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## **Place2Be in the inner city: A school-based mental health service in the United Kingdom**

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*“Life is not about how fast you run, or high you climb, but how well you bounce.....”*  
(Tigger: Winnie the Pooh)

**Place2Be is an exemplar of a school-based mental health service in the United Kingdom. Risk and resilience for mental health and emotional wellbeing are explored and the Place2Be clinical model is described. The model has been tested in engaging “hard to reach” parents, and the rationale for parental engagement is explored and described. The process of collaboration and partnership with schools is described and the importance of tenacity and resilience in the school-based clinician is highlighted.**

**Keywords: School-Based Family Counseling, Place2Be, hard to reach children and parents, multiple risk factors.**

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### **Child mental health in the United Kingdom**

According to a survey conducted in 2004 by the Office of National Statistics, ten per cent of children and young people aged 5 to 16 have a mental disorder that is associated with “considerable distress and substantial interference with personal functions”. The majority of these disorders fell into the categories of emotional, conduct or hyper-kinetic disorder. House and Loewenthal (2009) studied the links between childhood, wellbeing and therapeutic ethos. They examined the UNICEF report (Innocenti Report, 2007), which places Britain's children at the bottom of their league table of children's wellbeing, with data on child poverty ranking the United Kingdom 24th out of the 27 European Union countries in their index of child poverty and

deprivation. The report also draws attention to the low ranking of the United Kingdom on a number of key measures, including the physical and mental health of its children and adolescents, their sense of life satisfaction and wellbeing, their experience of violence and bullying, and their family stability and cohesion. The term “toxic childhood” was coined by Sue Palmer (2007) in response to the survey’s suggestion that children in the UK are the unhappiest and unhealthiest in Europe, with the dramatically increasing use of behavioral control drugs such as Ritalin and Concerta, which are presently prescribed for 450,000 children in the United Kingdom (Green, McGinnity & Meltzer, 2004). Conduct problems or oppositional behavior, which is manifest in the primary school environment, is leading to rising numbers of children being permanently excluded from school, and there is particular concern at the large percentage of Afro-Caribbean boys in this cohort.

This is similar to data reported in the USA. Carlson and Sincavage (1987) conducted a survey of 110 members of the National Association of School Psychologists and reported that family variables were seen as highly relevant to children's school problems. A survey of the student clients of school-based family counselors (SBFCs) in San Francisco (Gerrard, 1990) showed that over 85% of the children referred by teachers, parents, or self-referred had significant problems at home. Crespi and Hughes (2004) described some of the crises affecting adolescents in schools as including alcohol and drug addiction, teenage pregnancy, divorce, abuse, and family discord.

### *Risk factors*

The incidence of such psychological problems in children and their families can be related to the presence of so-called risk factors (Rutter, 1975; Durlak, 1995). A single risk factor can be associated with several different problems for the child. For example, poor academic achievement is a significant risk factor for later school failure, drug misuse and behavioral problems. Rutter (1975) examined six risk factors associated with child psychiatric disorders, including being male, insecure attachment, parental abuse (physical, sexual and emotional), domestic violence or abuse or volatile family dynamics, academic or school failure, and persistent bullying. Outcomes for children exposed to only one risk were similar to those for children exposed to none. Those exposed to two risk factors, however, were four times more likely to have severe emotional or behavioral difficulties, or a clinically diagnosable disorder. Those exposed to four or more risk factors were 20 times more likely to have difficulties. This suggests that risks can have a domino effect, where one problem can lead to the development of a series of other problems. For example, if a child is abused, then he or she is more likely to be removed from its family and become a “looked after child” who is placed in the highest risk category for academic failure, drug misuse and homelessness in adult life (Jackson, Hill & Lavis, 2008). Such risk factors are to some extent culturally determined; for example, maintaining ‘social face’ is more important for Chinese than it is for Europeans (van Schalkwyk, 2010, 2011).

According to a survey conducted in 2004 by the Office of National Statistic there is considerable evidence that risk factors for mental ill-health in primary school-aged children are linked with socio-economic deprivation, vulnerability, and chaotic families. In another survey, 140,000 such families were identified with multiple problems such as substance abuse, unemployment and poor health, which cost society around £12bn a year in health and social services. Children growing up in such families are severely disadvantaged in terms of

educational attainment, life skills and future prospects (Barclay's Wealth and New Philanthropy Capital, 2011).

### *Long term effects*

A child's formative years have a huge impact on its development and long-term prospects, and the above-mentioned risks are more likely to have long-term serious impacts if they comprise ongoing problems within the child's life at home and school, rather than one-off traumatic events. It is estimated that more than one million children in the United Kingdom under the age of 15 have a diagnosable mental health problem. However, a high proportion of these children do not receive a mental health intervention. A recent analysis of a large-scale longitudinal study (Kim-Cohen et al., 2003) indicated that 75 % of those who met criteria for one of 17 mental disorders at age 26 had a disorder diagnosed by the age of 18, and 57 % by the age of 15. A third of those treated for depression at the age of 26 had diagnosable mood symptoms in childhood. According to Barclay's Wealth and New Philanthropy Capital (2011), 80% of crime is committed by adults who had conduct problems as children. In similar vein, families with a mentally ill parent have a damaging effect of the child's school functioning, though little attention is usually paid to this in research on the relationship between a child's school and family functioning (Reupert & Mayberry, 2010).

### *The hard to reach child*

Baruch, Fonagy and Robins (2007) conceptualized a useful new perspective in their focus on reaching "hard to reach" children and young people, whom they associate with social inequality which is rooted in material and social adversity, and they have a startling but relevant metaphor of the "buried child", lying under the rubble of cumulative psychosocial risk:

*"...taking help to the child, rather than expecting the child to seek help is perhaps the single most important lesson that the cumulative nature of risk teaches us."*

(Baruch, Fonagy & Robins, 2007, p.7)

In this paper they delineate the double bind of the "hard to reach" individual and group having a cluster of risk factors for mental health problems or learning disabilities, but also facing a range of barriers to accessing mental health solutions. The constellated disadvantage that children experience in many inner-city areas also threatens to overwhelm their parents' coping mechanisms and capacity as parents and mentors. Stigma and a fear of being judged, blamed or "reported to social services" is deeply threatening to parents in many inner-city communities, and is exacerbated by cultural and class factors, and anxieties in newly arrived migrant or refugee communities (Everts, 2008). To outside agencies, such stresses may show up as resistance to intervention by families (Gerrard, 2008). Many of the children and families in primary and secondary schools are seen as having problems that are too complex, too sedimented and intractable to reach, and the "hard to reach child" is the child with the greatest risks of all. Children's conduct problems need to be understood by the school system in order to tolerate and engage with the child who is "hard to reach".

## **Implications for intervention**

The above findings indicate that appropriate and successful intervention requires countering a wide range of risk factors that have often been present for a long time, and that make a child hard to reach. Resilience factors range from being female, having good communication and problem-solving skills, having a sense of humor, and having a capacity to plan. A UK-based review of research into risk and resilience in children (National Children's Home Report, 2007) identified key factors that promote resilience, including coping and reframing skills in children, the presence of unconditional positive support from parents, strong social networks, and positive school experiences. Such resilience can also be related to effective couple and family functioning (Everts, 2008; Gerrard, 2008). Durlak (1995) cautions that a "one-shot" approach to addressing children's mental health can dissipate over time, that both program persistence and intensity are needed to make a difference to a child's mental health, and that multi-component interventions over a number of years are critical. That echoes the point made earlier by Baruch, Fonagy and Robins (2007) about the double bind created by "hard to reach" individuals who face multiple risk factors as well as barriers to accessing mental health solutions. With reference to students who have been excluded from high school (Smith, 2011), and ones subjected to school violence (Marchetti-Mercer, 2008), both authors similarly emphasize the need for a broad-based, systemic and multi-disciplinary approach.

It is here that School-Based Family Counseling (SBFC) presents a compelling and comprehensive approach to helping children succeed at school and overcome personal and interpersonal problems. According to Gerrard, SBFC "...integrates school counseling and family counseling models within a broad based systems meta-model that is used to conceptualize the child's problems in the context of all his or her interpersonal networks: family, peer group, classroom, school (teacher, principal, other students), and community. When a child is referred to the SBFC professional, the child's problem may involve one or all of these interpersonal networks. However, irrespective of the level of interpersonal network affected, the SBFC professional will relate positively with the child's family in order to reinforce positive change with the child" (Gerrard, 2008). In recent years, a number of writers have described the development of intervention programs in a variety of international contexts that incorporate the basic elements of SBFC, including Carter and Evans in Los Angeles (2008), Minke in Delaware (2010), Morotti in Alaska (2010), and Smith in New Zealand (2012).

### *The school as a context for intervention*

It can be argued that, for children and young people growing up with pernicious and constellated disadvantage, education provides a key critical path to resilience building. The educational system is a universal provision which promotes the development of a sense of achievement, competence and emotional intelligence (Sung, 2012). It provides for socialization into the wider culture and is a safe arena for normative peer-to-peer, as well as adult-to-peer, contact. It can open up new opportunities (Rutter, 1975) and increase the range of available resources to a child (Masten, 1990). School-based mental health which is consistent and accessible to children can target and work to address the real risks to the child in its environment, and find solutions that may address the spiral of failure and disengagement. In the UK, Carr (2006) acknowledges that children are likely to benefit from mental health treatment if they and their families accept that there is a problem, are committed to resolving it, and accept the approach of the therapist or mental health team. He emphasizes the characteristics of the mentally healthy school which has a

favorable impact on behavior and attainment. These include authoritative leadership, good teacher modelling, an understandable curriculum, and the avoidance of stigmatizing troubled children. Sung (2012) emphasizes fostering social intelligence, while Smith (2012) stresses the need for an inclusive ethos towards families and being flexibly responsive to change. Intervening early with behavioral, emotional and conduct problems supports not only the child at risk, but also its classroom peers and the wider community, since there is a strong and enduring link between the adverse effects of an interrupted education and young people who commit offences and enter the criminal justice system (Barclay's Wealth and New Philanthropy Capital, 2011).

*The importance of family and multi-agency intervention.*

But school-focused resources by themselves are not sufficient. The need for SBFC comes from the inadequacy of traditional school counseling and agency-based family counseling models in dealing with children who are failing at school because of family problems. Crespi and Hughes (2004) present an argument for school-based mental health services for adolescents as a way to offset restrictions imposed by managed care in the UK. Stinchfield (2004) describes research that indicates that traditional office-based therapy is not always effective with at-risk families, and advocates family-based therapy that includes involvement of school personnel. Lau (2012) illustrates how this may involve the use of sophisticated forms of intervention, like the use of a multi-family group with youth who had refused to attend school in Hong Kong. Gerrard suggests that school counselors are not equipped to intervene effectively with the families of these students. As he says: "SBFC minimizes this triangulation because the school-based family counselor is not seen as a 'third party' but rather is viewed as part of the school system. The SBFC counselor is an advocate for the child, the family, and the school. The focus of the counseling is on working with parents and families to help their children succeed in school." (Gerrard, 2008).

While speaking from different cultural contexts, Carr (2006) in the UK and Smith (2012) in New Zealand both refer to the importance of multi-agency thinking and strategies; to a positive therapeutic alliance based on warmth, empathy and positive regard for the child; and to a systemic approach wherever possible. They both emphasize a collaborative approach, with an assessment conducted from the vantage point of respectful curiosity and an "invitational" approach to parents and professionals. Both are critical of coercive directiveness, and promote an approach of collaborative consultation that does not seek to find the "true" formulation of the problem with the child or their family, but the most useful formulation of the problem, which fits with the facts of the situation, and which opens up feasible options for problem resolution. This reflects Place2Be's position, described below, within the school system where the approach is to "think complex, talk simple", and to attempt to re-label deficits or problems to optimistic, positive, or problem-free labels and solutions.

Gerrard's literature review describes six main benefits of such SBFC for schools (2008), including improved academic functioning of the students receiving SBFC, lessening of students' emotional and behavioral problems, decreased classroom disruption of other students, improved functioning of the students at home, improved relationships between schools and families with children having school problems, and cost effectiveness. However, Gerrard notes that the SBFC literature is primarily descriptive and process-focused (2008). There is a relative absence of outcome studies, particularly studies comparing SBFC in its various forms with traditional

approaches to school counseling. While the logic of combining school and family counseling interventions is compelling, evidence-based support is sparse. The SBFC literature as it currently exists is primarily US-based and reflects what is primarily an Amero-centric perspective on counseling. Of particular relevance to this article is a recent study by Carter et al. (2011), who conducted a pilot evaluation of the implementation of SBFC in the Los Angeles area. They found that strategies used had considerable impact and generated positive attitudes. They note, however, the need for more systematic use of qualitative and quantitative strategies to assess significant aspects of attendance, behavior and academic achievement.

### **Place2Be rationale and core structure**

Against this background of conceptual frameworks and developing SBFC-related practices, the Place2Be approach provides a distinctive perspective, based in the United Kingdom and focusing on students with serious psychological problems. Developed within the UK's educational and mental health structures, Place2Be is a charity and a voluntary organization that was established in 1994 to improve the emotional wellbeing of children, their families, teachers and the school community. Place2Be works mainly in primary schools, and over the past five years has established a school-based mental health program in 170 primary schools. It has also piloted a successful model of therapeutic support for 7 secondary schools, to address the needs of pupils in years seven and eight (pupils aged eleven to thirteen) with transitional, emotional and psychological difficulties.

The aim of Place2Be's therapeutic service is to provide a professional team comprising a qualified counselor or clinician, and between four and eight volunteer counselors (depending on the size of the model), who may be qualified or in the later stages of their therapeutic training. The counseling takes place in a dedicated Place2Be room in the school, enabling children to explore problems and their life situation through talking, art psychotherapy, play, and creative work to promote self-esteem, emotional resilience and coping strategies that enable the child to cope with stress and distress in its home or school life.

The core elements of Place2Be – and the cornerstones of the organization – are relationship, self-awareness, play and change. The quality of the therapeutic relationship is one of the most accurate predictors of outcomes. A safe and helpful therapeutic relationship depends on a high level of self-awareness from the therapist. Play is the language of the child and a vital part of child development. The therapist needs to be playful, in order to hear properly what the child wants to express. It is a combination of these three elements that affects the fourth: positive change for the child (Wilson, 2004).

The Place2Be model provides early clinical intervention for children with significant risk factors to promote the “ordinary magic” of resilience (Masten, Best & Gourmezy, 1990). Many of the children face constellated disadvantage which can be persistent and misunderstood by schools which experience the challenging behavior of “acting out” children.

There are several distinctive characteristics in Place2Be's menu of interventions:

- It is embedded in the school system and offers a range of therapeutic interventions in a normal setting, thus reducing the possibility of stigma for child and family.

- It has a clear evidence base to assess the impact on children, employing the Goodman Strength and Difficulties Questionnaire (SDQ) and the associated Clinical Outcomes in the Routine Evaluation Outcome Measure for Parents (Goodman, 1997).
- It offers a range of interventions, including universal (Place2Talk) and targeted individual counseling, for 12 to 18 children, based on a service model of two and a half to four days per week.
- The service is systemic and engages a range of stakeholders, from children and parents to school staff, external professionals and agencies.
- Place2Be aims to provide consistent on-going therapeutic support, and has been in schools for an average of 10 years across many areas or “hubs”.
- Place2Be targets those children who present with emotional and behavioral difficulties at school, and who may therefore be at risk of exclusion, or having difficulties in the classroom – they may be disruptive or unable to concentrate, and may be failing to engage with attainment goals or targets.

### **Place2Be program specifics**

Place2Be provides an integrated, responsive and flexible school-based mental health service comprising:

- One-to-one counseling sessions for 50 minutes a week for 12 children, for a time period ranging from one term to one year;
- Group therapy, based on a Kolvin model (Kolvin et al., 1981) for six children with two adult group facilitators, in an eight-week program;
- Place2Talk, a lunchtime self-referral service, which is open to all pupils in a Place2Be school (both individual children and groups);
- Place2Think, a consultation service offered to teachers and school staff that considers a child's behavior and the provision of therapeutic guidance, and offers advice to staff members;
- Place for Parents, a counseling service for parents;
- A referral and assessment service to establish a child's needs, and to refer them to a Place2Be intervention or an appropriate external service.

Based in the school, the school project manager is responsible for a team of four volunteer counselors who provide the one-to-one sessions for children. School project managers undertake the clinical assessment of children referred by school staff, and meet with parents, teachers and the child. The assessment consists of using the Goodman SDQ, administered pre- and post-intervention, in an attempt to define the child's risk factors, resilience and difficulties from the perspectives of the child, the class teacher and the parent. School project managers are responsible for managing this service, ensuring that quantitative and qualitative data are obtained and recorded in an end-of-term report. However, their emotional experience, beliefs and rapport are not recorded or examined in this data, and there is no attention paid to the cumulative effect of holding and containing such a diverse range of needs.

There is also increasing provision in many Place2Be schools for a parent worker who provides short- and long-term therapy to parents. The organization currently has 11 parent counselors working in many primary schools for half a day per week. They support the parents

of children receiving a Place2Be therapeutic intervention, and provide them with short- and long-term counseling and psychotherapy, for a time period ranging from 3 to 12 months.

Place2Be is currently piloting work in Early Years Children's Centres, providing support to parents and children under the age of five, with counseling and play therapy for children. Indeed, the charity was established in response to increasing concern about the extent and depth of emotional and behavioral difficulties experienced by children in schools, and the difficulties in accessing external services and professionals to support the child in the school.

### **Place2Be effectiveness**

Place2Be has always sought to demonstrate the relevance and effectiveness of the school-based mental health service, through evidence-based practice. The following process data has been collected to date. In 2011 / 2012 (Place2Be, 2012- Internal report, unpublished)

- 2,787 children were in a one-to-one therapeutic intervention;
- 11% of these children were subject to a child protection plan;
- 890 children were in a group work intervention;
- 43% of the entire cohort were from a lone-parent family;
- 54% (1,375) were receiving free school meals; and
- 49% of the entire cohort were designated as children with special educational needs.
- 2.5% were looked-after children.

Outcomes are measured using Goodman's SDQ (Goodman, 2001), where teacher, parent and child are requested to complete a widely used screening and assessment questionnaire both before and after clinical intervention. It consists of 25 statement questions which are grouped into five psychological attributes, four of which represent negative aspects of the child's behaviour (the Difficulties Scale). These four sub-scales representing difficulties cover emotional symptoms, conduct problems, hyperactivity, and peer relationships. The fifth scale represents the child's strengths i.e. the child's pro-social and positive behavioral qualities. The pre-intervention scores are compared with the post-intervention scores, to see whether there is any measure of change, and whether the child falls within the normal, borderline or abnormal categories of overall distress or social impairment.

Each Place2Be child's clinical intervention is assessed through the SDQ. In 2009 / 2010, 74% of parents, 71% of children and 65% of teachers reported improvements in children's Total Difficulties scores, following Place2Be's support and clinical intervention; and 84% of parents reported an improvement in children's problems on the SDQ after Place2Be intervention. The following table demonstrates the SDQ-based impact of clinical intervention on Place2Be primary and secondary school children in 2012/2013:

2012/13 academic year	PRIMARY SCHOOLS			SECONDARY SCHOOLS		
	Teacher SDQs	Parent SDQs	Child SDQs	Teacher SDQs	Parent SDQs	Child SDQs
Number of closed cases with data available	1837	1439	1200	62	45	38
% improved - all children (closed cases)	67%	74%	68%	63%	74%	75%
% improved - for children in the abnormal range (closed cases)	80%	84%	88%	79%	82%	75%
% abnormal pre-intervention (closed cases)	48%	49%	33%	60%	55%	35%
% abnormal post-intervention (closed cases)	30%	24%	15%	35%	30%	15%
% improved in classroom learning for those with considerable difficulties pre-intervention	70%	-	-	68%	-	-
% improved in less burden on teacher/class with considerable difficulties pre-intervention	68%	-	-	70%	-	-

The primary outcome is reduced levels of psychological difficulties, as assessed by comparing pre-and post-intervention total difficulties' scores from the SDQs. The results are broadly similar for the three types of respondent and it must be borne in mind that, according to Carr (2006), twenty-five percent of any clinical cohort of children cannot be helped by psychological methods since their primary difficulty resides within the family system rather than within the child.

These results are similar to the findings by Weare and Nind (2011) in a review of fifty-two programs of school-based intervention. Fifty programs had a positive impact and significant effects on individual children, classrooms and schools. The effects noted include a 25% improvement in social and emotional skills, and a 10% decrease in classroom misbehavior, anxiety and depression. These findings suggest that school-based family counseling interventions can have a profound impact on troubled children with significant risk factors.

**Place2Be room and the process of partnership**

Place2Be places time and emphasis on negotiating the partnership with each school. This can take several months, since there is a requirement that the school provide office space for the school project manager and the Place2Be therapy room for the clinical work. Place2Be insists on sole use of a room which becomes the Place2Be therapy room for clinical work. The organization has learned that shared use of the space can undermine the therapeutic rationale for a safe, boundaried, secure and consistent space which can be reparative and holding for children

who are experiencing a volatile or chaotic home environment. It is important to be open and transparent with schools about the process of school-based counseling, and it is necessary to engage the whole school community. Place2Be does not assume that all school staff are naturally receptive, respectful and understanding of school-based counseling, and it is important to negotiate the intricacies of partnership, mutual expectations and needs. The ultimate aim is to become part of the school fabric and the school community, and yet remain “meta” to the school system and retain independence. Some teachers may dismiss counseling, seeing it as “treats for naughty children”, and it can take time to show them the complementary possibilities of therapy and benefits to the child, parent and teacher.

### **Reaching “Hard to Reach” Parents**

Place2Be’s flexible, systemic model can reach “hard to reach” parents who may be wary or suspicious of counseling or “professional intrusion.” Parents can have legitimate reasons for avoiding engagement with the therapeutic service. They may be fearful of authority, or of being “blamed” for their child’s difficulties or needs. They may also be wary of the stigma of accepting therapeutic help and may wish to conceal their own mental health problems, substance misuse, or domestic abuse and violence. They may be anxious that counseling could lead to their child being monitored or removed from them by social care, or that the barrier of shame about their illiteracy or their “family business” is exposed. Many parents who are “newly arrived” and seeking asylum may have learned to be cautious or suspicious of authority figures and thus avoid Place2Be. Ethically we must have written consent for the clinical work, and it is far more effective to engage with parents as part of the assessment and the systemic and collaborative approach. Thus Place2Be clinicians make strenuous efforts to engage with anxious or avoidant parents. This can be achieved with “quiet tenacity” and careful use of language to describe the counseling work. “Problem-free” talk is utilized, with avoidance of terms or jargon which may alienate parents. “Help for your child” using play and art therapy is described, and parents are often approached in the playground at “drop off” time. There is a no-blame approach to missed appointments and our latest internal research found that on average in inner city schools there were four missed appointments with parents until engagement on the fifth appointment.

Place2Be’s approach to understanding children’s emotional and psychological needs, and engaging with parents is to “think complex, talk simple,” since engagement with parents and teachers is critical to support the therapeutic goals of the counseling intervention. Ambivalence, anxiety and numerous missed appointments are expected and are, indeed, part of the everyday experience of Place2Be school project managers in the inner-city. The primary author was tempted to title this final project “The Therapist in the Rain”, because the quiet and determined capacity to understand, respect and work with the “hard to reach” parent is crucial in achieving consent for therapeutic work in Place2Be schools. For most school project managers waiting in the rain on a wet morning, in order to attempt to engage a parent who has already “missed” five appointments and is avoiding you, is a testament to the resilience and understanding of some extraordinary individuals.

It is simply not possible to be a therapeutic “mole” in a warm and dry therapy room, and wait for the parent to arrive, and engage with the written consent and the Goodman SDQ. In all the interviews with school project managers and the ten members of the co-operative inquiry group, over four years, the primary author does not recall a single complaint about this necessity

to be determined and resilient as a school-based mental health professional. Further to this, the possibility of “professional injury”, when teachers are avoidant or dismissive of therapy, is a normal experience for the school counselor, until she or he is “accepted” and valued as a part of the school team, which can take a minimum of one or two years.

Such tough pragmatism is also revealed in the understanding and practice of looking “ordinary” and “speaking in an ordinary way” about children's mental health to parents, teachers and children. Our research study has revealed that newly arrived members of different cultures are often suspicious of external professionals, and of their capacity to be professional, yet accessible and “acceptable” to parents and the local community.

Our experience echoes the wider literature that reveals important ethical issues around the level of training needed to do SBFC, including Place2Be work. Family counseling is a type of group counseling and can be a challenge for counselors who are introverts or who have been trained only in individual counseling. There is a need for SBFC academic programs that are integrated; that is, programs that are not just a splicing together of family therapy and school counseling/school psychology/school social work/special education programs; but have a genuinely eco-systemic view of the family-school system, as well as the child's peer and community subsystems. That is as true in the UK as it is in the USA.

## **Conclusion**

This paper has suggested that embedded SBFC in the form of Place2Be can ameliorate mental health problems. For most children and young people, the constellated disadvantage of poverty and poor housing, insecure attachments and adult relationship dynamics mean that they will not simply “grow out of it”. Rather, mental and emotional difficulties in primary school mark the early stages of difficulties that continue well into adult life. Three quarters of adults with mental health disorders had one in childhood, and research suggests that disorders with an onset in childhood have much more serious adult consequences, than later onset conditions. Although “ordinary magic” may be experienced in the dedicated Place2Be therapy room, it is also in being an integrated part of the school system and a key player in the “team around the child”. The Place2Be program reflects core principles of SBFC, and may help to illustrate how the application of such principles is best applied in different cultural contexts.

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