staff.	
Islington CAMHS		7	1	We believe a more neutral position on whether schools are a net source of risk or protective factors in a child's life would be helpful in section 1.1.20.	Thank you. The recommendation was not meant to imply that schools contribute to poor social, emotional and mental wellbeing, but rather to highlight that they could be part of the solution. We have reworded the recommendation to convey this more clearly.
Islington CAMHS	Evidence Review D	General	General	Evidence Review D highlights that CYP with SEND have been disproportionately impacted by COVID (p.50 L47 to to p.51 L2) and so are more vulnerable at this time.	Thank you. The committee heard expert testimony about the impacts of COVID on children with SEND and took this into account when making their recommendations. As a result of this consultation they have highlighted the importance of including children and young people with neurodiversity and

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					communication needs. For example recommendations 1.1.4, 1.1.8, 1.1.15, 1.2.5, 1.3.6 and 1.4.2.
Islington CAMHS	Evidence Review H	426-427	References 107 and 108	We question why the evidence for effectiveness of depression prevention groups based on interpersonal psychotherapy (IPT-AST groups) has been excluded from consideration. Study 107 evaluated IPT-AST against an active control group – usually a stronger test than treatment as usual. Study 108 was excluded for taking place outside of school hours, which seems overly restrictive. Schools may choose to implement interventions outside hours themselves, and it seems overly cautious to assume that an intervention that is successful on a school site after hours could not be successful during the school day. We ask the committee to reconsider the exclusion of IPT-AST, which in our experience is an effective, acceptable and comprehensively manualised school-based intervention.	Thank you. The protocol specified that only studies with a usual care comparison would be included and that interventions had to be delivered as part of the school day. 107 was excluded because it did not meet the usual care comparator criteria and 108 because it was delivered outside of school. The decisions on what was included in the protocol were made by the committee during the early development of this guideline. They agreed that it would be most useful to compare interventions to the day-to-day experience of children and young people (ie no intervention/usual practice) rather than comparing head-to-head interventions as, for this guideline, they were more interested in what works rather than what works best. In terms of delivery outside of school hours, this was a pragmatic decision taken to define what counted as a school-based intervention.
Islington CAMHS	Guideline	General	General	Islington CAMHS has worked in the borough's schools for over fifteen years, with our embedded clinicians visiting every school weekly or fortnightly. Together with the School Wellbeing Service (our implementation of MHSTs), Neurodevelopmental Pathway colleagues in the specialist schools, and other partners in the London Borough of Islington, we provide a tailored, school-based mental health service spanning aiming to reach	Thank you. Please see responses to individual comments. The comment IDs for other individual comments from Islington CAMHS are as follows: 53, 169, 224, 333, 334, 338, 343, 351, 356, 362, 363, 370, 375, 392, 397, 417, 435, 436, 437, 452, 473, 481, 484, 495, 501, 518, 521, 522, 529, 530, 531 and 532.

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				every pupil through a combination of whole-school approaches, universal and targeted input. We welcome the fact that NICE has created a guidance on SEMH provision in primary and secondary schools. We are delighted to see principles that have guided our service, like the importance of a solid whole-school approach, relational practices and trauma-informed working, feature prominently in the draft guidance. There are some areas of the draft guidance which concern us, however. These are given in detail in the line-by-line comments below, but can be summarised as follows: • We don't agree with the assertion made several times in the draft that no additional resources are needed for schools to implement the guidance since the recommendations reflect existing best practice. This does not fit with our experience and in places seems at odds with the acknowledgement in the guidance that time and other resources will be required. • We feel that the mentions of stigma in the draft guidance are weighted towards the risks of	

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				individual interventions and 'singling out', do not present these risks in the context of the possible benefits for the student, and do not advise schools on how to minimise the chances of stigma or victimisation for pupils receiving help. • The importance of school-specific risk factors for mental health could be more clearly emphasised throughout, with a more neutral stance on whether school is a net source of developmental risk or resilience for a given pupil. • We suggest that more specific mention of interventions that school could use or commission is made in the targeted help section of the guidance. • There is no mention of emotion-based school avoidance as a specific area of need. This is a pity given its close connection with school practice and its increasing prevalence in our experience. We suggest it is mentioned to raise awareness in the guidance. There could be more clarity that targeted support needs to be tailored to an individual's needs rather than a pathway that all young people of concern would follow.	

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				For example, for one child this might include incorporating a sensory diet into their school day, for another child it might include targeted academic support, and for another child it might include time out of their school day to see a psychologist.	
Islington CAMHS	Guideline	4	5	We welcome the recommendation for relational approaches. However, in relation to question 1 this will be challenging to implement in the context of the new DfE behaviour guidance which emphasises a behavioural approach.	Thank you. The committee was aware that national guidance uses both relational and behavioural approaches.
Islington CAMHS	Guideline	4	5	It may be confusing to say 'reinforces' a relational approach, since reinforcement is a key principle of behavioural approaches. 'Encourages' or 'supports' would be more congruent.	Thank you. The committee decided to use the wording "strengthens relational approaches".
Islington CAMHS	Guideline	4	9	We suggest that the success or otherwise of a school's implementation of relational approaches must be evaluated in a way that includes pupil experience feedback. One side of a relationship (e.g. staff alone) can't reliably assess how well it is going from all perspectives.	Thank you. The committee agreed that student involvement is important alongside parental involvement and reflected this in the guideline, for example see recommendation 1.1.15.
Islington CAMHS	Guideline	4	11	In addition to taking into account neurodiversity, trauma-informed approaches and parental co-production we would add the impact of social injustice and racism.	Thank you. The committee were mindful that many factors could be taken into account and determined that the impact of social injustice and racism was too specific to add into recommendation 1.1.4.

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Islington CAMHS	Guideline	5	1	We suggest that Section 1.1.6 should offer more specific and ambitious guidance about how to promote good engagement with mental health services. Other steps that could be recommended besides referral pathways include: named staff links on both sides; regular scheduled meetings, inviting mental health services to locate in schools; making pupils and parents aware of the links with services like CAMHS; finding opportunities for shared training.	Thank you. The committee discussed this but decided not to include specific guidance about how to promote good engagement with mental health services. Mental health services available will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date.
Islington CAMHS	Guideline	5	9	• It is not clear to us why the new Senior Mental Health Lead role in schools is not named explicitly here. Doing so would help to clarify lines of responsibility and promote uptake of the role.	Thank you. The committee decided not to explicitly specify a lead, as schools / colleges should have freedom to decide who would suit the role best. However, they did agree to clarify that the lead person should be senior person with authority to make decisions and authorise expenditure.
Islington CAMHS	Guideline	5	11	Our experience in schools indicates that staff require not only CPD but also supervision/consultation spaces to support their wellbeing and implementation of the school approach when working with particularly challenging cases, e.g. gang membership, a very traumatised child, behaviour that causes concern or harm. Implementing specific whole-school approaches like trauma-informed practice themselves require time for training and follow-up consultation which must be protected for all relevant staff if the approach is to be successful.	Thank you. Recommendations 1.1.10 and 1.1.11 suggest that staff should be offered protected time and space for supervision and support.

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Islington CAMHS	Guideline	5	13	We suggest that training in recognising and supporting pupils with common mental health needs (e.g. anxiety and depression) would be helpful to add into the bracketed list.	Thank you. This is covered in section 1.3 of the guideline "Identifying children and young people at risk of poor social, emotional and mental wellbeing".
Islington CAMHS	Guideline	5	20	We suggest that teaching assistants should be explicitly named as needing access to consultation and peer supervision, since they often have the most close contact time with pupils with additional SEMH needs, and typically face greater hurdles to accessing such support than teachers.	Thank you. Teaching assistants are included in "teachers and other school staff".
Islington CAMHS	Guideline	5	23	This is ambiguously phrased in our view, implying that staff need to understand how pupils interact with their environment, rather than (as presumably intended) how personal risk factors interact with environmental risk factors in different ways for each pupil.	Thank you. The committee discussed this and were content with the current wording.
Islington CAMHS	Guideline	6	2	We suggest amending to '...parents and carers representative of the range of experiences and needs in the school in designing...' For example, those who care for children with neurodevelopmental differences, those representing the ethnic and cultural groups in the school, etc.	Thank you. The recommendation has been worded in line with NICE style.
Islington CAMHS	Guideline	6	9	We believe the guidance should be explicit about the 'lead person' being the school's Senior Mental Health Lead.	Thank you. The committee decided not to explicitly specify a lead, as schools / colleges should have freedom to decide who would suit the role best. However, they did agree to clarify that

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					the lead person should be senior person with authority to make decisions and authorise expenditure.
Islington CAMHS	Guideline	7	18	We suggest that this point ought to mention differentiation as required so that this teaching is accessible to all children and young people.	Thank you. The committee decided not to mention differentiation in recommendation 1.2.4, as it refers to universal provision. By definition, universal provision is offered to all pupils and any differentiation would be at the school / college's discretion.
Islington CAMHS	Guideline	9	Box 1	We suggest that "Behavioural difficulties" might be better phrased as "Engaging in behaviours that cause concern".	Thank you. The committee wanted to avoid using pejorative terms such as behavioural difficulties.
Islington CAMHS	Guideline	9	Box 1	An "extended period of low mood" is given as an example of a change in behaviour, but this is not a behaviour. Consider an alternative example of a behaviour that may indicate low mood, e.g. becomes withdrawn in the classroom or at break times, becomes more disruptive in class, begins to attend lessons late, etc.	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Islington CAMHS	Guideline	9	Box 1	Neurodevelopmental diagnoses are missing from this box, e.g. autism, ADHD, intellectual disability. These are key risk factors for poor SEM outcomes and are evident in Evidence Review D.	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the

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					Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Islington CAMHS	Guideline	9	8	Some children and young people may have existing assessments, e.g. from CAMHS or Educational Psychology. Guidance might reflect that it is necessary to ensure handover of these as a child progresses through education and across teachers with key recommendations reflected in a support plan.	Thank you. Recommendation 1.3.3 has been expanded to include "Take into account any existing assessments, for example from educational psychology or child and adolescent mental health services (CAMHS)."
Islington CAMHS	Guideline	10	18	There have been some wonderful examples of good practice liaising with families where schools have been able to put in place a home-school liaison role rather than relying only on class teachers to carry out this role. This does however have a cost implication for schools.	Thank you. Unfortunately, NICE no longer maintains its shared learning database due to lack of resources and therefore is unable to add examples of good practice to it.
Islington CAMHS	Guideline	11	9	We are concerned that the advice about stigma may inadvertently dissuade staff from providing targeted individual support. It is very important that pupils can access individual school-based support in a confidential way, but it is usually impossible to avoid some awareness among peers that the pupil has been doing something they haven't. The decision is	Thank you. The committee discussed this and agreed to add "proactively normalise seeking support" to recommendation 1.4.7.

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				whether the risks from this imperfect confidentiality outweigh the benefits of the intervention for the pupils; usually they do not. In our view section 1.4.7 might steer staff away from accepting a 'good enough' level of confidentiality and unhelpfully raise concern that any tailored provision means 'singling out'. We also suggest that this section of the guidance addresses what schools can do to minimise stigma in positive ways e.g. normalising leaving class for an SEMH provision of some kind.	
Islington CAMHS	Guideline	11	12	We suggest that section 1.5 recommends that schools identify and communicate with the professional network around the child, if there is one, as part of good transition support.	Thank you. The committee agreed with this suggestion and have added an extra bullet point to recommendation 1.5.2.
Islington CAMHS	Guideline	13	1	As above, we believe the Senior Mental Health Lead role should be named here.	Thank you. The committee decided not to explicitly specify a lead, as schools / colleges should have freedom to decide who would suit the role best. However, they did agree to clarify that the lead person should be senior person with authority to make decisions and authorise expenditure.
Islington CAMHS	Guideline	13	19	Since assessing belief is not always straightforward for younger pupils, we suggest expanding the definition of 'Psychological safety' to make clear the other ways it can be inferred e.g. from help-seeking behaviours, showing feelings, etc.	Thank you. The definition is to describe psychological safety. It does not discuss assessing it.

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Islington CAMHS	Guideline	10 to 11	9 onwards	The section on Targeted support does not reference putting in place a support plan, nor how this support might be evaluated or monitored over time. This would be a helpful addition. It might also be helpful to reference how this information is passed on over the years in education. It is our experience that this targeted support can be challenging for schools to implement. There can be cost implications in terms of staff numbers for the school, and broader resource implications. For example, there is currently a shortage of occupational therapists and speech and language therapists in our area which means that schools do not have the support they may typically expect to train up their teaching assistants and put groups in place.	Thank you. The committee added a recommendation about working collaboratively with external agencies and the professional network around the child. The committee was aware of difficulties in accessing services but has no control over service levels since these are negotiated locally. Recommendation 1.1.20 recommends making the local offer clear to schools.
Islington CAMHS	Guideline	23	5	We disagree that the recommendations for following a whole-school approach do not generally need additional resources because they reflect current best practice. It is our experience that schools seeking to adopt and maintain a comprehensive whole-school approach always need significant additional time to do the training and engagement mentioned at line 10. INSET days do not provide enough time and are not the best format for ensuring a whole-school approach is maintained in routine staff practice over time. Consultation, group	Thank you. The committee discussed and agreed that INSET days do not provide sufficient time to dedicate to a whole school shift. They emphasised that the demands are mostly in terms of time, particularly for CPD, ongoing staff training and support. The wording of the rationale and impact section has been amended to state that "the committee recognised that adopting and maintaining a whole-school approach needs significant additional time".

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				reflective practice and supervision are essential and require additional resources.	
Islington CAMHS	Guideline	11 to 12	21 onwards	This section does not include guidance to have a written transition plan for how a young person will be prepared for their move, nor visual supports for the young person (e.g. photographs, timeline).	Thank you. Evidence regarding written transition plans and visual supports were not identified in the evidence review or brought up by the committee. Therefore, they have not been included in this section of the guideline.
Islington CAMHS	Guideline	28	19	In our view it is essential that schools take responsibility for the supervision of the SEMH specialists they employ, as well as ensuring they have the relevant training and experience. Supervision may come from other staff members or peer arrangements, but external supervision can be very valuable.	Thank you. Recommendations 1.1.8 – 1.1.13 discuss supporting staff, including offering them CPD, supervision and support.
Islington CAMHS	Guideline	28	30	As above, we suggest amending this section to give a more realistic and balanced account of the risks and benefits of individual support in schools, and to make clearer the steps schools should take to minimise stigma while offering targeted help to those who need it.	Thank you. This section is used to explain the committee's rationale and impact for making the recommendations on targeted support. Additionally, following committee discussion, recommendation 1.4.7 was amended to include "proactively normalise seeking support".
Islington CAMHS	Guideline	29	13	There is evidence that peer mentoring interventions provide at least as much benefit to the psychological wellbeing of the mentor as the mentee and it would be good to see the concept of mutual benefit reflected here.	Thank you. This was not identified in the evidence reviews or by the committee and therefore has not been included in this section.
Islington CAMHS	Guideline	29	22	As above, we disagree that the recommendations for targeting support are 'unlikely to have a resource	Thank you. This was discussed by the committee and it was their view that the recommendations were unlikely to have a

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				impact' simply because they reflect current best practice. This is not our experience and lines 24-27 acknowledge that there will be resource impacts of time and money.	substantial resource impact. NICEs resource impact team have produced a statement to support the implementation of this guideline. It can be found on the guideline webpage. This notes that cost will most likely be met with a reprioritisation of resources rather than by spending additional time and money.
Kent School Health Service				Collated feedback on the NICE guideline's consultation on behalf of Kent School Health's emotional health offer including the KCHFT's School Nursing Service and Children and Young Peoples Counselling Service. This is an excellent paper drawing on the existing skills and knowledge of schools to be inclusive and offer whole school approaches through a spiral curriculum and wider offer to support emotional health, mental health and wellbeing. Interesting and positive that the approach is to move away from labelling which is good and using statements like "symptoms of anxiety and depression" make it clearer that this is not necessarily formal diagnosis.	Thank you for your support.
Kent School Health Service				Reflections of best practice: If we can all aspire to best practice then this document does indeed reflect best practice. However, will this be high priority and followed by all schools or given the same value and kudos? I hope this document is utilised to its maximum and informs school policy as per recommendation.	Thank you for your support.
Kent School				Additional Comments: the use of Mental Health Support Teams will be vital, but not yet in all schools	Thank you for this information.

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Health Service					
Kent School Health Service		4		What main points in the document impact School Health: page 4: Whole School Approach is vital in contributing to the guidance with support to schools on resilience/PSE/mindfulness etc. Partnership working and links with external agencies are strengthening our approach, as well as wellbeing conversations with schools to identify gaps and strengths. The Resilience Toolkit is a vehicle to engage and ensue robust governance. There is no direct reference to School Nursing Service as a resource; however, there is mention of 'utilising other services,' which could relate to the School Nursing offer. This document may give us the evidence/research base that schools require to encourage increase in uptake of our health and wellbeing questionnaire we offer to schools.	Thank you. The committee decided not to make direct reference to School Nursing Service as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. School nurses are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
Kent School Health Service		5		Supporting staff: page 5 This is something that we are starting to respond to following wellbeing calls. We can also signpost directly to Wellbeing for Education Return and TEP for additional support. We support teacher development through training around key public health priorities, and	Thank you for this information

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				have commissioned sessions from PHSE Association to enhance this. Anna Freud Links Programme roll-out in Kent also supports this and we are part of the strategic group steering this work. School staff often highlight a lack of 'clinical' supervision, especially where there are problematic year groups or very vulnerable cohorts, but I do think this has strengthened through the pandemic.	
Kent School Health Service		6		Local support: page 6 Whilst we know (because we are in the system) that concerns from schools are raised and escalated, there is again a disconnect between schools feeling fully supported, and them feeling that they are lost. There are long waits and high thresholds for specialist support, and this can often feel discouraging for schools and families.	Thank you. Unfortunately this is not an issue that can be resolved with NICE guidelines.
Kent School Health Service		7		Universal curriculum content: page 7 The WSA Team are well placed to support this – we are providing training and awareness on utilising a spiral curriculum, seeking advice from expert organisations to add value to our offer around key topics, and covering both EHWB and RSE within our service offer (training, support, resources and curriculum).	Thank you for this information.

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				We work closely with commissioners and KPHO to identify those schools who may need a greater support network due to risk factors for poor social and emotional wellbeing, but those schools are at points not able to respond to additional offers of support.	
Kent School Health Service		8		Identifying children and young people at risk of poor social, emotional and mental wellbeing: page 8 We are providing training to school staff around having Resilience Conversations with children and young people to identify key strengths and difficulties, and to identify where there may be adverse childhood experiences. The Resilience Toolkit looks at universal (whole school) support as well as targeted interventions, enabling schools to start to build a picture of young people/families in their community. We are able to engage Special Schools to work on the Resilience Toolkit, and have begun to include them in wellbeing calls, alongside scoping where they could be invited to participate in TLM questionnaires.	Thank you for this information.
Kent School Health Service		10		Targeted support: page 10 *more relevant to clinical teams/counselling service, but across the board I would be confident that we are offering robust care. Via The Resilience Toolkit offer, we	Thank you for this information.

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				can direct schools to a toolkit to support peer-to-peer support, which has been extremely popular with schools.	
Kent School Health Service		10		Tools and Techniques (page 9): page 10: When selecting a tool or technique to assess social, emotional and mental wellbeing, take into account: the child or young person's needs." Important to add 'with consideration of their wishes and feelings.' (Comment from our counselling service) The guidelines show tools for measuring mental and emotional well-being of children in terms of outcome scales and scoring of mental health presentations, the emphasis in the guidelines seems to be on schools taking a more pro-active approach to children's mental health, however, my concern would be that school staff would not be sufficiently qualified in mental health to record these outcome measures or know what to do if the outcome measures show significant mental health risk, the guidelines do not provide information on what to do with the scores for the child. Suggesting that the school either 'monitor or offer targeted support' my question would be, how would they monitor and what targeted support would they offer. I could not see any suggested 'techniques' to use with children with mental health presentations, only measurements? (Comment from our School Health Service) Using evidence-based outcome measures to evaluate our own	Thank you. We have added wishes and feelings as you suggest. The tools suggested by the guideline are for assessing children's social, emotional and mental wellbeing and intervening with targeted support if their wellbeing is poor. Children who show signs of mental ill-health would be directed into the appropriate services to assess them and their needs. This is not the role of teachers as you note. The decision to recommend the use of these tools was based on the committee's expert opinion.

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				work (Goals Based Outcomes, Child Outcome Rating Scale) and directing schools to information about similar tools (via Anna Freud Centre).	
Kent School Health Service		11		Support with school-related transitions and other life changes: page 11. On the whole, I believe this is well managed, and through the pandemic we managed to produce narrated sessions to support schools requesting additional help.	Thank you for this information.
Kent School Health Service		11		Page 11: "Explain the support to the child or young person and involve them in decisions about the support offered to them, including when and where it is offered." This is paramount to the process. Page 12: "After transitions between schools: Check on an ongoing basis to see whether the child or young person is settling in and thriving after moving to a new school. Offer them tailored support if necessary. Check more regularly if the child or young person is at a higher risk of poor social, emotional and mental wellbeing." Will 'regularly' be quantified? Page 13: "Behavioural approaches An approach to classroom or school management that focuses on establishing clear expectations for appropriate behaviour, monitoring behaviour, and then reinforcing appropriate behaviour and redirecting or sanctioning inappropriate behaviour" What provision will there be for those out of education?	Thank you. The committee agreed that it was important to have buy-in from children and young people and that this was central to the relational approach. Regarding transitions, the committee discussed this and agreed that it would not be helpful to arbitrarily quantify 'regularly' since this would depend partly on the child or young persons need and partly on the way the school operated. It was agreed that it would be more helpful to allow schools to determine this based on their existing practice. The definition of behavioural approaches has been removed.

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London Borough of Harrow	Guideline	1	7	**Description of scope of guidelines:** "It aims to promote good social, emotional and psychological health to protect children and young people against behavioural and health problems." This may seem like a minor point but we feel the purpose of the guidelines and what schools do should be to promote good social emotional and psychological health… full stop… because this is what schools should be about i.e. supporting the development of emotionally and psychologically healthy individuals and not just for the purpose of guarding against mental health problems. It might just take a change to read something like: "It aims to promote good social emotional and psychological health, and to protect children and young people against behavioural and health problems."	Thank you. The scope of the guideline is determined at the start of the process and underpins the review questions and process. We are unable to change the scope following the development of the guideline.
London Borough of Harrow	Guideline	4	5	**Inclusion:** The second paragraph is a powerful opener to the whole guidelines that we welcome very much. However, we would like to see more mention of the principle of 'inclusion' as part of the ethos of a school or college that is as supportive as possible of student emotional wellbeing.	Thank you. The principle of inclusion has now been mentioned to recommendation 1.1.2. and added to the rationale and impact section of the guideline.

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London Borough of Harrow	Guideline	6	13	**Role of headteacher:** The guidelines are spot on here and elsewhere in the document in terms of thinking of the role of the school / college leadership, however we feel that more needs to be done specifically to support the position of the headteacher. As the guidelines state under the definition of 'psychological safety', emotional wellbeing depends on us having places where we can express our feelings without fear of judgement or humiliation. Headteachers are more exposed than anyone in the world of education to the potential for judgement and humiliation. Headteachers often report how isolated and unhappy they can feel. As so much of the culture in a school / college depends on the tone set at the top, for staff and pupils to feel 'psychologically safe' it is essential that the headteacher has spaces where s/he can feel 'psychologically safe'. The word 'vulnerable' is not used in the guideline's definition of 'psychological safety' but that is effectively what we are talking about. It is also something that so many headteachers feel they are not allowed to be. Without a headteacher who feels 'psychologically safe' and is able to tolerate their own vulnerability any attempt	Thank you. The committee agreed to change recommendation 1.1.1 to clarify that it was important to support the wellbeing of staff as well as children and young people.

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				to introduce whole school approaches is much less likely to succeed. An additional paragraph is needed that makes more mention of the support that governing bodies, local authorities, regional commissioners, MAT boards etc. should all ensure that headteachers can be supported sensitively by being offered and using places of 'psychological safety'. This needs to be spelled out more clearly.	
London Borough of Harrow	Guidelines	5	19	Supervision needs to be defined. The definition / explanation in the document on supporting school staff by the Anna Freud Centre is very good: https://www.annafreud.org/media/11451/3rdanna-freud-booklet-staff-wellbeing-new-address-april-2020.pdf#page=6 In Harrow we recently ran a number of professional supervision groups for different constellations of school staff. One of the key findings of our academic evaluation of this project was that professional supervision groups did not work so well where the head or managers of that group of staff were involved. The committee might like to think about	Thank you. The committee discussed this, but believed that teachers were very familiar with supervision as it is part of their current practice.

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				including mention of this aspect that needs careful thought when setting up any supervision groups.	
London Borough of Harrow	Guidelines	5	20	Peer supervision needs to be defined. We would also question how peer supervision can be sustained in the long run without some form of external expert input. As we have set out in some of our comments above, schools are operating in an environment which, without strong support/protection from governors, etc., could be defined psychologically as 'persecutory' as the external pressures and judgements are so great. In that context it is a natural human reaction to become a group of 'insiders' battling against hostile external forces – 'splitting' to use the psychological term. This is what an external professional is there to guard against. There is a risk of creating only nominally psychologically spaces without any external challenge. The committee might like to consider forms of words to highlight this risk when setting up peer supervision groups.	Thank you. The recommendation has been reworded to clarify. The guideline does not recommend setting up peer supervision groups. School staff would normally be supervised as part of their role and this can be both internal and external. Mechanisms for peer supervision in individual schools are for those schools to decide depending on the way the school is set up and run. .

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London Borough of Harrow	Guidelines	6	9	Role of 'lead person': while it does have resource implications there needs to be recognition that the lead person needs to have sufficient protected capacity to carry out the role and influence change. Possibly also some reference to the capacity given to the designated Senior Mental Health Leads, and other Senior Leadership, in order to implement the whole school approach.	Thank you. Schools / colleges have the freedom to choose who the designated lead person should be depending on who they feel would be best suited to the position. As this will vary across schools / colleges, NICE cannot be too prescriptive about capacity given to this role.
London Borough of Harrow	Guidelines	7	7	Teaching and learning / general pedagogy: It is pleasing that the draft guidance has a focus on mainstreaming social and emotional wellbeing into the curriculum. However, we feel that there could be more weight placed on pedagogy itself as part of the recommendations regarding the whole school approach. Under the definition of 'whole school approach' on p.14 of the draft guidance the first bullet point is: "curriculum, teaching and learning" and reference is then made to the PHE / DfE guidance: Promoting children and young people's mental health and wellbeing - A whole school or college approach. However, within this PHE / DfE document the only real reference to curriculum, teaching and learning is to adjuncts to teaching and learning i.e. additional lessons on the Penn Resilience Program or Healthy	Thank you. The committee discussed your comment and agreed that the quality, breadth and personalisation of teaching and learning is important, but that this guideline is not about the quality of teaching and learning but about promoting the social, emotional and mental wellbeing of students and staff.

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				Minds etc. (See pages 17 + 18 of the PHE / DfE guidance.) In doing so the focus is on the students and not on universal pedagogy which is about what the teachers are doing and how they view their pupils etc. This is a significant gap in terms of developing a whole school approach. The quality, breadth and personalisation of teaching and learning in general has perhaps more impact on emotional and mental wellbeing than, say, the quality of PSHE lessons, or resilience groups etc. Quality – e.g. that the teaching itself is engaging and inspiring; Breadth – e.g. that there is sports, arts and opportunities contributing to student wellbeing; Personalisation – e.g. that there is vocational curriculum matched to needs where academic is less well suited to some. How does the young person's experience of teaching and learning in the school enable all CYP – with varying abilities, interests etc. The draft NICE guidance uses the wonderful term of 'curiosity' which underpins so many of the best approaches to better emotional wellbeing. In term of	

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				pedagogy building 'curiosity' about pupil distress in learning situations include approaches: • relating to the theories of Vygotsky, such as the 'Zone of Proximal Development' and 'scaffolding' in learning which, while clearly at the basis of aspects of national policy (for example the initial teacher training core curriculum Standard 1.1, DfE 2019) tend to be sidelined when the discussion turns to behaviour. • from personal construct theory, such as the idea of a personal philosophy of learning: a student believes that capacity to learn is fixed by nature 'I am never going to be any good at maths' and therefore can see no point in making an effort in the subject. (We note that the phrase 'mixed-ability' class, as opposed to 'mixed-attainment class' is still current in much of the language around teaching and learning generally.) These approaches have implications for whole curriculum design in any learning institution: there is a limit to what the individual teacher can do when the ethos of their surroundings is (rightly) to challenge students, but without offering them flexibility and empathy in finding paths to learning.	

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London Borough of Harrow	Guidelines	7	7	Exam pressure: When in Harrow we surveyed 6,000 of our young people 'exams' emerged as the biggest worry for our pupils in KS 4/5: https://youngharrowfoundation.org/images/downloads/ypfWebsite/hay_harrow_digital_brochure.pdf#page=20. The PISA study found that the UK's 15 year olds have the lowest level of life satisfaction of any country in Europe and the only factor that correlated – almost perfectly – to this was 'fear of failure': https://www.childrenssociety.org.uk/sites/default/files/2020-11/Good-Childhood-Report-2020.pdf#page=23. Some of the countries that put less pressure on their pupils achieve better academic performance – at least according to the PISA standardised assessments e.g. Finland. Schools are in a difficult position but some manage this better than others. A quote from a 16 year old in the Children's Commissioner for England's Big Ask survey 2021 illustrates how pupils can feel who are in schools that do not manage this well: "despite constant mental health assemblies, the reality is that schools pressure their students immensely". We would like to see a much clearer statement under the section on the 'Universal Curriculum	The committee agreed that exam pressure can be detrimental to children and young people's social, emotional and mental wellbeing. However, as no evidence regarding exam pressure was identified in the evidence reviews. The committee decided not to explicitly mention this in the guideline.

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				content' or within the definition of 'Whole School Approach' along the lines of: "Schools and colleges should be aware of their role in sometimes putting excessive pressure on pupils in regard to performance in exams and should develop understanding of when pressure is counter-productive to both pupil wellbeing and performance and that this can vary between pupils."	
London Borough of Harrow	Guidelines	7	20	Strengths-based approaches: The guidelines recommend using "non-judgemental 'strengths-based' approaches to support children and young people's social, emotional and mental wellbeing." We very much support this recommendation but this needs more definition and a brief rationale; it should have an entry in the section on 'Terms used in this guidance' along with an example from a school / college setting that illustrates what 'strengths-based' is, as well as what it is not.	Thank you. The recommendation explains what it means by strengths-based approaches – ". These are approaches to improve or develop their: • self-worth (for example, self-esteem, empowerment, self-care) • skills (for example, problem solving skills, social skills, communication skills) • resilience (for example, coping skills and strategies, perseverance)".
London Borough of Harrow	Guidelines	8	3	Mindfulness: We feel it would be a mistake for the guidance not to give more consideration as to when mindfulness would be contra-indicated.	The committee reconsidered the evidence on mindfulness-based approaches and discussed the evidence at length. It was noted that recommendation 1.2.7 states "consider universal interventions informed by mindfulness". The strength of this recommendation implies that it is not always appropriate

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				Mindfulness can increase awareness of all manner of feelings, including negative feelings. Adults report that mindfulness can make them feel more rather than less emotionally fragile. Research from 2016 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5353526/) in regard to adults found that: "A cross-sectional study on the effects of intensive and long-term meditation reported that over 60% of individuals had at least one negative effect, which varied from increased anxiety to depression and full-blown psychosis. Qualitative research on mindfulness meditation shows that it may increase the awareness of difficult feelings and exacerbate psychological problems." A study from 2017 (https://journals.sagepub.com/doi/10.1177/0004867417716309) of the potential negative impact of mindfulness (written by authors who say they teach mindfulness themselves) comes to the conclusion that the studies highlighting the negative impact are small but that they "would argue that it is a lack of understanding of the nuances of mindfulness among some instructors – and the subsequent poor teaching of mindfulness – that is likely to pose the greatest risk to patients."	to use interventions informed by mindfulness, such as instances where the intervention is contra-indicated.

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				It seems irresponsible to recommend mindfulness as an approach without more caveats along the lines of "staff delivering mindfulness sessions should be sensitive to pupils who may have negative experiences while practising mindfulness".	
London Borough of Harrow	Guidelines	8	6	Rhythmic physical activity: We presume this mainly means dance which we acknowledge can be hugely beneficial in terms of accessing and giving expression to emotions. The links between movement, dance, music and trauma are well established. We feel it might be worth defining more what 'rhythmic physical activity' means.	Thank you. A definition for rhythmic physical activity has been added to the "Terms used in this guideline" section.
London Borough of Harrow	Guidelines	8	12	Contradictory messages in guidelines: The recommendation to identify CYP who are 'at risk' of poor social, emotional and mental wellbeing has the potential to run counter to the recommendation to adopt strengths-based approach. You can see the pitfalls of un-mindful identification of 'at risk' children when it comes to Looked After Children or children with SEND. They invariably tick a large number of 'at risk' boxes, and so	Thank you. The committee clarified that they were not suggesting schools use tools to screen every student in order to identify those who are struggling emotionally, but that school staff should use observation and relationships to identify those students they have concerns about and then use appropriate tools to assess them.

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				professionals who deal with them can have a natural tendency to define them by their weaknesses and problems. Many of us have been in meetings about a LAC or SEND child where none of the professionals can answer the question: "what does this child do well?" If you have staff trained in the key contributory factors for mental wellbeing / ill-health i.e. trauma-informed approaches (and all the different ways that trauma can be cumulative in terms of abuse / neglect / attachment / deprivation / racism etc.), they will be as well placed as possible to identify children who are struggling emotionally. And in the same vein, staff well-trained on SEND issues will be well placed to identify and support – or seek support for – children with SEND. Using any other 'tool' to identify children who may be predisposed to struggle emotionally means you go looking for problems where more often than not there are none because even children who tick many ACE boxes can thrive when they have sufficient protective factors that counterbalance the negatives.	

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				It might also be worth pointing in any mention of 'tools' to the need for a school to think about how to create the right conditions for students to talk to and be heard by key adults i.e. this comes back to the relational aspect and the quality of those relationships in a school or college. We can see from the comments on p.25 of the guidance that there was a very considered debate among the committee members on this topic but if tools are going to be mentioned we hope the committee can put emphasis on the first priority being to have well-trained and supported staff before any 'tools' or 'metrics' are applied and the guidance should make this clearer. (See also our comments on observation / tools below.)	
London Borough of Harrow	Guidelines	8	12	Need to give primacy to staff ability to spot a struggling child: This section needs to put more weight on what has been reduced to just one word in the second paragraph: "observation". "Tools" around mental health can be disempowering and a sense of disempowerment runs against the grain of whole school approaches. This needs to be a human, not a mechanical system.	Thank you. The committee discussed this and decided that the importance of all staff being empowered to support children and young people's social, emotional and mental wellbeing is adequately covered in the whole-school approach section of the guideline. This is particularly highlighted in the recommendations that fall under the "Supporting staff" heading. This in turn will hopefully make staff feel more empowered when identifying children and young people at risk of poor social, emotional and mental wellbeing.

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				The primary way to identify and support children who are in distress is to have staff at all levels in a school or college who feel empowered and able to use their gut instinct, the confidence to trust it, the permission to use it and – crucially – a space to discuss it as this will guard against the pathologising of pupils who, for example, a member of staff finds too challenging. This comes back to the importance of high quality supervision and similar approaches. If teachers and teaching staff have a space which is like a gym for that muscle in their minds that helps them spot the child who is struggling that is far more effective than any mechanical tool that anyone can devise. It reinforces the ethos that has to underpin any successful whole school approach, creates a space for "curiosity" as the guidelines put it so well, and models something for teachers by creating space for "psychological safety" that the teachers can then give back to the pupils.	
London Borough of Harrow	Guidelines	13	18	Maintaining spaces of psychological safety: It is very welcome to see the inclusion of psychological safety in this draft guidance. Psychological safety is essential to a whole school approach but it is both a	Thank you. The terms used in this guideline section intends to give simple explanations of concepts so that people can understand the guideline.

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				complex and paradoxical phenomenon. It is complex because what makes one person in a group feel safe, can make another person in the same group feel unsafe; it is paradoxical because if you aim to make things completely safe, things actually start to become more unsafe. We feel it is important that the guidance acknowledges this complexity, otherwise we are potentially setting organisations up to fail when they try to create and maintain spaces that are more psychologically safe. Psychological safety in groups depends on the creation of a tolerant, boundaried space where there are predictable, fair rules. This is the part that almost everyone can sign up to at the beginning. The difficulty comes in maintaining this under pressure when the boundaries are being tested and the balance can easily tip a group or organisation over into intolerance, sanctions and exclusion when confronted with behaviour or thoughts that some members (particularly the leadership) find too challenging. We suggest that the definition of psychological safety would benefit from a slight expansion to cover more components of maintaining spaces of	

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				psychological safety that could include the points that: • There is an understanding that it is normal when under pressure we all retreat into more judgemental, stereotypical, intolerant, critical and retaliatory ways of thinking and behaving. • The group has and gains confidence that it can manage challenging behaviours and thoughts, and conflict between members of the group / organisation, and that through resolving conflict the group / organisation can grow.	
Mental Health Foundation	Guideline	General	General	This guidance would benefit from using more accessible terms for the target audiences. Words like "intervention" in a school context can mean something as straightforward as a phone call to parents; further, the word is often used in a behaviour management/punitive context, which means it can have negative connotations. Words like "universal" and "targeted" could either be explained or substituted for "approaches for everyone" and "approaches for those at greater risk".	Thank you. The committee discussed this and agreed that explanations should be provided for terms such as 'universal' and 'targeted'. The committee also discussed the use of the word intervention but decided to keep this term as they deemed it an accessible term.

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Mental Health Foundation	Guideline	4-5	1.1.6	Consider adding additional bullet points: • Having a publicly available, written mental health policy that sets out the school's whole-organisation approach to mental wellbeing Maintaining a register of psychological hazards and the steps taken to mitigate them.	Thank you. The committee discussed this but decided not to add these bullet points as these may not be feasible to produce and maintain.
Mental Health Foundation	Guideline	4	1.1	This section would benefit from a paragraph on preventing mental health problems. Prevention is included in the rationale for the decision to include the whole-school approach (pg 19, line 11), so it is important to state that aim in the body of the guidance to ensure that school leaders are sighted on a proactive, preventative approach.	Thank you. The committee discussed this but agreed it was already clear that the aim of the guideline was to prevent poor social, emotional and mental wellbeing.
Mental Health Foundation	Guideline	4	3	Suggest changing "support positive social, emotional and mental wellbeing" to "promote positive social, emotional and mental wellbeing"	Thank you. The committee discussed this but decided to keep the wording "support positive social, emotional and mental wellbeing" as the language sounded more nurturing.
Mental Health Foundation	Guideline	4	4	Suggest adding a clause or sentence explaining what the "whole-school approach" is. The term is used throughout the document and a short explanation at the start would help readers to understand the concept without having to jump to the glossary at the end of the document.	Thank you. It is standard NICE process to provide explanations of terms in the terms used in this guideline section of the document.

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Mental Health Foundation	Guideline	4	13	Change "parental co-production" to "co-production with parents and children"	Thank you. The committee were content with the current wording.
Mental Health Foundation	Guideline	4	15	Consider adding some examples of ways that the whole school approach could be monitored and evaluated, for example by tracking changes in wellbeing using one of the measures included in PHE's 'Measuring the mental wellbeing of children and young people' guidance; logging and periodically reviewing psychological hazards and their mitigations; or measuring levels of mental health literacy in students and staff.	Thank you. The committee decided not to provide examples of how to monitor and evaluate whole-school approaches. They were mindful that different schools will have their own systems and there is no one correct way to conduct monitoring and evaluation.
Mental Health Foundation	Guideline	5	1.1.12	• Add a sentence on teachers understanding that they can help and the value of their care and attention. There is often a fear in schools that mental health interventions need to be carried out by a professional, but there is a lot of value in teachers showing that they care, checking in with a child, and asking about how a child feels. Certainly, this is much better than appearing to avoid something and leaving it to the school's pastoral support alone.	Thank you. The committee agreed that the spirit of this was already encapsulated in the recommendation.
Mental Health	Guideline	6	1.1.16	The designated lead should also be responsible for ensuring that other staff are appropriately knowledgeable about mental health and the steps they	Thank you. The committee did not see any evidence to support this specific approach, however the current recommendations

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Foundation				can take to support pupils at the school. For a whole-school approach to work, the designated lead must follow the "train the trainer" model, rather than taking sole responsibility for mental wellbeing at the school.	encompass this within the recommendations about CPD for teachers.
Mental Health Foundation	Guideline	6	17	Add to the end of the sentence "and in which mental wellbeing is proactively promoted."	Thank you. We believe this is implied throughout the guideline and does not need to be explicitly stated here.
Mental Health Foundation	Guideline	6	21	Replace "content" with "approaches". "Content" implies that the school's universal approaches are curriculum-led rather than holistic.	Thank you. We have amended this.
Mental Health Foundation	Guideline	9	9-10	Move the brackets to after "monitor their social, emotional and mental wellbeing". As it currently stands, it looks like the "recommendations on tools and techniques" will cover both monitoring and targeted support when the section only covers monitoring.	Thank you. We have moved this as you suggest.
Mental Health Foundation	Guideline	9	6 (Box 1)	This box conflates risk factors with indicators that someone might be experiencing a mental health problem. We suggest that this box be split into two boxes. One should include "risk factors for poor mental health", and include: • Adverse childhood experiences, including:	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.

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				○ experience of a household with domestic violence ○ parental abandonment through separation or divorce ○ a parent with a mental health problem ○ being the victim of abuse (physical, sexual and/or emotional) ○ being the victim of neglect (physical and emotional) ○ a member of the household being in prison ○ growing up in a household in which there are adults experiencing alcohol and drug use problems. • Chronic illness or poor general health • Experiences of poverty or social disadvantage • Experiences of discrimination or stigma • Being bullied • Social isolation The second box should include "signs that a child or young person might be experiencing mental health problems, specifically: • Behavioural difficulties • Changes in behaviour, such as extended low mood or withdrawal	

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				• Self-harm or suicidal ideation • Educational difficulties • Taking part in bullying • An inability to concentrate or pay attention	
Mental Health Foundation	Guideline	10	1.3.6	Consider adding a bullet point on "the burden on teaching staff"	Thank you. The list of factors mentioned in recommendation 1.3.6 is not designed to be exhaustive and the committee agreed that the examples given were sufficient.
Mental Health Foundation	Guideline	10	4	Add "and how it will be used"	Thank you. The committee believed this was implicit in the current wording.
Mental Health Foundation	Guideline	11	11	Add "by considering how the intervention would look from the perspective of the child." Additionally, from our engagement with school children through our programmes, we have heard that children would value a "safe space" in schools where they could take time out of their day in a safe, predictable environment. This space could be supervised by a pastoral worker, allowing children to open up if they want to, but without there being any expectation that they should do so. Safe spaces such as these would need to be described using non-stigmatising language and their design	Thank you. The committee agreed that children would already have been involved in this because of earlier recommendations. The committee was interested in the idea of safe spaces, but did not hear enough evidence that they were effective to be able to make a recommendation.

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				coproduced with school children to ensure that they deliver what the children need. This is an example of how an intervention might be approached to avoid unintended adverse consequences.	
Mental Health Foundation	Guideline	12	1.5.2	Where possible, primary and secondary schools should maintain close connections to facilitate some events/meetings between pupils in Year Six and members of the secondary school, to help to ease transition. For children leaving secondary school, high-quality careers advice and guidance is an important way of mitigating the potentially difficult transition from secondary school into adult life. This is especially important for disadvantaged children who are less likely to be going on to higher or further education.	Thank you. The committee agreed that close liaison between schools was implicit in recommendation 1.5.2 and 1.5.3.
Mind				**Rec 1.1 Whole-school approach:** Mind supports the recommendation to adopt a whole-school approach to support positive social, emotional and mental wellbeing in primary and secondary education. The findings of Mind's report – Not Making the Grade (2021) – highlights why having a whole-school approach to mental health is so important. It identified that some young people find that mental health support at secondary school is hard to access or doesn't meet their	Thank you for your support.

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				needs. Less than four in ten (38%) young people surveyed said they had received support from school for their mental health. Over a third (36%) of young people told Mind that they did not want mental health support from their school. For some young people, this was because school was not a trusted setting. Stigma associated with seeking support and concerns about confidentiality were identified as reasons for not seeking help.	
Mind				**Rec 1.3 Identifying children and young people at risk of poor social, emotional and mental wellbeing:** Mind supports this recommendation and welcomes the advice for schools to consider behavioural difficulties as a risk factor for poor mental wellbeing. Mind's report (2021) found that almost half (48%) of young people had been disciplined at school for behaviour that was due to their mental health. Over one in four (27%) of those who had been subjected to these interventions said that they had been placed in isolation and one in ten (10%) had been physically restrained by staff. The use of isolation as a punishment is likely to fall disproportionately on young people experiencing mental health problems, especially those struggling to manage	Thank you for your support.

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				their behaviour. Segregating young people can have the opposite of the intended effect, making them feel distressed, traumatised and potentially worsening their mental health, behaviour and ability to excel in school. Both teachers and parents recognised that young people affected by mental health problems at school can face a punitive response. Half (50%) of school staff and parents and caregivers (52%) were aware of young people at their school being disciplined for behaviour that was related to their mental health. Parents described incidents of their child being threatened with or experiencing exclusion and being shouted at or told off in front of other students.	
Mind				**Rec 1.4 Targeted support:** Mind welcomes the recommendation to provide targeted individual or group support to children and young people who have been identified as needing additional social and emotional support or mental health support. However, it is crucial that the barriers that prevent some young people accessing support and/or finding it helpful are recognised and that support is tailored to meet their needs. These issues were explored in Mind's report (2021). Young men from Gypsy, Roma, and Traveller	Thank you. The committee had lengthy discussions about the ways that children and young people internalise poor social, emotional and mental wellbeing, and reflected this in recommendation 1.3.2 and the associated rationale and impact section. They agreed that more research needed to be done to help identify the early signs and made a research recommendation about this. Recommendation 1.4.7 addresses the issue of normalising help-seeking and 1.4.6 encourages interventions to help children and young people to express difficult feelings.

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				backgrounds identified a number of barriers to getting support. A lack of confidence was the most common reason given for not asking for help. Others talked about being self-conscious. Interviewees mentioned struggling to open up about how they felt, with some concerned this would show weakness. Another identified discriminatory attitudes towards Gypsies and Travellers as a reason for not asking for help. Young people who took part in focus groups as part of this inquiry said that secondary school was made more challenging by the lack of Black school staff and a belief that White teachers did not understand them or their culture. This meant that they were less likely to open up to teachers and ask for support. When support was provided, it frequently did not meet their needs and was undermined by a lack of trust between young people and staff. Mental health and education professionals told Mind that young men were more reluctant to acknowledge distress and talk about it to others and that young women were more likely to ask for mental health support. There was also concern about a lack of understanding of how young men express their difficulties, which can lead to their mental health problems not being recognised. Despite being more likely to have received support, we found evidence that mental health support at secondary	

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				school is not meeting the needs of young women. Of those who did receive support from school for their mental health, young men were significantly more likely than young women to find it very helpful (26% compared to 6%). This could be because of the higher prevalence of trauma among young women and their need for a level of mental health support that schools are not equipped to provide.	
Mind				**Rec 1.5: Support with school-related transitions and other life changes:** Mind supports the recommendation to train staff to recognise the wide-ranging impacts of transitions and life changes on children and young people's social, emotional and mental wellbeing, taking into account that they may differ between individuals, for example by cultural background, age and gender. Mind also recommends providing training for teaching professionals at secondary school on trauma-informed care. The training should include the different ways that young men and women typically express their mental health problems and respond to trauma. Mental health professionals who shared their experiences as part of Mind's report (2021) identified	Thank you. The committee discussed this and added to recommendation 1.5.1 that it was important that staff are trained to understand the different ways that children and young people typically express their mental health problems and respond to trauma.

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				sexual and emotional abuse, witnessing domestic abuse, and worries about having enough food to eat as traumatic events experienced by the young people they supported. Young people's experiences of trauma can and do affect their learning. Examples included young people being unable to focus for long periods of time or follow instructions and struggling to problem-solve. Mental health professionals identified that difficulties in learning could frequently lead on to poor self-esteem and a further deterioration in mental health.	
NASUWT – The Teachers' Union	Guideline	4	Lines 17-22	1.1.6: We suggest that a bullet is added before the first bullet point which says: making clear that social, emotional and mental wellbeing applies to pupils, staff and leaders	Thank you. We have added the point that 'social, emotional and mental wellbeing applies to staff, children and young people' to recommendation 1.1.1.
NASUWT – The Teachers' Union	Guideline	4	Lines 5-8	1.1.2: We suggest that this is amended to say: Ensure that the school has a culture and ethos that promotes positive social, emotional and mental wellbeing and that this reinforces relational approaches and recognises the importance of psychological safety. Take into account that purely behavioural approaches used in isolation have limited impact.	Thank you. The committee decided to amend recommendation 1.1.2 to the following: Ensure that the school has a culture, ethos and practice that strengthens relational approaches and inclusion, and that recognises the importance of psychological safety.
NASUWT – The Teachers' Union	Guideline	4	Lines 9-10	1.1.3: We suggest that the point is expanded to say: 'Social, emotional and mental wellbeing should be embedded in all school policies and procedures. Policies and procedures should be reviewed regularly to make	Thank you. The recommendation has now been expanded to: Review policies and procedures regularly to make sure that they promote social, emotional and mental wellbeing positively and consistently. This should include making sure that they are

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				sure that they promote social, emotional and mental wellbeing positively and consistently. This should include making sure that they are consistent with relational approaches to social, emotional and mental wellbeing.	consistent with relational approaches to social, emotional and mental wellbeing.
NASUWT – The Teachers' Union	Guideline	4	Lines 14-15	1.1.5: We suggest that this is reworded to say: Monitor and evaluate the impact and effectiveness of the whole school approach as part of the school improvement strategy	Thank you. The recommendation has now been expanded to: Consider monitoring and evaluating the impact and effectiveness of the whole-school approach as part of a school improvement strategy.
NASUWT – The Teachers' Union	Guideline	5	Line 20	1.1.11: It isn't clear if this point just relates to peer supervision for teachers and other staff in relation to managing social, emotional and mental wellbeing of pupils or those they manage. We think this is important, although we prefer 'support' to 'supervision. We also believe that peer support/supervision can also be useful as a tool for promoting teachers' and other school staff's social, emotional and mental wellbeing more generally since it recognises the benefits of working collaboratively and the limitations of top-down styles of management. We recommend that that point is amended to say: 'Make peer support available for teachers and other school staff both in relation to their role in managing the social, emotional and mental wellbeing of pupils and those they manage and more generally'.	Thank you. We have added support to this recommendation.

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NASUWT – The Teachers' Union	Guideline	6	Lines 8-12	1.1.16: The paragraph should also include the point that the designated lead should be a person in a leadership post who has strategic responsibilities and oversight of social, emotional and mental wellbeing across the school..	Thank you. The committee agreed to clarify that the lead person should be senior person with authority to make decisions and authorise expenditure.
NASUWT – The Teachers' Union	Guideline	6	Lines 13-17	1.1.17: Amend the paragraph to say: 'In order to implement whole-school approaches effectively, ensure that the school's core values, culture and practices secure and promote the psychological safety of pupils, staff and leaders. For example…' We think that the example provided is a good one.	Thank you. The current recommendation is in NICE style and has not been changed.
NASUWT – The Teachers' Union	Guideline	6	Lines 24-27	1.1.19: We think that this paragraph should be amended so that it is clear that public health departments and children and young people's mental health services need to do more than take into account and be responsive to the concerns of schools and colleges in the area. The guidance should be amended to make it clear that public health departments and children and young people's mental health services need to be proactive in identifying the views, issues and concerns of schools and colleges in the area and ensure that appropriate services and support are in place to address the issues and concerns and to meet needs.	Thank you. The committee discussed your comment and agreed that the wording of the recommendation was quite passive and needed to be more proactive, so have amended the wording to include 'proactively gather.' The committee discussed how JSNAs and local needs assessments can proactively to identify and address schools needs.

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NASUWT – The Teachers' Union	Guideline	7	Lines 7-11	1.2: Section 1.2 needs to emphasise that schools should promote good social and emotional wellbeing as part of preventative work. We think that paragraph 1.2 might be the most appropriate paragraph to state this point. An additional sentence might be added to the end of the paragraph which says something like: *'Ensure that the curriculum addresses both strategies for preventing and managing social, emotional and mental health challenges*'.	Thank you. The committee discussed this but agreed that it was implied in the current recommendation.
NASUWT – The Teachers' Union	Guideline	7	Lines 4-6	1.1.21: The paragraph needs to be amended slightly. It would be more appropriate to say: The local integrated care system and schools should identify opportunities to work together to ensure that practice to support the social emotional and mental wellbeing of children and young people is coherent and effective.	Thank you. The committee did not see a clear distinction and so kept the wording they had agreed.
NASUWT – The Teachers' Union	Guideline	8	Lines 3-5	1.2.6: The guideline appears to be saying that all pupils should receive mindfulness. We think it would be more appropriate for schools to determine what approaches they will use to promote good social and emotional wellbeing. We also think the paragraph should be amended to emphasise the importance of prevention. We recognise that mindfulness is a useful strategy and believe it should be given as an example. We suggest that the paragraph is reworded as follows: *Consider teaching all pupils interventions that can help to promote positive social, emotional and mental wellbeing and*	Thank you. The committee saw some evidence for Mindfulness (see evidence review B and C). They agreed that Mindfulness might not be useful in all settings so they made a recommendation to 'consider' Mindfulness. Please see Making decisions using NICE guidelines. This explains how we use words to show the strength (or certainty) of our recommendations.

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				manage social and emotional challenges, e.g. mindfulness. This should include teaching pupils to use the intervention and supporting them to use the intervention.	
NASUWT – The Teachers' Union	Guideline	8	Lines 6-8	1.2.7: It may be useful to include reference to some examples of rhythmic physical activity (e.g. running, dance).	Thank you. A definition for rhythmic physical activity has been added to the "Terms used in this guideline" section.
NASUWT – The Teachers' Union	Guideline	8	Lines 12-13	1.3: We believe that there is a need to add an additional paragraph before 1.3.1 which makes it clear that while all staff should be alert to the social, emotional and mental wellbeing of their pupils, including identifying when there may be issues and concerns, there should be a member of staff or a team who is responsible for leading the work to identify and support pupils who are at risk. We believe that the paragraph should also make it clear that some of the actions set out in 1.3 are likely to be carried out by the person or team with that lead responsibility.	Thank you. The committee decided not to explicitly specify a lead, as schools / colleges should have freedom to decide who would suit the role best. However, they did agree to clarify that the lead person should be senior person with authority to make decisions and authorise expenditure.
NASUWT – The Teachers' Union	Guideline	6 and 7	Lines 28-29 and 1-3	1.1.20: We are concerned that the wording of the advice could lead to Joint Strategic Needs Assessments being written to expect schools to contribute some or all of the support needed because other services are stretched or services have been cut. It must be clear that schools are responsible for education and that their contribution	Thank you. The committee discussed this but agreed that it was clear that the recommendation was asking JSNAs to acknowledge the contribution of schools to improving wellbeing.

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				to JSNAs will be primarily education-focused. We believe that the wording of the second sentence of the paragraph needs to be amended to make it clear that the school is being asked to contribute evidence to support the identification of poor social and emotional wellbeing, and the impact that poor social and emotional wellbeing is having on the pupils' learning and their likely learning outcomes.	
NASUWT – The Teachers' Union	Guideline	9 and 10	Lines 17-20 and 1-8	1.3.5 and 1.3.6: We would expect the actions outlined under 1.3.5 and 1.3.6 to be carried out by a person with designated responsibilities for pupils' social, emotional and mental wellbeing rather than being something that every member of staff would do. We recommend that immediately after the sub-heading Tools and Techniques and before 1.3.5, a new paragraph/sentence is added which says something like: The person or persons with designated responsibility for assessing young people's social, emotional and mental wellbeing should consider the following guidelines on tools and techniques.	Thank you. The committee discussed this but believed that responsibility for children and young people's social, emotional and mental wellbeing lies with all members of staff to some extent. This is fundamental to the whole school approach.
NASUWT – The Teachers' Union	Guideline	10 and 11	Lines 9-20 and 1-11	1.4: We recommend that 1.4.1 is amended to make it clear that the school should have clear guidance, etc. i.e. add 'School' to the start of the sentence. However, we also believe that each of the subsequent paragraphs under 1.4 (i.e. 1.4.2-1.4.7)	Thank you. NICE believes that it is implied as the guideline focusses on primary and secondary education. Also, the committee noted that "school" does not take into account other educational settings such as colleges and post-16 education providers. We have added a sentence at the start of the guideline that states 'For the purposes of this guideline, the

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				are also things that schools should ensure are in place. While School might be added to the beginning of each paragraph it may be more appropriate to add some text at the beginning of the section that makes this clear. This approach would also enable the guideline to clarify that this should be part of the whole school approach. It would also permit recognition that all staff may need to take action to address some issues, e.g. in relation to 1.4.7.	term 'school ' covers schools, colleges, further education providers and other educational settings'.
National Network of Mental Health Leads/The Root Of It	Guideline	General	General	There is nothing to reflect the involvement of the community in supporting whole-school approach, such as religious groups, childminders, after school clubs, youth organisations.	Thank you. Recommendation 1.1.6 states that whole school approaches should be supported by "strengthening links to external agencies that can provide additional support, such as local children's health and care services and relevant voluntary and community sector organisations"
National Network of Mental Health Leads/The Root Of It	Guideline	General	General	There is nothing to reflect the importance of working with community assets on children's mental health outside of school, such as working with the developers of a new estate to influence the playground design, or helping preschools develop their provision…	Thank you. Recommendation 1.1.6 states that whole school approaches should be supported by "strengthening links to external agencies that can provide additional support, such as local children's health and care services and relevant voluntary and community sector organisations"

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National Network of Mental Health Leads/The Root Of It	Guideline	General	General	Whilst there are recommendations for staff training, there is an absence of recommendations for training for senior leaders on culture, ethos, strategy and whole-organisation barriers that may affect the implementation of the recommendations.	Thank you. We believe this is implicit in recommendations 1.1.7 and 1.1.8.
National Network of Mental Health Leads/The Root Of It	Guideline	6	4-7	This is good, but does not cover how the setting empower the children to be able to support their own wellbeing or the wellbeing of their peers.	Thank you. It is not the aim of the guideline to inform users how settings empower children to be able to support their own wellbeing or the wellbeing of their peers. Instead, the guideline aims to promote good social, emotional and psychological health to protect children and young people against behavioural and health problems.
National Network of Mental Health Leads/The Root Of It	Guideline	6	1-2	This recommendation does not reflect the involvement of wider family or caregivers.	Thank you. Recommendation 1.1.14 refers to involving parents and carers.

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National Network of Mental Health Leads/The Root Of It	Guideline	7	15-17	Add "and developmental needs" – a child with SEND who is operating in young childhood despite being aged older will need a curriculum that reflects their needs.	Thank you. We are unsure what you are referring to, however, developmental age is highlighted in recommendations 1.3.6 and 1.4.5.
National Network of Mental Health Leads/The Root Of It	Guideline	7	8-9	This guideline needs to reflect the developmental nature of the Mental Wellbeing content in the DfE curriculum. There are age-related expectations in the curriculum and this recommendation needs to include the wording "developmentally appropriate" or similar to reflect that this knowledge/skill is age-related, but also learning related (i.e. if they haven't been taught it before they need to be taught it before moving onto the higher level objectives).	Thank you. We are unsure what you are referring to, however, developmental age is highlighted in recommendations 1.3.6 and 1.4.5.
National Network of Mental Health Leads/The Root Of It	Guideline	10	18	This does not reflect co-production – replace "Talk to" with "Work with"	Thank you. The committee agreed that 'talk to' was not the best wording and have changed this to 'Actively involve'

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National Network of Mental Health Leads/The Root Of It	Guideline	11	General	There is no consideration under transition for the transition of care/interventions	Thank you. That is beyond the remit of this guideline which focuses on primary and secondary education.
National Network of Mental Health Leads/The Root Of It	Guideline	11	8	Add "and discuss" before difficult feelings.	Thank you. The committee thought this was implicit in 'express' and did not change the wording.
National Network of Mental Health Leads/The Root Of It	Guideline	11	8	Add "and their experiences" to the end of the sentence.	Thank you. The committee agreed this was a useful addition.
NHS England	Guideline	General	General	This guideline should outline the practical steps and advice that staff should take when there are safeguarding concerns. It would be particularly helpful for staff to have an	Thank you. Safeguarding is well established in schools and the roles of various professionals are set out in law. All schools must follow safeguarding guidance including information

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& Improvement				understanding of escalations to Local Authority, Mental Health services etc.	sharing. The system for doing this is an operational matter for each school
NHS England & Improvement	Guideline	5	10	This guideline should have greater focus on how staff should share and/or raise concerns, should they have identified issues. This guideline should outline the process of supporting staff if there is a concern about a child's wellbeing, where they may need to liaise with the Local Authority. •	Thank you, there is no one universal process for sharing and raising concerns. Systems will vary across different schools.
NHS England & Improvement	Guideline	6	1	This guideline should consider Shared Decision-Making approaches for supporting families.	Thank you. Shared Decision Making in educational settings is beyond the remit of this guideline, however, recommendation 1.1.15 recommends involving children in discussions about WSA and getting their agreement.
NHS England & Improvement	Guideline	9	6	This guideline should include key risk factors for poor social, emotional and mental wellbeing, including the below for consideration: • Frequent absenteeism • Child Carers • Children living with family/carers that have chronic health conditions • Parents/carers that may have alcohol/substance misuse issues	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.

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				• Experience of domestic violence • Poverty • Signs of abuse or neglect	
NHS Sheffield CCG	Guideline	4	1.1.1	It would be helpful to make stronger links between emotional wellbeing and readiness to learn, that a healthy emotional wellbeing educational culture will impact on attainment and attendance and link to Ofsted categories of Behaviour and Attitudes and Personal Development	Thank you. The committee discussed this but decided that the guideline already links to outcomes about wellbeing and readiness to learn. They also agreed that recommendations should centre around the culture of the school rather than Ofsted categories of Behaviour and Attitudes and Personal Development.
NHS Sheffield CCG	Guideline	4	1.1.1	It would be helpful to make align the guidance as to how providing EWB culture within education leads to other key outcomes such as building executive function and emotional regulation skills, leading to improved employability skills, reduced anti-social and criminalised behaviours and both physical and mental health outcomes see Harvard Centre on the Developing Child, Bruce Perry, James Heckman. Louise Bomber	Thank you. The committee added a comment about this to the rationale and impact section of the guideline.
NHS Sheffield CCG	Guideline	4	1.1.1	It would be helpful to stress in the guidance that educational settings provide incredible opportunities for e*xperiential* learning for children and young people to build their emotional resilience, intelligence and literacy, through the everyday interactions schools provide with adults, peers and being productive, and active. Such as : providing secure reliable adult relationships, navigating and enjoying peer relationships, by providing	Thank you. The committee agreed that all of these things are inherent in the current recommendations.

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				opportunities for debate and discussion to build emotional literacy skills (during Tutor time and / or Circle Time), by including whole school approaches for CYP to check in and notice their emotional regulation needs, such as Zones of Regulation. Schools can help CYP experience emotional regulation, enabling them to feel good emotional regulation to then seek it, and develop strategies around it.	
NHS Sheffield CCG	Guideline	4 And 17	1.1.2	Sheffield Healthy Minds whole school approach to emotional wellbeing has now worked with 80% of schools in Sheffield and has over 10,000 survey responses from pupils, parents / carers and school staff. The model has been developed in collaboration with Sheffield schools integrating psychological theory, neurodevelopmental research, mental health practice with key educational based approaches. The model provides a coherent framework to develop EWB practice at a whole school and individual level – utilising three key psychological components:	Thank you for this information

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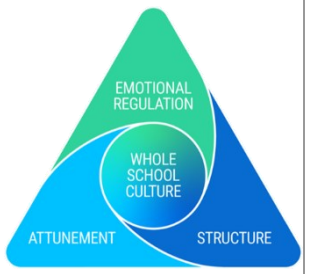
				Structure: Provides the foundations to create as calm and safe an environment as possible. Consistent responses, boundaries and predictability are the foundation for emotional safety in schools.  **Attunement/ Relationship:** The key protective factor for emotional wellbeing is the quality of relationships / interactions experienced. Schools offer tremendous opportunities for pupils to feel connected to others – both staff and peers. Our relationships with others also shape how we see ourselves: are we likeable, worthy of care, effective, etc. For some pupils school plays a critical role in providing a safe secure adult relationship in their lives. **Emotional regulation:** The ability to adjust our internal state – emotions and physical needs – to appropriately manage the context we find ourselves in. It is key that pupils and staff learn to notice and understand their emotional state to make the right adjustments to remain rational and productive, drawing on external and internal resources. Staff too will be able to think and reflect when emotionally regulated	

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				We would be interesting in conducting more formal research around this.	
NHS Sheffield CCG	Guideline	4	1.1.3	Including a critical incidence policy to address and significant events which will impact on emotional wellbeing across the school community – such as suspected suicide, including communication and support across the school community, externally and knowledge of local multi—agency systems in such an event.	Thank you. This recommendation refers to all school policies and procedures, including critical incident policies.
NHS Sheffield CCG	Guideline	17	1	Other recommendations for further research – develop the evidence base re whole school emotional wellbeing interventions, develop the evidence for interventions to meet CYP mental health needs for moderate level concerns or low level concerns with co-morbidities, develop the evidence based for trauma informed whole school approached	Thank you. NICE research recommendations are specifically to cover areas of the guideline where the committees ability to make recommendations was restricted by the evidence base.
nurtureuk	Guideline	4	3	nurture**uk** agrees that schools should adopt a whole-school approach to support positive social, emotional and mental wellbeing in primary and secondary education, and recommends that a whole-school approach to nurture is the specific approach adopted. Nurture is integral to addressing pupils' social, emotional and mental health needs and a key part of the solution to school exclusions. nurture**uk** believes this approach should be supported by several key tools and resources	Thank you or your support.

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				including; The Boxall Profile®, the six principles of nurture, and nurture groups. The concept of nurture highlights the importance of social environments – who you're with, and not who you're born to – and its significant influence on social emotional skills, wellbeing and behaviour. Children and young people who have a good start in life are shown to have significant advantages over those who have experienced missing or distorted early attachments. They tend to do better at school, attend regularly, form more meaningful friendships and are significantly less likely to offend or experience physical or mental health problems. Children who have missing early childhood nurturing experiences or who have experienced early childhood trauma are less well prepared for the transition into school environments and are more likely to engage in destructive patterns of behaviour and relationships leading to exclusions and disengagement from learning. The nurturing approach offers a range of opportunities for children and young people to engage with missing early nurturing experiences, giving them the social and emotional skills to do well at school and with peers, develop their resilience and their capacity to deal more	

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				confidently with the trials and tribulations of life, for life. It is based on and guided by the six principles of nurture. They are: ● Children's learning is understood developmentally ● The importance of nurture for the development of wellbeing ● All behaviour is communication ● The classroom offers a safe base ● Language is a vital means of communication ● The importance of transition in children's lives nurture**uk**'s National Nurturing Schools Programme (NNSP) is a whole-school approach that upskills school staff to embed a nurturing culture. It includes support for students and staff, working across the curriculum and involving pupils, governors and parents. It requires senior leadership commitment, staff development, a supportive culture, and importantly, sufficient resources. Today there are hundreds of National Nurturing Schools around the UK. Teachers are trained to focus on emotional needs and development as well as the academic learning of all pupils, and to embed the six principles of nurture throughout the policies and practises of a school.	

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				Use of the Boxall Profile® is a core component of the National Nurturing Schools Programme. This unique online tool assesses the social, emotional and mental development of pupils aged 4-18. It provides teachers with a precise picture of a pupil's strengths, as well as any difficulties which could affect their learning. Based on these results, the Boxall Profile® also tells teaching staff what type of support each pupil needs, providing them with practical strategies and techniques for the classroom or nurture group to help pupils achieve their full potential. The Department for Education (DfE) commissioned *Supporting Mental Health in Schools and Colleges* survey shows that half (51%) of institutions conducting universal and/or targeted screening use the Boxall Profile®. It has been highlighted in a number of reports, most recently: ● Estyn's 2020 *Learner resilience - building resilience in primary schools, secondary schools and pupil referral units* as a tool useful in the assessment of nurture group pupils.	

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				● Estyn's 2020 *Effective school support for disadvantaged and vulnerable pupils – case studies of good practice* as part of an example of good practice in schools.	
nurtureuk	Guideline	5	11	nurture**uk** agrees that staff should have continuing professional development (CPD) to support both their own wellbeing and the implementation of the school's approach and recommends that nurture is a key part of all teacher training programmes and mandatory CPD for teachers who are already qualified**.** Challenging behaviours are often rooted in unmet attachment needs and/or adverse childhood experiences (ACEs). Teachers should be trained, through initial teacher training and CPD, to understand the impact of unmet attachment needs and ACEs on a child's development and behaviour. This upskilling can help teachers to feel empowered to address the causes of behaviour and to defuse difficult situations by supporting teachers to understand what a child is communicating.	Thank you for your support.
nurtureuk	Guideline	5	15	nurture**uk** agrees that staff should be signposted to quality-assured local and national resources to support their wellbeing and specific resources are available on our website. https://www.nurtureuk.org/product/nurturing-peer-supervision/	Thank you for the support.

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nurtureuk	Guideline	6	18	nurture**uk** agrees that a graduated response approach should be implemented. nurture**uk**'s own graduated approach to nurture includes a range of tools, strategies and interventions to enable provision of varying levels of support in school. It ensures that every child has the opportunity to learn successfully, whatever their level of social, emotional and mental health (SEMH) need.	Thank you for the support.
nurtureuk	Guideline	10	1	Rec 1.3.6 nurtureuk agrees that these factors should be taken into account when selecting a tool to assess social, emotional and mental wellbeing. As previously mentioned, the Boxall Profile® is a unique online psycho-social assessment tool enabling teachers to develop a precise and accurate understanding of individual children's social and emotional competencies, and to plan effective interventions and support activities. It is a highly regarded diagnostic and assessment tool that has been cited by the Department for Education (Department for Education, 2018, Mental Health and Behaviour in Schools Guidance) and is the most popular measurement used in schools to understand the wellbeing and support needs of their pupils (Department for Education, 2017, Survey: supporting mental health in schools and colleges).	Thank you for your support.

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				The Boxall Profile® is a tool for educators to monitor the behavioural and mental health needs of children aged four to 18. It suggests interventions and sets targets for education professionals to utilise, and measure against over time, so they can provide the best, hands-on support. Currently the Boxall Profile® is widely used when teachers identify that a pupil may have social, emotional and mental health needs, though increasingly schools are using it to gain a better understanding of the wellbeing of their whole school populations. By profiling all children in a school, the teaching staff have a more rounded view of the children and young people in their care. To date, the Boxall Profile® has 30,000 active education professionals assessing the social, emotional needs of hundreds of thousands of pupils.	
nurtureuk	Guideline	10	10	We agree there should be clear guidance on how to identify individual children and young people and groups of people for targeted support based on their specific needs. The Boxall Profile® allows teachers to develop a precise and accurate understanding of individual children's social and emotional	Thank you for this information.

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				competencies, and to plan effective interventions and support activities.	
nurtureuk	Guideline	11	15	We agree that staff should be trained to recognise the wide-ranging impacts of transitions and life changes on children and young people's social, emotional and mental wellbeing. The importance of transitions in children's lives is one of the six principles of nurture that have successfully underpinned nurturing approaches for over 50 years.	Thank you for the support.
Our Time	Guideline	5	14	Staff must also be trained in understanding the impact of parental mental illness on children and young people, and also how to provide support. Training and resources provided by Our Time Schools covers this topic, and has been rolled out by our partners.	Thank you. The committee considered your suggestion but agreed that this example was too specific to add to the recommendation. They agreed that parental mental illness is just one of many potential factors that teachers need to consider, without having to list them all in the guideline. The committee also considered that the impact of parental mental illness is sufficiently covered in other guidance, particularly 'Keeping children safe in education.'
Our Time	Guideline	5	23	To explicitly include - staff must understand the impact of parental mental illness on children and young people, and how to support them.	Thank you. The committee considered your suggestion but agreed that this example was too specific to add to the recommendation. They agreed that parental mental illness is just one of many potential factors that teachers need to consider, without having to list them all in the guideline. The committee also considered that the impact of parental mental

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					illness is sufficiently covered in other guidance, particularly 'Keeping children safe in education.'
Our Time	Guideline	7	6	Encourage cooperation with adult mental health services/children's social care to share information - appropriately and where possible - to identify a child that may need support due to parent/carer's mental ill health.	Thank you. The committee highlighted the complexity and potential resource implications of schools engaging with adult mental health services so did not want to specify this in the recommendation, but they agreed that effective information sharing where possible and appropriate is important so they added this to recommendation 1.1.22.
Our Time	Guideline	7	11	Reference should be made in the curriculum to the needs of children who have a parent with a mental illness. Evidence shows that a whole school approach which allows CYP to know they are not alone, get a good age-appropriate explanation and have access to a trusted adult, builds resilience. Early intervention makes a big difference. PSHE resources from Our Time Schools include this topic as part of broader mental health teaching, and have had very positive feedback from our partners.	Thank you. The RSE curriculum is set by DFE, not NICE. The committee considered your suggestion but agreed that this example was too specific to add to the recommendation. They agreed that parental mental illness is just one of many potential factors that need to be considered, without having to list them all in the guideline. The committee also considered that the impact of parental mental illness is sufficiently covered in other guidance, particularly 'Keeping children safe in education'.
Our Time	Guideline	9	6	Parental mental illness should be included in this list as a standalone item, as it is a key driver of mental health difficulties in children and young people (*Mental health of children and young people in England, NHS Digital, 2017*).	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the

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					Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Our Time	Guideline	9	6	Identifying behaviours should also include: withdrawn and tired, anxious, hyper vigilant, over responsible/resistant to support, neglected appearance, difficulty in concentrating, late, absent, homework issues, isolated.	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Our Time	Guideline	10	10	Any assessment of a child potentially affected by parental mental illness should take into account the fear of exposure, their sensitivity to shame and reluctance to reveal their family difficulties, out of loyalty to family. They may fear being identified and offered help, due to lack of understanding about mental illness and a lack of vocabulary in relation to this.	Thank you for this information.
Our Time	Guideline	12	27	Explicit reference needed to parents or carers facing mental health difficulties or illness, and the impact on their children.	Thank you. The committee agreed with this suggestion and have made explicit reference to mental health difficulties or illness in recommendation 1.5.7.

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Our Time	Guideline	28	10-16	Need to engage with parents or carers - where possible and appropriate - on broader lived experience of children, to identify if there are issues of mental ill-health within families that will impact on the child.	Thank you. The guideline recommends the involvement of parents and carers in developing the whole school approach (recommendation 1.1.14) and in decisions about targeted support for their child (1.4.3).
Parentkind				**3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)** As a national charity, Parentkind give those with a parenting role a voice in education. We invest substantial resources in representing parent views on their child's learning to local, regional and national governments and agencies because evidence tells that parental participation in education benefits all children in all schools and society as a whole. Parentkind is home to a network of PTA fundraisers in the UK. We bring specialist fundraising support and advice to parent volunteers so that every school can benefit from a successful PTA. Our 13,000 PTA members raise over £120+ million per year, placing us alongside some of the largest charities in the UK. As we will outline in our responses below, implementation of a whole-school approach to social, emotional and mental wellbeing throughout the educational journey of a child can be more effectively embedded into the education system in conjunction with a framework for best practice parental	Thank you for this example of good practice. Unfortunately, NICE no longer maintains its shared learning database due to lack of resources and therefore is unable to add this training to it.

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				participation, as embodied by Parentkind's Blueprint for Parent-Friendly Schools. The necessity of parental buy-in for a whole-school approach to succeed, where parents reinforce values and behaviours at home, means that best parental participation practice is necessary for schools' wellbeing policies to work effectively. Parentkind is happy to share more details about its Blueprint for Parent-Friendly Schools, and how it can best be used in conjunction with NICE's wellbeing in schools guidance. Similarly, for teachers to be able to get buy-in from parents effectively, they will benefit from bespoke parental engagement training, which equips them with the skills, confidence and knowledge to develop a strong partnership between homes and schools, and maximise the benefits of positive parental participation. Taking part in Parentkind's online training for schools would be ideal for school leaders when looking to upskill teachers in readiness to implement a whole school approach to wellbeing.	
Parentkind				**4. This guideline was commissioned before the coronavirus pandemic and therefore the original review questions have not taken into account the impact of COVID-19 on the current school environment. NICE have completed additional searches to identify evidence relating to issues caused by COVID-19 on schools and expert**	Thank you for your support.

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				witnesses have been brought in to discuss its impact. However, there is currently limited evidence in this area. Please tell us if there are any particular issues or evidence relating to COVID-19 that we should take into account when finalising the guideline for publication. Parentkind regularly polled parents throughout the pandemic and partial school closures to build up research evidence of how they perceived their child's education was affected, any impact on their or their child's wellbeing, and what additional resources they needed to help their child and support their learning. The coronavirus pandemic has undoubtedly changed and increased the role of parents in children's education, but the overall picture is mixed. Parents have become more engaged in their child's learning and feel more confident in helping them, but at the same time, their concerns about their child's mental wellbeing and lower engagement in their studies have grown. Throughout the periods of partial school closures, we saw parents' confidence in their ability to support their child's learning increase significantly. More than half of parents (53%) responding to our third coronavirus survey in July 2020 said that they were more engaged in their learning compared to before lockdown. However, 57% reported that their child was less engaged in	

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				his/her learning compared to before lockdown. In the same survey, 70% of parents selected 'mental wellbeing' from a range of options they thought schools should focus on when their child returns. The second most popular option was 'curriculum learning', selected by 57%. This shows the overwhelming parental support for a focus on mental wellbeing in schools, including embedding it within the curriculum. At the same time, parents remained concerned by the overall impact of the pandemic on their child's education, and this concern increased with the age of the child and the proximity their child's cohort came to taking exams. Concerns quickly grew about the impact of school closures and the disruption to learning to children's mental health and wellbeing. Our second coronavirus survey (field work April to May 2020), taken by over quarter of a million parents representing over 400,000 pupils, found that parents' worries were growing. Primary among these were their child not seeing their friends and socialising (48%), their child missing out on learning from teachers (38%), one or more of their family members catching Covid-19 (35%) and their child's mental health (35%). Against that backdrop, coupled with lingering parental concerns about education recovery, exam cancellations, the fair grading of exams and the negative impact of the	

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				pandemic on children's overall wellbeing, we would suggest that a whole school approach to wellbeing is timely and would win parental support.	
Parentkind	Guideline	4	2	Parentkind agrees that a whole-school approach is best and that it should run throughout the primary and secondary phases. This must include meaningful two-way communication with parents who can reinforce values and behaviours instilled in children in classrooms in the home learning environment. Ensuring sound parental participation requires knowledge of best practice and a formalised approach. Rolling out Parentkind's Blueprint for Parent-Friendly Schools is a practical and cost-effective solution to meet this need. It is built on an evidence-based easy to apply framework, incorporating a self-assessment tool. This results in fast improvements to existing parental participation strategies in a sustainable way that does not substantially increase teacher workload. Five key drivers and best practice enable every school to implement great parental participation.	Thank you for your support.
Parentkind	Guideline	4	9	Whenever school policies that directly impact parents or family life are updated, it is good practice to ensure that parents are consulted. Schools can use Parentkind's Blueprint for Parent-Friendly Schools, driver two (effective two-way communication) to help with ensuring	Thank you. This is covered in recommendation 1.1.14 "Involve parents and carers in designing and implementing the whole-school approach".

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				best practice in gauging parental feedback. Further details are given in comments below to ensure that a demographically representative cross-section of the parent community is able to share its views.	
Parentkind	Guideline	5	11	Teachers should be trained either in ITT or CPD in parental participation, as there are particular skills that will ensure they are equipped to maximise the benefits of having parents on board with any overarching wellbeing policy. Parentkind's training is conducted in line with the Blueprint for Parent-Friendly Schools. Online workshops and masterclasses have been developed for senior leaders and teachers, providing practical tools, techniques and actions that schools can embed to cultivate an environment that nurtures parental involvement in all areas of their child's education.	Thank you. The CPD needs of teachers will vary by teacher and school and therefore the committee were not able to be specific about it.
Parentkind	Guideline	6	2	Mental health and well-being have gone mainstream in parental priorities for their child's education and schooling. Protracted periods of isolation from peers, academic stress and general unpredictability in day-to-day life and learning took their toll on children throughout the pandemic. Our most recent annual parent survey, the Parent Voice Report 2021 (taken by 3,751 parents), shows that mental health and wellbeing is a major priority for nearly nine in ten parents, even though it has been near the top of the agenda and its prominence growing over recent years. Parents now see	Thank you for this information.

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				it as a hugely important area for schools and the curriculum to focus on. Parents must be part of the national conversation on how schools can play their part in helping to address the building mental health crisis among young people. Parentkind's Blueprint for Parent-Friendly Schools provides the ideal solution for maximising the potential of parental participation. It is essential to get right the methods of meaningful consultation with parents to ensure buy-in, and to ensure a close relationship between homes and schools built on mutual trust.	
Parentkind	Guideline	6	9	Parents should be made aware of who the designated staff contact is, and provided with details of how to contact them to raise comments or concerns about the guidelines on social, emotional and mental wellbeing at the school. The school website is a good place to provide these details.	Thank you. This level of detail is to be decided by individual schools. Differences in the way schools work mean that NICE is only able to give high level recommendations so that schools can implement them in a way that suits their service delivery.
Parentkind	Guideline	7	8	Parentkind research shows that parents would strongly support this approach. In our third coronavirus survey (July 2020), 70% of parents selected mental wellbeing from a range of options they thought schools should focus on for when their child returned to the classroom. The second most popular option was curriculum learning, and by contrast that was only selected by 57%.	Thank you for this information.

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				Our Parent Voice Report 2021 revealed similar findings in that 87% agreed that a good education for their child goes beyond exam results. Bullying is a major cause of mental ill-health among children, and we found that only 60% said that bullying was dealt with fairly by their child's school. There was a sizeable middle area of 19% who neither agreed nor disagreed, and 10% who said they did not know, but that left 11% of parents disagreeing. Clearly, more than one in ten disagreeing that bullying is dealt with fairly by the school is a worryingly high number, and as bullying is identified in the mental wellbeing risk factors, it is an area we would suggest (from what parents are telling us) requires careful attention. When it comes to the school environment, 82% said their child feels safe at school, but sadly 6% disagreed. Similarly, although 80% agreed that their child is happy at school, 7% disagreed (and the satisfaction ratings are much higher in both questions for primary parents). Although three quarters (75%) agree that respect and courtesy are in evidence throughout the school community among teachers, other staff, children and parents, 7% disagreed. Our Parent Voice Report 2021 also asked questions on the role of education and what areas parents consider to be important for the curriculum to focus on. For parents	

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				indicating that they consider it 'very important', 'develops good mental health and well-being' was selected by 60%, which was considered important by 87% of respondents overall. It was ranked fifth highest overall among parental priorities, with 'develop skills that are useful outside of school (e.g. critical thinking, problem solving, teamwork, working to deadlines)' coming in first. However, no other option achieved such a large proportion of parents considering it 'very important'. For both primary and secondary school, the top skill/capability that children should leave with was selected as 'self-confidence'. At primary level, this was followed by 'empathy and awareness of others'. Clearly, as our extensive evidence shows, the vast majority of parents would be fulsomely supportive of a curriculum that embeds mental health and wellbeing, and although there is an appetite for this throughout the school phases, it is especially prominent at primary level.	
Parentkind	Guideline	10	18	Maximising the potential of positive parental interactions requires the learning of best practice and how to implement it. Parentkind's online training can equip teachers with the confidence and the skills to ensure conversations with parents are successful.	Thank you for this information
Parentkind	Guideline	11	21	It is essential to build connections with parents at the start of a child's educational journey, whether that is	Thank you for this information. The guideline encourages schools to involve parents and carers both in overall school decisions and in targeted support for their children.

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				at primary or secondary school. Establishing mutual trust and building a rapport with parents early on is a great way to ensure a close working partnership between home and school throughout a child's education.	Recommendation 1.1.6 also asks schools to you're a mechanism in place for feeding back to parents and carers.
Parentkind	Guideline	17	2	Our Parent Voice Report 2021 found that parents of children with SEND are much likelier to report their child's experience of mental health issues across the board compared to parents who do not have a child with SEND. This encompasses homework-related stress (55% versus 37%), anxiety (55% versus 34%), exam stress (46% versus 32%), bullying (45% versus 27%), the pressure to constantly engage with social media (34% versus 16%), depression (38% versus 11%), cyber-bullying/online abuse (35% versus 11%), self-harm (30% versus 6%), an eating disorder (28% versus 5%), sexual harassment (25% versus 4%) and substance misuse (23% versus 3%). These figures underscore the much greater vulnerability and higher risk of children with additional needs or disabilities. The data show that they are more susceptible to mental health impacts and social challenges within their peer group.	Thank you for this information.
Parentkind	Guideline	18	6	Parents want to see adequately-funded school-based mental health services to provide additional support for their children. Our Parent Voice Report	Thank you. Funding of mental health services is not within NICEs remit and will need to be negotiated by local commissioners.

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				2021 found that parents' most popular option to support mental health in schools is mental health support workers embedded in every school to provide timely support (34%). Other popular measures are professional, age-appropriate counselling services available in school (33%) and regular discussion of mental health issues in wider school life to help bring difficult issues into the open (31%).	
Parentkind	Guideline	20	23	We agree that a whole-school approach required ongoing engagement with the whole school community, and designated leads in this area. Parentkind's Blueprint for Parent-Friendly Schools is a cost-effective and straightforward way to embed best practice parental participation in every school. This will ensure that a representative cross-sample of parents are heard on the policy and can raise any concerns about the whole-school approach.	Thank you for your support.
Parentkind	Guideline	21	23	Communication between schools and parents, carers and families is essential. Please see Parentkind's Blueprint for Parent-Friendly Schools for more on how two-way communication between homes and schools can be maximised.	Thank you for this information
Parentkind	Guideline	28	10	Schools need to give due consideration to day-to-day issues such as shift work patterns and carer responsibilities to ensure that parents have the	Thank you. This is covered by recommendation 1.1.14 "Involve parents and carers in designing and implementing the whole-school approach". Communication support for children, young people and their families, whose first language is not English

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				opportunity to have their voices heard. It is essential to use technology to give more parents the opportunity to have their say, such as providing online surveys or emails. Technology should not be exclusively used, or it will alienate parents who may not have broadband at home, or ready access to digital devices. It's important also to overcome any potential barriers: communications should be provided in different languages so that those parents whose first language is not English can be included in any two-way communications. Schools should also consider reaching parents who may not have a positive view of their own school experience, or who may have challenges with reading. It is often best to ask them how they would like to be communicated with and offer them options. Some will thrive in a focus group situation, where others would prefer to answer an online survey in the privacy of their home. See key driver two of Parentkind's Blueprint for Parent-Friendly Schools for more on effective two-way communication between schools and homes.	has also been highlighted in the equality impact assessment for this guideline.
Parentkind	Guideline	31	3	It is important to engage with parents when their child first arrives at the school, whether that is when they transition to secondary school, or if a child moves to a new school. It is important for schools to have a process of engaging new parents if a child	Thank you for your support.

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				joins part-way through an academic year, as that is often when families need the most support. Parental participation can become habitual, so if parents are encouraged to engage in a strong home and school partnership from day one, they will likely remain easier to engage for the duration of the child's educational journey.	
Parentkind	Guideline	32	18	Parents in general strongly support these duties placed upon schools. The importance of child mental health has become more widely accepted. Protracted periods of isolation from peers, academic stress and general unpredictability took their toll on children throughout the pandemic. Parents also report (through our Parent Voice Report 2021) that homework-related stress is much more of an issue for secondary (45%) and post-16 (48%) students, though still three in ten (30%) primary parents report that they are concerned. Anxiety follows a similar trajectory, increasing from 32% at primary to 41% at secondary, reaching a high of 44% at post-16. Exam stress (35% overall in 2021) has lessened since 2018 (41%). Although pupils have experienced anxiety caused by uncertainty over the arrangements for exams, the overall reduction is likely to be because exams were cancelled in 2020 and 2021 and replaced by teacher assessed grades.	Thank you for your support.

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				With many stresses on young people's mental health and wellbeing, and with parents increasingly worrying about their child's mental wellbeing, a new whole school approach is to be welcomed. As acknowledged in the guidance, it can only succeed by fully engaging parents throughout the process. Please contact Parentkind for any further details about the suggestions for parental participation that we have made in our submission.	
Partnership for Children	Guideline	7	General	Useful to consult or signpost to Education Endowment Foundation review on Social Emotional Learning recommendations and evidence review. Consider adding 'explicitly teaching SEL skills' and 'integrate and model SEL skills through everyday teaching' into universal curriculum content and whole school approach. Improving Social and Emotional Learning in Primary Schools | EEF (educationendowmentfoundation.org.uk)	Thank you. The committee considered your suggestion but did not think it was necessary to refer to this resource. Recommendation 1.2.5 states that approaches to improve / develop children and young people's skills (for example, problem solving skills, social skills, communication skills) should be used. How this is integrated into the curriculum is a decision to be made at the school level.
Partnership for Children	Guideline	7	7	Include a recommendation for protected weekly curriculum time	Thank you. The committee agreed that staff already get protected planning time so did not consider it necessary to add this.
Partnership for Children	Guideline	7	8	Choose curriculum/intervention that is not only evidence based but also culturally affirming and relevant to their school community and needs. See useful information on SEL and equity: Equity and SEL - Casel Schoolguide	Thank you. The committee discussed your suggestion and agreed to add that the curriculum should be relevant to their school community and needs.

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Partnership for Children	Guideline	9	6	Add Young Carers	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Partnership for Children	Guideline	14	General	Recommendations for research should include strengthening the evidence base on effective promotion of mental health and wellbeing/SEL in schools – see report: NESET-AR2-2021.pdf (nesetweb.eu)	Thank you. NICE research recommendations are specifically to cover areas of the guideline where the committees ability to make recommendations was restricted by the evidence base.
Partnership for Children	Guideline	17	2	And what interventions are effective in supporting and improving their mental health and wellbeing	Thank you. NICE research recommendations are specifically to cover areas of the guideline where the committees ability to make recommendations was restricted by the evidence base.
Place2Be				Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. • If fully implemented, everything covered would have a significant impact on the school environment and the wellbeing of staff, families and pupils. • Much of it will be challenging to implement and takes Senior Leadership Teams and Governing Bodies to be behind 100% this. The initiatives need a Senior Mental Health Lead, adequate funding, and it would help to have more clarity of who commissions/pays for it.	Thank you. The committee agreed that buy-in by senior leaders at the school was key to the success of this guideline. Decisions about commissioning and funding for individual schools are issues that need to be resolved locally since commissioning pathways and priorities vary from area to area.

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Place2Be				Would implementation of any of the draft recommendations have significant cost implications? • The Whole School Approach referred to in section 1.1. requires training for the Senior Mental Health Lead. This funding has been committed to in the short term, by the Government but needs long term, ongoing funding and investment. • The CPD for staff referred to in points 1.1.8 and 1.1.12 costs and should be invested in. • The 'peer to trusted adult' support referred to in point 1.2.8 could cost, particularly if with a counsellor or therapist. • The targeted support in section 1.4 would cost. As the guideline states this should be provided by trained experienced practitioners. This involves 'buying in' or commissioning a service and comes with significant cost implications.	Thank you. NICE has no control over national or local commissioning arrangements and is unable to influence this.
Place2Be				What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) • Dedicated funding / investment for schools for mental health and wellbeing. • Investment in the children's mental health workforce, e.g., a new apprenticeship, or training bursaries. • Point 1.1.21 about integrated care systems and schools is crucial but it does not clarify who should fund support.	Thank you. NICE has no control over national or local commissioning arrangements and is unable to influence this.
Place2Be				This guideline was commissioned before the coronavirus pandemic and therefore the original review questions have not taken into account the impact of COVID-19 on the current	Thank you for this information. The committee heard evidence about the impact of covid on children and young people's

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				school environment. NICE have completed additional searches to identify evidence relating to issues caused by COVID-19 on schools and expert witnesses have been brought in to discuss its impact. However, there is currently limited evidence in this area. Please tell us if there are any particular issues or evidence relating to COVID-19 that we should take into account when finalising the guideline for publication. • Mainly the increase in prevalence – 1 in 6 children and young people with a diagnosable mental health problem. • To note the pandemic exacerbated economic and social issues for many families, such as financial struggles, unemployment, and rise in domestic abuse. These factors have an impact on the mental health and wellbeing of children and young people. • A summary of available evidence is available in the latest DfE State of the Nation report - https://www.gov.uk/government/publications/state-of-the-nation-2021-children-and-young-peoples-wellbeing	mental health and took this into account when formulating the guidelines.
Place2Be				NICE have published a health economic tool to inform the impact of interventions on a range of student outcomes in relation to social, emotional and mental wellbeing in primary and secondary education. The tool aims to calculate the number of students who would be impacted by an intervention and the cost per outcome case. The tool includes an explanatory video. Please tell us if you have any comments on the tool, its usability or its content. • For info – Pro Bono Economics carried out independent analysis of Place2Be's counselling service in	Thank you for this information.

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				primary schools and found that for every £1 invested, £6.20 was returned to society. Further information can be seen here - https://www.probonoeconomics.com/place2be	
Place2Be	EIA	General	General	• Consider the communication and access barriers faced by some deaf or hearing-impaired children in receiving the right support. Consider the language barriers in terms of communicating with families and parents whose first language is not English.	Thank you. The committee agreed that the guideline needed to refer to communication needs more than it currently did, and they have added consideration of communication needs to recommendations 1.1.4, 1.1.8, 1.1.15, 1.2.5, 1.3.6 and 1.4.2.
Place2Be	Evidence	General		• Place2Be has evidence on the effectiveness of our services. We would like the Committee to please consider the following: ○ 25 years learning from practice and evaluation ○ Impact Report 2021 ○ Place2Be quality account List of research papers Place2Be has been involved in	Thank you for these references. None of them meet the inclusion criteria for any of the evidence reviews (as outlined in the review protocols). The individual protocols detailing the inclusion criteria for each review can be found in appendix A of each review. 25 years learning from practice and evaluation, Impact Report 2021 and Place2Be quality account would all be excluded on the basis of study design. Finning 2021 included a universal intervention but was not a RCT. Toth 2020 focusses on potential presenting issues for children referred for counselling and did not include usable outcome data. Cooper 2019 used an active control group, which was out of scope.

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					'Pro Bono Economics report for Place2Be' is not peer reviewed and therefore not eligible. 'In the eye of the 'perfect storm'' is not an intervention study and would be excluded on the basis of study design. 'Mental Health Service Models for Young People' POSTnote is not an intervention study and would be excluded on the basis of study design. Curvis 2013 does select for a population been identified as having poor social, emotional and mental wellbeing when validating the assessment tool. Lee 2009 does not appear to include a control group (excluded at title and abstract screening). 'The Effects of School Exclusion and Effective Interventions' is a case study and would be excluded on the basis of study design.
Place2Be	Guideline	General	General	• Consider whether NICE can offer any view on who should commission and pay for any mental health and wellbeing services. i.e., Schools' education budget?	Thank you. NICE does not define who should commission or pay for services. This is a matter for local and national commissioning bodies to agree. The committee agreed that since individual schools have very different set-ups, it would not be useful to define who should

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				• More clarity on who should perform these roles. Is it teachers or is it recommended that external experts are involved? • Consider referencing how this fits in with/has evolved from key policy initiatives such as the Green Paper, Future in Mind? • Could do with a dedicated section on Equality, Diversity and Inclusion (EDI). • Clarify whether the guideline applies to virtual schools and alternative provision. • Is there any legislation that NICE could refer to that underpins this guidance. For instance in Scotland there is Getting It Right For Every Child (GIRFEC) and United Nations Convention on the Rights of the Child (UNCRC) • Place2Be strongly agrees with the document and guidelines. Extremely helpful. Good to see an emphasis on relational approaches and self-report.	undertake the roles. Schools can decide what works best for them. The committee based their recommendations on the best available evidence and their own expertise and experience. This means that policy papers were not directly considered but rather formed part of the experts knowledge base. All NICE guidelines are accompanied by an equality impact assessment, and further detail is given in the rationale and impact section about inequalities and the inclusion health agenda. Thank you for your support.
Place2Be	Guideline	4	Section 1.1.1	Clarify *who* should lead on doing this - . I.e. the Senior Leadership Team, Governing body, and the Senior Mental Health Lead.	Thank you. The committee decided not to explicitly specify a lead, as schools / colleges should have freedom to decide who would suit the role best. However, they did agree to clarify that the lead person should be senior person with authority to make decisions and authorise expenditure.

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Place2Be	Guideline	4	1.1.2.	This could be expanded to say that purely punitive behaviour approaches that fail to recognise challenges the child is experiencing may have a **detrimental impact** on a child's mental health and wellbeing.	Thank you. The committee decided to remove the sentence regarding purely punitive behaviour approaches from recommendation 1.1.2.
Place2Be	Guideline	4	1.1.6	To the bullet point list add "And feedback loops including parents / carers."	Thank you. The committee agreed to add the following bullet point to the list: having mechanisms to feedback to parents and carers.
Place2Be	Guideline	5	1.1.10 and 1.1.11	• We would also recommend externally facilitated peer supervision groups. (Facilitated by expert clinicians.) Need to recommend reflective practice offered by a trained facilitator. Consider what systems/guidance/training would be needed to put this in place.	Thank you. The committee discussed this but decided not to recommend a specific facilitator. The most appropriate facilitator will vary across different schools depending on their systems and processes. Additionally, not all schools will have access to expert clinicians as facilitators.
Place2Be	Guideline	5	1.1.8	• Consider how this would be funded. • CPD must include relational and experiential engagement and activities (and not solely online/digital learning)	Thank you. CPD is already part of schools budgets. The committee did not consider evidence about the best way to undertake CPD since that is not the focus of this guideline.
Place2Be	Guideline	6	1.1.14	Add – ensure that opinions of families who have English as an additional language are heard and considered.	Thank you. This is covered in recommendation 1.1.15, which states "Ensure that the opinions of all members of the school community are taken into account and make appropriate

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					adjustments to take into account neurodiversity and communication needs".
Place2Be	Guideline	6	1.1.16	Clarify whether this is the same person as the (DfE funded) trained Senior Mental Health Lead.	Thank you. The committee decided not to explicitly specify a lead, as schools / colleges should have freedom to decide who would suit the role best. However, they did agree to clarify that the lead person should be senior person with authority to make decisions and authorise expenditure.
Place2Be	Guideline	6	1.1.18	After this final bullet point, add another one stating - Include emotional / relational literacy as a core learning target in the same way that English & Mathematical literacy are taught and measured.	Thank you. The committee discussed your suggestion but agreed that this was outside the remit of this guideline.
Place2Be	Guideline	7	1.2.1	Evidence based is crucial, but schools will need guidance about how to find out if something is evidence based.	Thank you. We believe that "evidence-based" is a well understood term in educational settings.
Place2Be	Guideline	7	1.2.5	Add to the bullet point list 'their ability to ask for help and to seek support'.	Thank you. This example is too specific to be added to the list in recommendation 1.2.5.
Place2Be	Guideline	8	1.2.6	Not sure about mindfulness being recommended for all children and need to make sure it involves a trained professional.	Thank you. The committee saw some evidence for Mindfulness (see evidence review B and C). They agreed that Mindfulness might not be useful in all settings so they made a recommendation to 'consider' Mindfulness. Please see Making decisions using NICE guidelines. This explains how we use words to show the strength (or certainty) of our recommendations. .

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Place2Be	Guideline	8	1.2.8	Peer to peer support should include training for peers.	Thank you. The level of training for peer supporters is a matter for local schools to decide.
Place2Be	Guideline	9	Box 1	• Consider adding these risk factors - o Poverty, the child's socio-economic circumstances o SEND o Discrimination, racism, homophobia Looked after children and children of experience in care	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
Place2Be	Guideline	9	1.3.2	You could add use of a Wellbeing Measurement.	Thank you. The committee agreed that there are many types of wellbeing measure, the quality of which can vary and some are not appropriate for certain schools, settings or needs, so they did not want to add this to the recommendation.
Place2Be	Guideline	10	Section 1.4	• Add a specific line about ensuring the targeted 1-1 support is appropriate for the individual's needs including cultural background. The support and any materials used should be culturally sensitive, appropriate and informed. Add a specific line about ensuring that the targeted 1-1 support is accessible for the needs of the child, e.g. SEND, specific communication needs.	Thank you. Recommendation 1.4.2 has been amended and now includes the following: "Any support should be culturally sensitive and take into account neurodiversity, communication needs and other needs of the child or young person."

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Place2Be	Guideline	10	1.4.2	As stated in the point 1.4.1, the intervention should be matched to the specific need.	Thank you. The committee discussed this suggestion but agreed this was already covered in many of the other recommendations in section 1.4.
Place2Be	Guideline	10	1.4.3	• Change "Talk to" to "Actively include". • There might be circumstances in which talking to the parents/carers might not be in the best interests of the child. For example, where there are risk factors at home and a competent young person is seeking counselling. Ethical decision-making is needed. Add to 1.4.3. that some targeted interventions may directly involve the parent's input, e.g., evidence-based parenting training programmes such as PIPT or Incredible Years. Alternatively, you could have a small separate section on parenting to explain this more.	Thank you. The committee agree and have changed 'talk to' to 'actively include' in recommendation 1.4.3. The committee also agree that parental involvement is not always appropriate, so have added the following text to the box on page 4 of the guideline to clarify this: "recommendations relating to parents or carers might be less relevant to older young people, especially those in post-16 education settings and may need to be interpreted accordingly."
Place2Be	Guideline	10	1.3.6	Add to the first bullet - what the child is saying, the child's voice, the child's desires/feelings.	Thank you. The committee agreed to add 'wishes and feelings' to recommendation 1.3.6.
Place2Be	Guideline	11	1.4.6	Peer to peer support should be provided by peers who have received training and guidance on how to support their peers. There should be ongoing training and support for the peer supporters post training.	Thank you. The level of training for peer supporters is a matter for local schools to decide.
Place2Be	Guideline	11	1.4.7.	Strengthen this and say proactively try to reduce stigma and normalise seeking support, fully	Thank you. The committee agreed with this suggestion and recommendation 1.4.7 has been amended to the following:

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				embedding the targeted support in the school environment and making it visible to all, not shrouded away. (e.g., an open-door policy when counselling sessions aren't taking place).	1.4.7 Aim to minimise the risk of any unintended adverse consequences and stigma and proactively normalise seeking support. Take care not to reinforce bullying by singling people out for support.
Place2Be	Guideline	13	18	Add - "Psychological safety is a perception of the individual; it isn't something that can be guaranteed through processes and policies. Commitment to creating safety is more an approach to relationships."	Thank you. The committee considered this but though it was an unnecessary addition.
Place2Be	Guideline	16	3	Place2Be can provide evidence of the effectiveness of targeted support and whether it varies by ethnicity and socio-economic status.	Thank you for this information.
Place2Be	Guideline	16	4	Place2Be can provide evidence of the longer-term impact of targeted intervention for primary-aged children https://link.springer.com/article/10.1007/s00787-021-01802-w#Sec17	Thank you for this information.
Place2Be	Guideline	16	4	Add - "Longitudinal / follow-up research looking at whether children who receive targeted group or individual interventions before the age of 11 are any more or less likely to develop further need into adolescence? Or, is early intervention a preventative measure? And would some of the targeted interventions be good as universal offers if young people who aren't receiving early intervention are	Thank you. The committee discussed this and agreed to amend research recommendation 3 so that this is covered. The recommendation now reads "What is the effectiveness (including long-term effectiveness) and cost effectiveness of targeted group or individual interventions for children and young people who have been identified as needing additional mental health support, and does it vary by ethnicity, and socioeconomic status or other cultural and personal factors?"

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				also going on to develop Social Emotional or Mental Health needs?	
Place2Be	Guideline	17	2	Place2Be's evidence shows that a higher proportion of pupils who have SEND received our targeted support than you would expect given the school population. Within the group of pupils who receive targeted support, those with SEND are more likely to have severe mental health difficulties, based on the Strengths and Difficulties Questionnaire, than their peers without SEND.	Thank you for this information.
Post Traumatic Stress Disorder UK	Guideline	10	1	Consider adding in 'previous traumatic experiences' as these could impact any tools or techniques suitability and effectiveness.	Thank you. The committee noted that the final bullet of recommendation 1.3.6 says "take into account contextual factors such as…" and provides a number of examples but not an exhaustive list, so they did not consider it necessary to add previous traumatic experiences to the examples given.
Post Traumatic Stress Disorder UK	Guideline	10	18	Consider adding 'where appropriate' to ensure that any instances of abuse at home are considered.	Thank you. The committee agreed to add text to this effect.
Post Traumatic Stress Disorder UK	Guideline	13	8	Consider changing to 'Events or situations which are, or are perceived to be, highly stressful and potentially traumatic….'	Thank you. Changes to the guideline mean that the definition of adverse childhood experiences has been removed.

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Royal College of Nursing	General	General	General	We do not have any comments to add on this consultation. Thank you for the opportunity to contribute.	Thank you or your support
Royal College of Occupational Therapists		7	18	Occupational therapists already work in partnership with schools in many areas of the UK, offering a range of whole-school and targeted mental health approaches. Our report, Occupational therapy - unlocking the potential of children and young people - RCOT includes an example of a school well-being hub which is run by an occupational therapist. Taking a preventative approach, the occupational therapist helps teachers deliver relaxation and mindfulness sessions. They also provide information and support to enable students to manage their own wellbeing by for example, looking at sleep, physical activity and daily routines. Intervening early reduces the risk of problems escalating and requiring input from specialist CAMH services.	Thank you. The committee decided not to make direct reference to occupational therapists as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. Occupational therapists are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
Royal College of Occupational Therapists		7	20	Occupational therapists take a strengths-based approach, offering practical support to help young people develop routines and enabling them to carry out the everyday activities that they value and that provide structure to their lives. These are key factors affecting social, emotional and mental wellbeing. Talking and creative therapies are only part of the solution and may not be appropriate for young people	Thank you. The committee decided not to make direct reference to occupational therapists as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. Occupational therapists are also covered by the 'health and

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				who are disabled or neurodiverse. By focusing on independence and self-management, occupational therapists help young people develop skills and confidence to look after their wellbeing, knowing when and how to seek further support should they need it.	social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
Royal College of Occupational Therapists		8 9	15 11	With expertise in physical and mental health, occupational therapists are well-placed to identify unmet special educational needs and disabilities, and provide support to teacher to address these.	Thank you. The committee decided not to make direct reference to occupational therapists as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. Occupational therapists are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
Royal College of Occupational Therapists		10	14	Occupational therapists are qualified to give targeted individual and group support to children and young people. We are regulated by the Health and Care Professions Council and are guided by the RCOT Professional standards for occupational therapy practice, conduct and ethics - RCOT	Thank you. The committee decided not to make direct reference to occupational therapists as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. Occupational therapists are also covered by the 'health and

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					social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
Royal College of Occupational Therapists		11	15	Occupational therapists work with people of all ages, so have the knowledge and skills to support young people and families at times of transition. An example of this work is included on page 6 of our report: Occupational therapy - unlocking the potential of children and young people - RCOT	Thank you. The committee decided not to make direct reference to occupational therapists as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. Occupational therapists are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
Royal College of Occupational Therapists	Guideline			The Royal College of Occupational Therapists (RCOT) supports the NICE 'Social, emotional and mental wellbeing in primary and secondary education' guideline. However, the vital role of occupational therapists in supporting students' social, emotional and mental wellbeing in education must not be overlooked.	Thank you. The committee discussed this but decided not to make direct reference to occupational therapists as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. Occupational therapists are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.

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Royal College of Occupational Therapists	Guideline			We support the key research recommendations	Thank you for your support
Royal College of Speech and Language Therapists	Guideline	General	General	A vast amount of research has been undertaken to highlight the close association of speech, language and communication disorders in children and their social, emotional and mental health. Given that speech, language and communication needs (SLCN) are the most common type of special educational need (Department for Education, 2021. Special educational needs in England), and the risks when these needs are not identified and supported, we are concerned that the guideline includes no mention of speech, language and communication needs, or the importance of supporting the development of communication skills as a means to promoting social, emotional and mental wellbeing. We make a number of suggestions below of amendments to specific sections of the guideline which could be made to the recommendations in order to address this.	Thank you. The committee decided to make amendments to certain sections of the guideline to highlight the importance of communication needs and skills. This included recommendations 1.1.4, 1.1.8, 1.1.15, 1.2.5, 1.3.6 and 1.4.2. The references in this comment was checked and none of them met the inclusion criteria for any of the evidence reviews (as outlined in the review protocols). The review protocols that

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				Please see below a comprehensive review of the literature, including reference to multiple **meta-analyses**, **systematic reviews** and **large-scale studies** that highlight these issues. Research indicates that many children with poor social, emotional and mental wellbeing have poor language skills – a meta-analysis has found that 81% of children with emotional and behaviour disorders had below average language abilities, with the mean comprehensive language score being significantly below average (Hollo, A., Wehby, J. H. & Oliver, R. M. (2014). Unidentified Language Deficits in Children with Emotional and Behavioural Disorders: A Meta-Analysis. Exceptional Children, 80(2): 169-186) Research also indicates that children with speech, language and communication needs are at increased risk of developing mental health problems during school: • Children with language difficulties have an impoverished quality of life in terms of moods and emotions and are more at risk in terms of social acceptance and bullying (Lindsay G. & Dockrell J. (2012). The relationship between speech, language and communication needs (SLCN) and behavioural,	detail the inclusion and exclusion criteria for each review can be found in appendix A of each review document. Hollo 2014 does not focus on interventions. Lindsay 2012 is a government report and would therefore be excluded on the basis of study design. Botting 2016 did not include usable outcome data on risk factors for poor social, emotional and mental wellbeing. Sullivan 2016 was conducted in a community population sample. Snowling 2006 measured rates of psychiatric disorders, which was not an outcome of interest. Benner 2002 focusses on the prevalence, strength, durability, and nature of language deficits, which are not relevant outcomes. Pickles 2016 does not use regression analysis or contain usable outcome data. Nelson 2005 focussed on language deficits, which were not a relevant outcome of interest.

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				emotional and social difficulties (BESD), Department for Education research report DFE-RR247 BCRP6: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/219632/DFE-RR247-BCRP6.pdf) • Rates of anxiety are higher in individuals with developmental language disorder (DLD)[1] than age matched peers and remains so from adolescence to adulthood; individuals with DLD have higher levels of depression symptoms than do peers in adolescence (Botting, N., Toseeb, U., Pickles, A., Durkin, K., & Conti-Ramsden, G. (2016). Depression and anxiety change from adolescence to adulthood in individuals with and without language impairment. PloS one, 11(7), e0156678) • Difficulties with pragmatic language (social communication) precede early and late adolescent psychotic experiences and early adolescent depression (Sullivan S.A., Hollen L., Wren Y., Thompson A.D., Lewis G. & Zammit S. (2016) A	Centre for Mental Health 2018 is a university / charity authored report and would be excluded on the basis of study design.

[1] Developmental Language Disorder (DLD) is a condition where children have problems understanding and/or using spoken language. There is no obvious reason for these difficulties – no hearing problem or physical disability explains them. An estimated 7.58% of children start school with DLD – the equivalent of two in every classroom (Norbury et al, 2016).

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				longitudinal investigation of childhood communication ability and adolescent psychotic experiences in a community sample, Schizophr Res;173(1-2):54-61.) • Longitudinal studies of children with identified SLCN demonstrate an elevated risk of social, emotional and behavioural difficulties in adolescence (Snowling, M.J., Bishop, D.V., Stothard, S.E., Chipchase, B., & Kaplan, C. (2006). Psychosocial outcomes at 15 years of children with a preschool history of speech-language impairment. Journal of Child Psychology and Psychiatry, 47, pp759–765.) Language difficulties are also strongly associated with behavioural problems – again, tightly linked to SEMH - with studies observing consistently higher levels of disruptive and antisocial behaviour amongst children also identified with speech and language needs. See for example: • Benner, G. J., Nelson, J. R., and Epstein, M. H. (2002). Language skills of children with EBD: A literature review. Journal of Emotional and Behavioral Disorders, 10 (1), pp. 43-59 • Pickles, A., Durkin, K., Mok, P., Toseeb, U. & Conti-Ramsden, G. (2016). Conduct problems	

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				co-occur with hyperactivity in children with language impairment: A longitudinal study from childhood to adolescence. Autism and Developmental Language Impairments. https://doi.org/10.1177/239694151664525 • Nelson, J. R., Benner, G. J., and Cheney, D. (2005). An investigation of the language skills of students with emotional disturbance served in public school settings. The Journal of Special Education, 39: 97-105) Conversely, good communication skills are a protective factor for children and young people: Analysis of data from the Millennium Cohort Study about children between the ages of 9 months and 14 years found that verbal cognitive ability appears to be a powerful protective factor against the development of childhood conduct problems, substantially reducing the likelihood among both boys and girls of being on any of the three higher risk pathways. The effect is particularly marked in relation to the 'persistent high problems' pathway (Centre for Mental Health (2018). Children of the millennium: Understanding the course of conduct problems during childhood. Online: https://www.centreformentalhealth.org.uk/publications/children-new-millennium)	

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Royal College of Speech and Language Therapists	Guideline	General	General	In response to Q4 regarding any particular issues or evidence relating to COVID-19, the following papers may be of interest: • RCSLT (2021) Speech and language therapy during and beyond COVID-19: building back better with people who have communication and swallowing needs This report found that the majority of children and young people who were in receipt of speech and language therapy prior to the pandemic received less speech and language therapy, or none at all during the first lockdown in spring 2020. 45% of respondents said that receiving less speech and language therapy had had a negative impact on their mental health. • Asbury, K., Fox, L., Deniz, E., Code, A., & Toseeb, U. (2021). How is COVID-19 Affecting the Mental Health of Children with Special Educational Needs and Disabilities and Their Families?. Journal of autism and developmental disorders, 51(5), 1772–1780. https://doi.org/10.1007/s10803-020-04577-2 • Samji, H., Wu, J., Ladak, A., Vossen, C., Stewart, E., Dove, N., Long, D. and Snell, G. (2021), Review: Mental health impacts of the	Thank you. You raise an important point, however, it is outside the remit of this guideline. Please see the scope document on the NICE website.

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				COVID-19 pandemic on children and youth – a systematic review. Child Adolesc Ment Health. https://doi.org/10.1111/camh.12501 The failure of provision for neurodiverse children during the covid-19 pandemic | The BMJ	
Royal College of Speech and Language Therapists	Guideline	4	11	Recommendation 1.1.4 Given the prevalence of speech, language and communication needs, and the impact on behaviour, suggest addition (in bold): Review regularly the school's accessibility plan and approach to understanding behaviour, taking into account neurodiversity, **speech, language and communication needs**, the value of trauma-informed approaches and parental co-production.	Thank you. The committee agreed to add the suggested text into the recommendation.
Royal College of Speech and Language Therapists	Guideline	4	22	Recommendation 1.1.6 Wider community health services, such as speech and language therapy, have a role to play in supporting the whole school approach. Suggest addition (in bold): strengthening links to external agencies that can provide additional support, such as local children's services, **community health services (for example, speech and language therapy)** and relevant voluntary and community sector organisations	Thank you. The committee discussed this but decided not to make direct reference to speech and language therapy as a resource. The committee noted that several difference services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. Speech and language therapists are also covered by the

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					'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
Royal College of Speech and Language Therapists	Guideline	5	11	Recommendation 1.1.8 It's important that staff understand the links between communication and social, emotional and mental wellbeing, in order that they can provide support in a way that is accessible. Suggest addition (in bold) Ensure that staff have continuing professional development to support both their own wellbeing and the implementation of the school's approach (including training in emotional literacy, trauma, neurodiversity, **communication needs** and relational approaches). NB The RCSLT has developed a free e-learning package – Mind Your Words – to support the children's workforce to understand how they can work together to remove communication barriers and help these children and young people achieve their potential. More information is available here: https://www.rcslt.org/learning/mind-your-words/	Thank you. The committee agreed to add the suggested text into the recommendation.
Royal College of	Guideline	6	4	Recommendation 1.1.15 Suggest addition (in bold):	Thank you. The committee agreed to add this suggestion to recommendation 1.1.15.

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Speech and Language Therapists				Involve children and young people in discussing and agreeing whole school approaches and tell them regularly about decisions to give them a sense of agency. Ensure that the opinions of minority and seldom-heard children and young people are taken into account. **Make appropriate adjustments to take into account neurodiversity and communication needs**.	
Royal College of Speech and Language Therapists	Guideline	8	1	Recommendation 1.2.5 Good communication skills are a protective factor for children and young people, and schools have an important role in supporting pupils of all ages to develop these skills. Suggest addition (in bold): skills (for example, problem solving skills, social skills, **communication skills**)	Thank you. The committee decided to add the suggested text into the recommendation.
Royal College of Speech and Language Therapists	Guideline	8	21	Section 1.3 A **meta-analysis** (Hollo, A., Wehby, J. H. & Oliver, R. M. (2014). Unidentified Language Deficits in Children with Emotional and Behavioural Disorders: A Meta-Analysis. Exceptional Children, 80(2): 169-186) has clearly concluded that speech, language and communication needs frequently go unidentified, particularly in children and young people with social, emotional and mental health needs. Based on this robust evidence, we would	Thank you. The reference in this comment was checked and it did not meet the inclusion criteria for any of the evidence reviews (as outlined in the review protocols). The review protocols that detail the inclusion and exclusion criteria for each review can be found in appendix A of each review document. Additionally, the importance of communication needs is now covered in recommendation 1.1.15, which states "Ensure that the opinions of all members of the school community are taken

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				recommend adding a separate recommendation about the need to identify underlying factors which may be contributing / presenting as poor social, emotional and mental wellbeing. **Consider whether underlying factors, for example, speech, language and communication needs, may be contributing to children and young people's social, emotional and mental wellbeing, and where appropriate make a referral to a specialist professional for an assessment.** The meta-analysis mentioned above found that, of the 81% of children with below average language abilities, none had previously been assessed for speech or language problems The Department for Education guidance on Mental health and behaviour in schools states that "Where there are concerns about behaviour, the school should instigate an assessment (as set out in paragraph 3.14) to determine whether there are any underlying factors such as undiagnosed learning difficulties, difficulties with speech and language, child protection concerns, or mental health problems."	into account and make appropriate adjustments to take into account neurodiversity and communication needs".

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				Furthermore, the Timpson Review of School Exclusions identified speech, language and communication needs as one of the underlying causes of poor behaviour. Early identification and provision of appropriate support for communication needs can help to mitigate the risk of social, emotional and mental health needs, and reduce the risk of exclusion from school.	
Royal College of Speech and Language Therapists	Guideline	9	6	Box 1 Research indicates that communication difficulties are a key risk factor for poor social, emotional and mental wellbeing – The Centre for Longitudinal Studies analysed data from the UK Millennium Cohort Study and found that communication difficulties were a statistically significant risk factor found to influence children's mental illness by the age of 11 years (Patalay P. & Fitzsimons E. (2016). Correlates of Mental Illness and Wellbeing in Children: Are They the Same? Results From the UK Millennium Cohort Study. J Am Acad Child Adolesc Psychiatry, 55:771–783.) The same study also identifies special educational needs as a risk factor.	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline. The references in this comment were checked and all would have been excluded on the basis of no usable outcome data.

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				Studies also link different kinds of neurodivergence to mental health, see for example: Lai, M. C., Kassee, C., Besney, R., Bonato, S., Hull, L., Mandy, W., Szatmari, P. & Ameis, S. H. (2019). Prevalence of co-occurring mental health diagnoses in the autism population: A systematic review and meta-analysis. The Lancet Psychiatry, 6(10), 819–829. https://doi.org/10.1016/S2215-0366(19)30289-5 Bishop, C., Mulraney, M., Rinehart, N. & Sciberras E. (2019). An examination of the association between anxiety and social functioning in youth with ADHD: A systematic review. Psychiatry Research, 273, 402-421. https://doi.org/10.1016/j.psychres.2019.01.039 Recommend adding communication difficulties, special educational needs and neurodivergencies to the list of risk factors.	

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Royal College of Speech and Language Therapists	Guideline	10	6-8	Recommendation 1.3.6 Many assessment tools and techniques rely upon a young person's language skills to both understand what is being said to them, and express themselves in response. Using an inappropriate tool with a child with speech, language and communication needs could result in an inaccurate result. It's important therefore that when selecting a tool or technique, the child's communication needs are taken into account. Suggest addition (in bold): contextual factors, such as the child or young person's chronological or developmental age, or ethnicity, and any communication needs (bearing in mind that assessment tools are context specific and vary in quality).	Thank you. The committee decided to add the suggested text into the recommendation.
Royal College of Speech and Language Therapists	Guideline	10	9	Section 1.4 Many mental health interventions are in the form of 'talking therapies' and/or rely heavily on a child's ability to use language to identify goals, articulate the difficulties and emotions they are experiencing, reflect on their behaviour and regulate their own emotions and interactions. There is therefore a need to consider children's language and communication ability in order to plan and deliver effective targeted interventions.	Thank you. The committee discussed this and agreed to add "Any support should be culturally sensitive and take into account neurodiversity, communication needs and other needs of the child or young person." to recommendation 1.4.2. However, they decided that the second suggestion in this comment was already covered by "Use trained experienced practitioners who are competent and who are quality assured to provide the support" in recommendation 1.4.2.

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				We would recommend adding two additional recommendations to this section: • Consider how interventions may need to be adapted to take into account neurodiversity and communication needs. Involve education and healthcare practitioners from multiple disciplines when planning targeted interventions	
School And Public Health Nursing Association		4	17	1.1.6 also include medical conditions policy Consider whole school information on the effects of significant loss on a child's education Specifically include collaborative work with specialist community public health nursing (SCPHN) School Nurse Pathway	Thank you. The school medical conditions policy has now been mentioned in recommendation 1.1.4. The committee decided not to make direct reference to School Nursing Service as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. School nurses are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
School And Public Health Nursing		6	12	1.1.16 The designated lead person should receive additional training in mental health in order to meet the needs of the pupils and school as a whole; and collaborate with designated SCPHN school nurse.	Thank you. The committee discussed the lead role and agreed that they would specify that it should be someone in a leadership role, however they did not feel able to comment on the training that individual might need since this would vary from school to school.

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Association					
School And Public Health Nursing Association		7	12	1.2.2 Specifically note the guidance from DfE regarding links between physical health and mental health. Note role of SCPHN School Nurse in this area.	Thank you. The hyperlinked document in recommendation 1.2.2 (Department for Education's relationships education, relationships and sex education, and health education guidance) notes the links between physical and mental health. The committee decided not to make direct reference to school nurses as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation about keeping the local offer directory up to date.
School And Public Health Nursing Association		8	15	1.3.1 Consider role of SCPHN School Nurse in universal and targeted assessment	Thank you. The committee decided not to make direct reference to School Nursing Service as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. School nurses are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.

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School And Public Health Nursing Association		9	6	Consider adding poor body image / obesity / LGBTQ+	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
School And Public Health Nursing Association		9	8	1.3.3 Consider referring into / role of the SCPHN School nursing service. Building in time for a SCPHN school nurse drop-in clinic	Thank you. The committee decided not to make direct reference to School Nursing Service as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. School nurses are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
School And Public Health Nursing Association		10	17	1.4.2 consider school nurse or mental health support teams.	Thank you. The committee decided not to make direct reference to School Nursing Service as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation

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					(1.1.20) about keeping the local offer directory up to date. School nurses are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
School And Public Health Nursing Association		11	12	1.5 Note work of SCPHN School Nurse in role of all transition points. Plus consider possible School health / school nurse champions for additional peer support.	Thank you. The committee decided not to make direct reference to School Nursing Service as a resource. The committee noted that several different services and occupations will be involved in CYP's social, emotional and mental wellbeing and did not want to single out any in particular. Additionally, resources and services schools will have access to will widely vary across the country. However, the committee decided to make a new recommendation (1.1.20) about keeping the local offer directory up to date. School nurses are also covered by the 'health and social care practitioners' bullet under 'Who this guideline is for' section at the start of the guideline.
School And Public Health Nursing Association		12	19	1.5.3 -1.5.4 Include medical conditions policy and individual health care plans Note the links between poorer self-esteem of obese children compared to children with cancer.	Thank you. The committee discussed this, but agreed that this was not the right place to reference medical conditions policies and individual health care plans. However, medical conditions policies have now been mentioned in recommendation 1.1.4. Links between poorer self-esteem of obese children compared to children with cancer were not identified in the evidence review and therefore not mentioned in the guideline.

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School And Public Health Nursing Association		26	6	Note the links between physical and mental health.	Thank you. The hyperlinked document in recommendation 1.2.2 (Department for Education's relationships education, relationships and sex education, and health education guidance) notes the links between physical and mental health.
School And Public Health Nursing Association		30	26	Points 21-25 Note the evidence links between bereavement and bullying.	Thank you. We are unable to respond as we are unsure what your comment refers to.
School And Public Health Nursing Association	Guideline	4	11	1.1.4 Review regularly the school's accessibility plan and approach to understanding behaviour, taking into account neurodiversity, the value of 13 trauma-informed approaches and parental co-production. Please include a medical conditions policy in this section.	Thank you. Medical conditions policy has now been included in recommendation 1.1.4.
The Challenging Behaviour		6	General	**Involving families and pupils** We support the recommendation in the guidance to involve parents and carers. There must be a range of virtual and in person opportunities for family carers to get involved, including written surveys, one to one	Thank you for your support.

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Foundation				phone calls, and focus groups. Similarly, parents and carers must be involved when making best interest decisions for their relative.	
The Challenging Behaviour Foundation	Guideline	General	General	**Equality Act Reasonable Adjustments** Currently the guidance makes no reference to the legal duty to make reasonable adjustments under the Equality Act 2010. Whilst the guideline gives helpful examples of reasonable adjustments we feel it is important the this legal duty is specifically referenced in the guidance so that it is clear that making reasonable adjustments is a legal duty and not an optional recommendation.	Thank you. As you note this is already a legal duty and has been for over 10 years. The committee did not feel it was necessary to reiterate it in this guideline.
The Challenging Behaviour Foundation	Guideline	4	2	**Whole school approach** There needs to be clear statutory training, reporting and recording guidelines of any incidents of restrictive practices, to ensure that children and young people in educational settings are not being unnecessarily and inhumanely restrained or secluded. All school staff must receive training in understanding behaviour as communication of an unmet need, and positive approaches to support, in order to prevent the unnecessary use of restrictive interventions on children and young people. Incidents of restraint must be accurately recorded and reported, and this information shared with family carers.	Thank you. It is beyond NICE's remit to make statutory guidance.

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				As part of their restraint in schools inquiry, the Equality and Human Rights Committee (2021) (Restraint in schools inquiry: using meaningful data to protect children's rights | Equality and Human Rights Commission (equalityhumanrights.com)) recommended mandatory minimum standards should be set for recording the use of restraint in schools. In 2020, the Challenging Behaviour Foundation and Positive and Active Behaviour Support Scotland published a report showing that almost 88% of parents were aware of a time where their child had been restrained or secluded at school. This report also demonstrated how using restraint and seclusion unnecessarily can negatively impact the mental and physical wellbeing of children, as well as impacting on their ability to confidently access education services.	
The Challenging Behaviour Foundation	Guideline	4	7	**Whole School Approach** We support the recommendation in the guideline to take into account that behavioural approaches used in isolation will have limited impact. It would be helpful for the guideline at this point to link to NICE guidance 'Challenging Behaviour and Learning	Thank you. The committee discussed this but decided that it wasn't helpful to link to this guideline because it is too specific for the recommendations they have made.

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				Disabilities: prevention and intervention for people with learning disabilities whose behaviour challenges'. (Overview | Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges | Guidance | NICE) It is vital to emphasise the importance of understanding the reasons for an individual's behaviour, particularly when supporting a child or young person with learning disabilities.	
The Challenging Behaviour Foundation	Guideline	4	11	We suggest adding that parents must be consulted when making best interests decisions.	Thank you. Recommendation 1.4.3 refers to involving parents in decisions about offering targeted support to their children, recommendation 1.1.14 encourages involving parents in designing and implementing whole-school approaches.
The Challenging Behaviour Foundation	Guideline	5	11	**Supporting staff** Training for staff should also include understanding challenging behaviour, and positive approaches to support. Understanding behaviour as communication of an unmet need can ultimately reduce the need for restrictive practices, which we know can be traumatic for the individual, their family and the member of staff involved.	Thank you. The CPD needs of teachers will vary by teacher and school and therefore the committee were not able to be specific about it. The guideline does not recommend restraint or restrictive practices.

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				The Northern Ireland Commissioner for Children and Young people report '*Neither Seen nor Heard - a Rights Based Review on the Use of Restraint and Seclusion in Educational Settings'* (2021) finds that restrictive practices have the potential to cause trauma to the individual child, their peers and the staff involved. **niccy-restraint-and-seclusion-main-report-final-16-dec-21.pdf**	
The Challenging Behaviour Foundation	Guideline	5	21	**Supporting staff** We are pleased that the guidelines include understanding pastoral needs. However, there should also be mention of supporting staff to understand a child's disability, and how that can affect their ability to access education and support. Understanding a child's needs and how to support them could improve staff implementation of the school's approach and staff's own wellbeing as they may be less likely to become distressed when a child demonstrates behaviours described as challenging.	Thank you. Recommendation 1.1.11 has been amended to include support.

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The Challenging Behaviour Foundation	Guideline	6	6	**Involving families and pupils** We support the recommendation to ensure that the opinions of 'Seldom-heard' children and young people are taken into account. This must include children and young people with severe learning disabilities and profound and multiple learning disabilities who do not communicate verbally. For further information about how to effectively gather the views of this group of individuals, please see here: Valuing the views of children with a learning disability (challengingbehaviour.org.uk) and Stop, Look and Listen to me (challengingbehaviour.org.uk)	Thank you. We have reworded this recommendation to make it clearer. Thank you for this example of good practice. Unfortunately, NICE no longer maintains its shared learning database due to lack of resources and therefore is unable to add this training to it
The Challenging Behaviour Foundation	Guideline	8	14	**Identification and risk factors** The physical and mental wellbeing of the child or young person's family/carers could be a risk factor for poor social, emotional and mental well-being, especially if a child's main carer is struggling or feeling overwhelmed. This is very important to consider, especially when supporting children and young people with learning disabilities. Emerson (2007) found children with learning disabilities are more likely to have a parent with poor	Thank you for this information.

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				physical and mental health than a child without a learning disability (Emerson, E., and Hatton, C. (2007). Mental health of children and adolescents with intellectual disabilities in Britain. *British Journal of Psychiatry*)	
The Challenging Behaviour Foundation	Guideline	8	14	**Identification and risk factors** We suggest experience of restrictive practices (in the school environment or elsewhere) should be added to the list of possible risk factors for poor social, emotional and mental wellbeing. In our update report 'Reducing Restrictive Interventions and Safeguarding Children' (2020), in addition to physical injuries some families also reported emotional injuries including nightmares, fear of school, trauma, post-traumatic stress disorder and deep psychological terror (rireportfinal.pdf (challengingbehaviour.org.uk)). This is likely to be just the tip of the iceberg. The Equality and Human Rights Committee (2021) found that one in ten schools that record restraint, do not record if there are any adverse impact on the child, including injuries and psychological impacts. Restraint in schools inquiry: using meaningful data to protect children's rights (equalityhumanrights.com)	Thank you. The use of restrictive practices was not identified in any of the studies in review D and E as a risk factor.

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				In the report of their restraint in schools inquiry, the Equality and Human Rights Committee (2021) recommended mandatory minimum standards should be set for recording the use of restraint in schools. Restraint in schools inquiry: using meaningful data to protect children's rights (equalityhumanrights.com) Recording the use of restraint is essential for identifying risk factors and ensuring the appropriate support is in place for children and young people.	
The Challenging Behaviour Foundation	Guideline	10	18	Targeted support We support the recommendation to talk to the parents and carers of young people when deciding on targeted support. Clear lines of communication with family carers are very important, particularly with families of young people with learning disabilities. School staff should be prepared to communicate with families in the format that suits them best.	Thank you for the support.
The Challenging Behaviour Foundation	Guideline	11	1	Targeted support Children and young people with severe learning disabilities and profound and multiple learning disabilities must be involved in decisions about the support offered to them.	Thank you. The committee discussed this and agreed to add "Any support should be culturally sensitive and take into account neurodiversity, communication needs and other needs of the child or young person." to recommendation 1.4.2.

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				For further information about gathering the views of this group of individuals, see here: Valuing the views of children with a learning disability (challengingbehaviour.org.uk) and Stop, Look and Listen to me (challengingbehaviour.org.uk)	
The Challenging Behaviour Foundation	Guideline	11	14	All transition and life changes We know that transition can be a particularly challenging time for individuals with severe learning disabilities and their families. Family carers in touch with the CBF have told us they often feel worried about what will happen once their relative requires transition support, and highlighted that this could be reduced by having access to better information, and planning in advance of their relative's transition. Person-centred transition support should be offered early to children and young people with learning disabilities and their families who are moving between schools/ education settings, and during transition between child and adult social care and health services.	Thank you. This is covered in recommendation 1.5.2.
The Listening Centre	Guidelines	General	General	The guidelines should incorporate comments related to the importance of having members of staff in school trained at least in basic mental health and some development psychology. Psychotherapists	Thank you. The committee discussed this but decided that due to varying access to occupations and services across the country, not all schools / colleges will have access to training from psychotherapists and school counsellors to provide training.

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				dealing with YPs and school counsellors should be invited to help with the training delivery and support with basic understanding of children's issues, especially ACE. Clear requirements should be issues to schools regarding the necessity to have their staff properly trained.	
West Berkshire Council		22	21	How will the coordination by the single colleague exist in schools….we have safeguarding leads, CiC (Children in Care) leads, Mental Health Well Being(MHWB) leads, SENCOs…where does this fit? There is significant cross over, so how do we ensure that the right person leads and they are not overwhelmed by the role?	Thank you. The decision about who should take that role is one for individual schools. The committee agreed that it should be a person in a leadership role and thought that it might often be the mental health lead, however they were aware that there are many different ways that schools can organise this and did not wish to be dogmatic.
West Berkshire Council		23	8	We agree that this is best practice, for some schools this will be a simple amendment to systems already in place, for others where culture change is necessary, resources will be a huge issue. How can this be addressed to prevent school leaders from 'opting out'?	Thank you. NICE guidelines in this area are not mandatory, and schools may wish to opt-out. The committee hoped that by making a sensible, useful and proportionate guideline they would encourage uptake. NICEs resource impact team have produced a statement to support the implementation of this guideline. It can be found on the guideline webpage.
West Berkshire Council		23	28	Incorporating this in to the curriculum is of course a good idea, but it will take time to achieve for any school as it will need to be a full curriculum review. What time, resources and support will be in place to assist with this work? This reinforces the need for these important changes to align with the performance expectations at the DFE.	Thank you. The decisions about time, resources and support will be made locally and will vary according to local commissioning arrangements.

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West Berkshire Council		26	31	Will the guidance lay out specific tools for leaders to use, as they are unlikely to have this expertise in schools?	The committee agreed not to identify specific tools because they would vary depending on the culture and ethos of the school and factors such as the developmental age of the children and young people, although they did express a preference for validated tools.
West Berkshire Council		29	24	Where will the 'time and money' come from?	Thank you. NICE do not provide funding or commission services. These issues will vary from area to area according to local commissioning arrangements and will therefore need to be negotiated locally.
West Berkshire Council	Guideline	5	18	1.1.10 How do you define 'pastoral roles'? Does it relate to any staff with 'pastoral lead' in their title, or all staff as they may all have some degree of pastoral responsibility? Agree that staff should be given protected time for supervision and CPD, but how will this happen given time and resource restraints?	Thank you. The committee agreed that all school staff have a pastoral role and that they would understand this.
West Berkshire Council	Guideline	5	20	1.1.11 We think this is essential 'Make peer supervision available for teachers and other school staff' however how will this be supported in schools when time is of a premium and the finances are not there to support it. Would schools be expected to do this in house, in clusters with other schools? How would staff learn about supervision models? Should external agencies (e.g. psychological) be identified as sources of support for this?	Thank you. The decision on how to incorporate this into individual schools lies with the schools themselves depending on how they work and the systems they have in place.

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West Berkshire Council	Guideline	5	21	1.1.12 Will there be a nationally provided training programme or will this be a local model?	Thank you. Training will be delivered at the school / college's discretion.
West Berkshire Council	Guideline	6	2	1.1.14 Agreed this is necessary. Will there be guidance on 'best practice' for schools to follow?	Thank you. Schools / colleges will have the freedom to decide how best to involve parents and carers in designing and implementing the whole-school approach.
West Berkshire Council	Guideline	7	8	1.2.1 Will guidance be produced for schools to include 'intent, implementation and impact' to align with OFSTED's curriculum expectations?	Thank you. NICE has not been asked to produce guidance on this
West Berkshire Council	Guideline	9	6 Box 1	Has the risk and protective factors table that is presented in the DFE's 'Mental Health and Behaviour in Schools' document been considered?	Thank you. The committee decided to remove the example risk factors in Box 1 and instead add a hyperlink to table 1 in the Department for Education's mental health and behaviour in schools document as you suggest. The committee also noted that the risk factors in the referenced table is not exhaustive and that the document was published before the COVID pandemic. This has been added to the relevant rationale and impact section of the guideline.
West Berkshire Council	Guideline	20	6	We are fully behind relational approaches and changes to policy and practice. The question remains as to how the right recommendations that are made here, can support school leaders to make change and be rewarded for this through performance tables and Ofsted inspections. This is	Thank you. NICE has no control over OFSTED inspections or accountability measures.

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				the right thing to do, but the accountability measures around outcomes, make this more challenging than it needs to be for schools.	