The New Walk School
Combined Therapeutic Policy and Therapeutic Offer

PACE-informed whole-school practice with integrated clinical provision

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Applies to	All pupils, staff, leaders, trustees, families and commissioned clinical professionals working with The New Walk School

Core statement: PACE informs everyone's approach at The New Walk School. The therapeutic offer is not only a clinical intervention pathway; it is a whole-setting relational culture in which every adult supports safety, connection, regulation, learning and repair.

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1. Introduction and purpose

This policy sets out The New Walk School's combined therapeutic approach, clinical provision and educational offer. It brings together the whole-school PACE Therapeutic Approach Policy and the detailed Clinical Educational Offer into one integrated therapeutic policy and offer.

The document explains how therapeutic practice is embedded in the daily life of the school; how pupils access clinical and therapeutic support; how clinical decisions are made; how progress is reviewed; and how staff, families and external professionals work together to support pupils' emotional regulation, relationships, safety and engagement in learning.

The policy applies to every adult in the school community. PACE is not a separate programme delivered by a small number of staff. It is the shared relational framework that informs classrooms, corridors, transitions, therapeutic intervention, behaviour support, safeguarding conversations, family work and professional collaboration.

2. School context and pupils' needs

The New Walk School provides specialist education for pupils aged 8 to 16 with Social, Emotional and Mental Health (SEMH) needs, autism spectrum conditions, learning difficulties and communication difficulties. The majority of pupils hold an Education, Health and Care Plan (EHCP) and have experienced disrupted or unsuccessful previous educational placements.

Many pupils present with co-occurring needs including ADHD, dyslexia, dyspraxia, sensory processing differences, attachment difficulties, high anxiety, adverse childhood experiences and trauma histories. Some pupils have learning disabilities, communication needs and neurodevelopmental differences that affect how they experience relationships, school routines, transitions and learning tasks.

For many pupils, traditional educational approaches have not been successful. Pupils may arrive with reduced self-esteem, distrust of adults, fear of failure and a fragile sense of emotional safety. Before sustained learning can take place, pupils need to feel regulated, accepted, connected and understood. The combined therapeutic offer is designed to make this possible.

3. Core principles of the combined therapeutic offer

- PACE informs everyone's approach. Every adult is part of the therapeutic environment, including teaching, support, administrative, premises, lunchtime, leadership and clinical staff.
- Therapeutic practice is relational before it is procedural. Staff connect before they correct, regulate before they reason, and repair before they reflect.
- Behaviour is understood as communication. Staff and clinicians ask what the behaviour may be telling us about need, threat, anxiety, communication, sensory load, trauma response or unmet support needs.
- The school is trauma-informed, attachment-aware and developmentally informed. Expectations remain clear, but they are applied with warmth, attunement and individualisation.
- Clinical provision is integrated with education. Clinical thinking informs routines, staff consultation, formulation, intervention planning, risk understanding and multi-agency work.
- Support is graduated and needs-led. Pupils may receive universal, targeted, specialist or crisis consultation support according to presentation, formulation, risk and engagement.
- Clinical decisions are governed by professional judgement, safeguarding duties, clinical formulation, supervision and pupil engagement.
- Therapeutic work is confidential within safeguarding limits. Information is shared proportionately and appropriately to keep pupils safe and to support consistent practice.

4. The PACE model as the whole-school practice framework

PACE was developed by clinical psychologist Dr Dan Hughes as a way of being with children who have experienced developmental trauma, attachment disruption or neurodevelopmental differences. At The New Walk School, PACE is not treated as a programme or a time-limited intervention. It is the adult stance that underpins every interaction.

PACE element	Meaning	How it is seen at The New Walk School
Playfulness	A warm, lightness of touch that communicates safety and reduces threat.	Warm greetings, shared humour that never shames, creative and hands-on learning, soft starts, and staff modelling that mistakes are part of learning.
Acceptance	Unconditional acceptance of the pupil's inner experience, while maintaining clear boundaries around unsafe or harmful behaviour.	Staff do not shame, ridicule or dismiss feelings. Pupils are supported back to regulation before repair and reflection. Staff distinguish between accepting the child and shaping the behaviour.
Curiosity	A stance of wondering about what is happening for the pupil without judgement or interrogation.	Staff use 'I notice' and 'I wonder' language, treat behaviour as communication, gather information through profiles and formulation, and avoid rushing to fix before understanding.
Empathy	The adult communicates that the pupil is not alone with difficult feelings and remains emotionally present.	Staff regulate themselves first, name feelings with warmth, do not minimise distress, and lead repair after rupture.

PACE does not remove boundaries. It changes how boundaries are held. Staff maintain consistent expectations and safety limits while using an attuned, relational approach that helps the pupil experience the adult as safe, predictable and on their side.

5. PACE in everyday school practice

5.1 The school day

Every part of the school day is designed to support regulation and connection. PACE-informed practice is visible before, during and after formal lessons.

Time of day	PACE-informed practice
Arrival	Meet-and-greet at the door; check-in conversation; soft start activities to settle the nervous system before academic demand.
Lessons	Predictable routines; visual timetables; clear expectations; sensory-aware environments; scaffolded tasks; co-regulation built into transitions.
Breaks	Adult-supervised, low-arousal options; structured social activities for pupils who find unstructured time difficult.
Lunch	Relationship-based support; staff model and support conversation, social expectations and regulation.
Reflection	End-of-day reflection using PACE-informed conversations about what went well, what felt difficult and what support was needed.
Departure	Calm, regulated exit; bridging conversation that helps the pupil leave safely and return the next day.

5.2 Responding to dysregulation

When a pupil becomes dysregulated, staff respond through a PACE-informed sequence. The sequence is relational rather than punitive and is adapted to the pupil's age, communication style, sensory profile and individual plan.

- Connect before correct: restore relational safety before reintroducing expectations, demands or consequences.
- Co-regulate: the adult uses calm tone, body language and pacing to support regulation.
- Stay curious: staff wonder what may be happening for the pupil without interrogation.
- Hold boundaries safely: staff make safety limits clear while keeping the relationship intact.
- Repair: once the pupil is regulated, the adult initiates repair, acknowledges rupture and reaffirms the relationship.

- Reflect: when the pupil is ready, adult and pupil consider what happened, what helped and what may need to be different next time.

5.3 Integration with behaviour support, curriculum and SEND

PACE is the foundation of behaviour support. The New Walk School does not use shaming or relationally rejecting responses. The school does use clear expectations, restorative conversations, natural consequences, individualised support plans and risk-informed strategies.

The curriculum is delivered through a PACE lens. Teachers plan for emotional access as well as academic access. Lessons use scaffolded tasks, regulation opportunities, sensory-aware adjustments, predictable routines and meaningful success experiences. Mistakes are normalised as part of learning.

Therapeutic planning is integrated with SEND provision. Pupil profiles, EHCP outcomes, regulation plans, communication strategies, risk assessments and clinical recommendations should align so that pupils experience a consistent approach across the school day.

6. The combined therapeutic offer: universal, targeted, specialist and crisis support

The therapeutic offer operates through a graduated, tiered model. Pupils may move between levels as need, risk, readiness and engagement change. PACE informs all levels of support.

Tier	Purpose	Examples of provision	Lead responsibility
Tier 1 - Universal	Whole-school relational and trauma-informed practice for all pupils.	PACE-informed routines; wellbeing and PSHE curriculum; predictable classrooms; sensory-aware practice; warm communication with families; staff induction; reflective practice; therapeutic language used by all adults.	Headteacher, Therapeutic Lead, SENCo and all staff.
Tier 2 - Targeted	Additional support for pupils whose needs require planned strategies beyond universal provision.	Small-group work; targeted regulation support; social skills and psychoeducation; classroom strategies; individual regulation plans; therapeutic mentor input; staff consultation and coaching.	Therapeutic Lead, SENCo, Clinical Team, teaching staff and therapeutic mentors.
Tier 3 - Specialist	Direct or indirect specialist clinical input where formulation indicates therapeutic intervention is required.	0-6 week assessment; clinical formulation; time-limited individual therapy; group therapy; counselling; psychotherapy; attachment-based and trauma-informed work; specialist risk/safety planning; EHCP and review input.	Clinical Team, Clinical Lead and relevant professionals.
Tier 4 - Crisis and consultation	Rapid clinical thinking and stabilisation after significant incidents or increased risk.	Crisis consultation; formulation-led debrief; risk/safety planning; stabilisation plan; multi-agency planning; step-down support; safeguarding liaison where required.	Clinical Lead, DSL, Headteacher, Therapeutic Lead and relevant external agencies.

Support can be direct, such as individual or group therapy, or indirect, such as staff consultation, modelling, coaching, formulation-led strategies and adjustments to the environment. Where a pupil is not ready or able to engage in direct therapy, indirect therapeutic support remains a valid and purposeful intervention.

7. Clinical pathway: access, assessment, formulation and review

Pupils access clinical support through a clear pathway. The pathway supports consistent assessment, planning, intervention and review. Each stage is recorded in the pupil's clinical file and reviewed in line with need, risk and presentation.

Stage	What happens	Expected output
1. Referral	A concern or need is identified by school staff, the SENCo, Therapeutic Lead, family, carer, external professional or through review of EHCP, risk or presentation.	Referral information and initial reason for clinical consideration.
2. Triage and allocation	The Clinical Team reviews need, risk, urgency, suitability for direct or indirect support, and available capacity.	Decision on priority, allocation and next step.
3. 0-6 week assessment	Clinical assessment may include records review, observation, staff/family consultation, direct therapeutic assessment and review of risk and engagement.	Assessment summary and emerging formulation.
4. Clinical formulation	The Clinical Team considers strengths, needs, maintaining factors, trauma and attachment context, communication, sensory needs, relationships and risk.	Formulation that informs strategy and intervention.

Stage	What happens	Expected output
5. Intervention plan	The plan identifies the intervention type, aims, practical strategies, roles, review arrangements and information-sharing requirements.	Written or recorded intervention plan.
6. Intervention delivery	Support is delivered directly or indirectly, according to formulation and clinical judgement.	Therapeutic sessions, consultation, staff coaching, strategies or multi-agency work.
7. Review	Progress is reviewed using observation, pupil engagement, staff and carer feedback, risk information and outcome measures.	Decision about impact and ongoing need.
8. Outcome decision	The Clinical Team decides whether the intervention should continue, adapt, step down or end.	Clear next steps shared with relevant staff within confidentiality and safeguarding limits.

8. Child-focused meetings, consultation and information sharing

Clinical discussions focus on the pupil's strengths, presentation, risk, formulation, intervention needs and practical strategies for school life. Consultation is designed to help adults understand the pupil and respond consistently.

The Clinical Team consults teaching staff, the SENCo, therapeutic mentors, carers, families and external professionals where their input is relevant to assessment or planning. Staff observations are considered as part of formulation and review.

Relevant strategies are shared through agreed school systems so that pupils receive a consistent approach. Clinical allocation, intervention planning and therapeutic decisions remain the responsibility of the Clinical Team. Information is shared on a need-to-know basis and in line with confidentiality, safeguarding and data protection requirements.

9. Assessment, formulation, risk understanding and planning

A 0-6 week assessment is completed for pupils requiring clinical input. The assessment is proportionate to need, risk and presentation and may include:

- review of EHCPs, previous assessments, CAMHS information and relevant school records;
- direct observation in the school environment;
- consultation with teaching staff, the SENCo, carers and families where appropriate;
- direct therapeutic assessment where clinically suitable;
- review of safeguarding information, risk, presentation and engagement.

The assessment leads to a clinical formulation and intervention plan. The plan identifies the pupil's needs, likely maintaining factors, recommended strategies, intervention type and review arrangements.

Key findings and strategies are shared with the SENCo and relevant staff to support consistency. Clinical records remain within the pupil's clinical file and are shared in line with confidentiality and safeguarding requirements.

The Clinical Team contributes to risk understanding through formulation, therapeutic input and therapy risk assessment. School risk assessments remain a school safeguarding and operational responsibility, informed by clinical input where appropriate.

10. Timetabling, clinical allocation and intervention delivery

Clinical sessions are timetabled according to pupil need, clinical priority, availability, risk and the likely impact on learning. The team aims to minimise unnecessary disruption to core learning while recognising that therapeutic input may need to take place during the school day.

Therapists are allocated according to formulation, therapeutic fit, pupil engagement, clinician role and clinical capacity. Higher-risk cases remain under Clinical Lead oversight and are reviewed through supervision and case discussion.

Timetabling and allocation are led by the Clinical Team. Staff consultation informs planning, but clinical decisions are made through clinical judgement and governance.

11. Individual and group therapy

Pupils may access individual or group therapy when this is identified as a relevant intervention. Interventions may include counselling, psychotherapy, psychoeducation, attachment-based work, trauma-informed support and regulation-focused work.

Therapy is introduced in a child-centred and developmentally appropriate way. Initial intervention blocks are reviewed to ensure the work remains relevant, safe and purposeful.

Where a pupil is not ready or able to engage in direct therapy, support may be delivered indirectly through staff consultation, modelling, coaching, therapeutic mentoring, formulation-led strategies and environmental adjustments.

12. Supporting pupils with additional needs

The Clinical Team adapts therapeutic support for pupils with learning disabilities, communication needs, neurodevelopmental differences and complex trauma. The approach remains relational, developmentally appropriate and accessible.

Assessment considers how additional needs affect communication, regulation, behaviour, relationships and access to learning. Strategies may include psychoeducation, social skills work, regulation support, impulse-management strategies, communication adjustments and staff consultation.

Specialist learning disability, speech and language therapy, occupational therapy and educational psychology input is used or commissioned where required and where this forms part of the pupil's identified need or plan.

13. Roles and responsibilities

Role	Responsibilities
Headteacher	Holds overall responsibility for the therapeutic ethos; ensures PACE is embedded in school systems; champions reflective practice; ensures recruitment, induction, staffing and quality assurance reflect the therapeutic approach.
Therapeutic Lead / Senior Mental Health Lead	Leads the therapeutic offer day to day; coordinates with clinical professionals; supports implementation of clinical recommendations; delivers or commissions PACE training and reflective practice; reviews provision against EHCP outcomes.
Clinical Lead and Clinical Team	Provide clinical oversight, assessment, formulation, intervention planning, supervision, case discussion, direct and indirect therapeutic support, risk understanding and clinical reporting where required.
SENCo	Ensures therapeutic and clinical strategies align with EHCP outcomes, pupil profiles, SEND provision, reviews and reasonable adjustments.
Designated Safeguarding Lead	Ensures safeguarding concerns are responded to and recorded appropriately; works with the Clinical Team where clinical information informs risk or safety planning.
Teaching staff	Apply PACE in every interaction; plan lessons with emotional, sensory and academic access in mind; contribute to pupil profiles, regulation plans, risk assessments and therapeutic strategies; engage in reflective practice.
Support and operational staff	Use PACE-informed communication and routines; support regulation during transitions, lunch, break, arrival and departure; understand that every adult contributes to the therapeutic environment.
Families and carers	Share relevant information, participate in review and planning where appropriate, and are supported through warm, curious and non-deficit-focused communication.

14. Staff training, supervision and reflective practice

PACE practice cannot be sustained without ongoing development and emotional containment for staff. Staff training supports a shared trauma-informed and PACE-informed approach across the school. Training includes theory, practical application, pupil-based examples, scenarios and reflection on current practice.

- Induction training in PACE, attachment, trauma-informed practice and the school's behaviour ethos for all new staff before they begin pupil-facing work.
- Annual refresher training for all staff, including operational and administrative colleagues.
- Reflective practice groups facilitated by an external clinician or appropriate senior practitioner, providing a space to think about pupils' inner worlds and the impact of the work on staff.

- Individual supervision or consultation where needed, particularly for staff working closely with pupils with complex needs or higher levels of risk.
- Specialist training in developmental trauma, attachment, autism, sensory processing, de-escalation and physical intervention where appropriate and authorised.

A regular staff reflection slot is scheduled on Monday afternoons from 2.00pm to 3.00pm where clinically and operationally appropriate. Reflective practice helps staff understand pupil behaviour, review what is working, identify what could be improved and agree consistent strategies.

15. Working with families and external professionals

PACE extends beyond the school gate. Families and carers are engaged through warm, curious and non-deficit-focused communication. Review meetings should explore strengths, need, formulation, progress and practical support rather than simply reporting incidents.

- regular communication that notices and celebrates small gains;
- PACE-informed parent and carer workshops or guidance where helpful;
- consultation with families and carers as part of assessment and review where appropriate;
- liaison with CAMHS, social care, virtual schools, educational psychology, speech and language therapy, occupational therapy and other external professionals where required;
- clinical input into EHCP, PEP and professional review processes where clinical involvement is required.

16. Confidentiality, safeguarding, records and governance

16.1 Confidentiality and safeguarding

Therapeutic work is confidential within safeguarding limits. Pupils are supported to express themselves safely, while staff remain clear that information must be shared where there is a risk of harm to the pupil or others.

Safeguarding concerns are shared with the Designated Safeguarding Lead and recorded on CPOMS in line with school procedures. Clinical staff complete annual Keeping Children Safe in Education training and work within the school's safeguarding policy.

Therapists follow the ethical frameworks of their professional bodies, including BACP and BPS where applicable. Information-sharing decisions take account of consent, safeguarding, risk, professional duties and the need for staff to implement consistent support safely.

16.2 Records and clinical governance

Clinical practice is governed through professional registration, ethical frameworks, supervision, safeguarding procedures and internal clinical oversight. Clinical records are maintained in the pupil's clinical file and are shared only as appropriate and proportionate.

Clinical staff are registered with, or work under supervision aligned to, relevant professional bodies such as BACP and BPS. All clinicians receive appropriate clinical supervision from senior therapists, clinical leads or externally commissioned specialists.

The Clinical Team reviews practice through case discussion, supervision, formulation review, outcome data and safeguarding oversight. This ensures therapeutic input remains safe, purposeful and responsive to pupil need.

17. Outcome measures, monitoring and evaluation

Progress is reviewed through observation, staff and carer feedback, direct therapeutic work, risk information and outcome measures. Baseline information is gathered during assessment and updated through ongoing review.

BERRI is used to track changes in behaviour, emotional wellbeing, risk, relationships and indicators of progress. SDQ may also be used where appropriate. Formal clinical review usually takes place every six months, or sooner when clinically indicated.

Clinical summaries are provided for EHCP, PEP and professional reviews where clinical input is required. Review dates should be shared with the Clinical Team in good time so that reports can be prepared and attendance can be planned where appropriate.

The Headteacher, Therapeutic Lead and Clinical Lead monitor implementation of this policy through learning walks focused on relational practice, pupil voice, family feedback, staff feedback, behaviour data, attendance, exclusions, progress against EHCP outcomes, supervision feedback, clinical review data and safeguarding oversight.

This policy is reviewed annually, or sooner if significant changes to practice, staffing, governance, statutory expectations or clinical evidence require it.

18. Clinical team

The team includes a Clinical Director, Clinical Lead, Deputy Clinical Lead / Senior Therapist, Assistant Psychologist, Clinical Assistants, counsellors and psychotherapists. Assistant Psychologists and Clinical Assistants receive appropriate clinical supervision. The team can also source specialist therapies such as speech and language therapy and occupational therapy when needed.

Role / named clinician	Current clinical offer detail
Clinical Director: Dr Anupam Gupta	Provides senior psychiatric and clinical oversight. Supports risk assessment, management planning, psychiatric history review and MDT care planning for young people.
Clinical Lead: Dr Aen-ul-Huda Faisal	Has a PhD in Psychology and is a Registered Member of BACP. Has extensive experience with children with neurodevelopmental needs, special schools, residential settings and Dyadic Developmental Practice.
Deputy Clinical Lead / Senior Therapist: Chirayu Goyal	Holds a master's degree in Counselling Psychology and is a Registered Member of BACP. Has experience with children, adolescents, families and residential children's homes, and is a certified DBT group facilitator.
Clinical Assistant: Eleanor	Holds a BSc (Hons) in Psychology accredited by the British Psychological Society. Has experience supporting young people with learning disabilities and complex trauma using PACE-informed practice.
Assistant Psychologist: Lisa	Holds a BA and MSc in Psychology accredited by the British Psychological Society. Has experience in community care, safeguarding and trauma-informed work with children and adults.
Clinical Assistant: Esha	Holds a BSc (Hons) in Psychology, Clinical Psychology and Mental Health accredited by the British Psychological Society. Supports pupils with anxiety, SEMH needs and complex presentations through a reflective, person-centred approach.

19. Related policies and references

19.1 Related policies

- Vision and Aims
- Behaviour Policy
- SEND Policy
- Curriculum Policy
- Safeguarding and Child Protection Policy
- Anti-Bullying Policy
- Staff Code of Conduct
- Data Protection and Record Keeping policies

19.2 References and practice sources

- Hughes, D. (2018). Building the Bonds of Attachment. Rowman & Littlefield.
- Hughes, D. and Baylin, J. (2012). Brain-Based Parenting. W.W. Norton.
- Bomber, L. M. (2007). Inside I'm Hurting. Worth Publishing.
- Department for Education. Mental health and behaviour in schools.
- Department for Education. Keeping Children Safe in Education.
- Department for Education and Department of Health. Special educational needs and disability code of practice: 0 to 25 years.

Appendix 1. PACE-informed response sequence

This appendix gives staff a practical sequence for responding to distress or dysregulation while maintaining safety and relational connection.

Step	Adult task	Example staff language
1. Notice	Observe signs of dysregulation, threat, sensory overload, withdrawal or escalation.	I notice this is feeling difficult right now.
2. Regulate self	Slow down, lower voice, reduce demands and adopt a calm stance.	I'm going to slow this down so we can work it out together.
3. Connect	Communicate safety and belonging before problem-solving.	I'm here. You're not in trouble for having a hard feeling.
4. Be curious	Wonder about what may be happening without blame or interrogation.	I wonder whether that felt unfair, or maybe it came too quickly.
5. Hold the boundary	Keep the safety limit clear and kind.	I cannot let anyone get hurt. I will help you move to a safer space.
6. Repair	Lead repair once regulation has returned.	That was hard. I still care about you, and we can repair this.
7. Reflect	Agree what helped and what needs to happen next time.	What helped your body calm down? What shall we try next time?

Appendix 2. Clinical pathway summary

The pathway below should be used as a working summary. Clinical judgement, safeguarding, pupil need and presentation determine how the pathway is applied in practice.

1. Referral received and recorded.
2. Clinical Team triages need, risk and suitability for direct or indirect support.
3. Pupil is allocated for assessment, consultation or immediate advice depending on urgency.
4. 0-6 week assessment is completed where clinical input is required.
5. Clinical formulation is developed and reviewed through supervision/case discussion.
6. Intervention plan is agreed and relevant strategies are shared with staff as appropriate.
7. Intervention is delivered directly or indirectly.
8. Progress is reviewed using observation, feedback, risk information and outcome measures.
9. Clinical Team decides whether to continue, adapt, step down or end the intervention.