Effective Joint Working between Child and Adolescent Mental Health Services (CAMHS) and Schools

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Mental Health Foundation



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Executive Summary

Effective Joint Working between Child and Adolescent Mental Health Services (CAMHS) and Schools.

This report sets out the findings of research conducted by the Mental Health Foundation commissioned by Department of Education and Skills to explore joint working between schools and CAMHS in England and identify ways in which this might be improved.

Background and aims of the research

The aim of the research is to help practitioners from both the health care services and education services working with children. It will also be of interest to a range of policy makers involved in providing services to children.

Research has shown an increasing prevalence of mental health problems in children. The provision of services for these young people has likewise received considerable interest. Research by the Mental Health Foundation and others indicate that services, especially CAMHS, are historically determined and fragmented and in many areas lacking in key personnel. It is increasingly recognised that to improve the ability of child and adolescent mental health services to provide effective care to children and young people, it is necessary to strengthen the support CAMHS provide to other services, such as schools. This requires multi-disciplinary teams and inter-agency working.

The research sought to:

- Identify models of joint practice between CAMHS and schools in relation to promotional work and early interventions for children experiencing mental health problems in school settings in England.
- Identify the theoretical, historical, contextual and other factors that have influenced these models.
- Explore the impact of local, social, cultural and economic factors on practice, and the impact of local and national policy.
- Identify which factors contribute, and which create barriers, towards effective practice of joint CAMHS and schools work.
- Explore effective practice issues within different models.

Methodology

The research used a combination of methods to seek to cover the breadth of concerns.

• A literature review was conducted to identify models and learn from practice developed elsewhere.

- A survey of existing practice using a semi-structured questionnaire to all CAMHS in England to scope the range and extent of practice. In total, 171 questionnaires were returned representing a 55% response rate.
- Four case studies were drawn from the questionnaires to look at interesting practice and a range of experience. These involved 59 semi-structured interviews with a range of staff from CAMHS, Education and Social Services.

Key Findings

- CAMHS structures are very different across the country; they cover different sizes of geographical area, and may be based in clinical or community settings.
- The majority of CAMHS who responded to the survey did work with schools (89%); 81% with secondary schools, 76% with primary, 72% percent with special schools for children with emotional and behavioural disabilities and 52% in special schools for learning disabilities. 40% were also working in early years settings.
- There was a wide variety of practice and structures in the way the CAMHS worked with schools. The most common form of work was **consultation and support to school staff**, often on a case by case basis with children referred to their service. They also provided consultation on behaviour, training and supervision to school staff, and contributed to health promotion activities. 70% of CAMHS provided **direct work with children**, included individual and group work in schools, assessment and observation. Many **worked with parents** in school settings, especially with early years and primary age children.
- Just over half the CAMHS who responded worked with Local Education Authorities. This included work with the educational psychology service, education welfare service and behaviour support services. The most intensive work was a joint integrated service, and secondments of staff between health and education.
- Clinical Psychologist, Community Psychiatric Nurses and Social Workers were conducting the majority of the work form the CAMHS teams in schools.
- This work in schools represented a relatively small proportion of the CAMHS resources. The majority were using core funding.

Issues in joint working

Models, structure and management

• All of the CAMHS in the case studies were based on a tiered structure. This reflects a commitment to inter-agency working and supporting Tier 1 services. The majority of the case study CAMHS teams were working closely with LEA support services to schools, and either running joint services or seconding staff.

- Factors that facilitated joint working were:
 - secondments between organisations;
 - being based in the same location;
 - flexibility of recruitment so that people moved between posts across organisations;
 - having a clear understanding of the different roles and expertise of members of staff;
 - having a clear rationale for working jointly which is shared with the team;
 - a commitment to joint working from all levels of the service;
 - joint working;
 - informal meetings, networking and team building.
- Key issues were **managing expectations** of the service, and being clear about referral criteria for schools, so that the service did not get overwhelmed with inappropriate referrals.
- Many of the projects outlined were receiving short-term funding and support from initiatives such as Health Action Zones, Education Action Zones, and Healthy School Standards. Some areas expressed concern about the long term funding for the work. Having pooled budgets across the services was felt to be very useful.
- **Different organisational and professional cultures** represent a challenge to joint working. This impacts on the relationship with children, the approaches to work and understanding of mental health issues, attitudes towards children's behaviour, information sharing and confidentiality, management and accessing services. The majority of these problems were being resolved by close joint working, good communication, and sharing policies.
- The skills of workers and good communication were key, including the ability to work flexibly, and creatively, being able to pool professional skills, confidence in their own skills and being approachable. The importance of knowing individuals was also stressed, which has implications for longer term funding and staff retention.
- Other key issues were the ways of **sharing information on cases**; **confidentiality** issues were raised and different approaches to sharing information. **Spending time in school** by CAMHS staff was important as it increased acceptance and knowledge both of health and school staff. However, it was important for health staff to remain part of the clinical team and receive supervision.
- National policies that facilitated the joint working were the HAS policy 'Together we Stand', Quality Protects, Social Inclusion Agenda and the Children's Fund Grant Process. There were a range of initiatives that had been instrumental in facilitating and funding the work including Education Action Zones, Health Action Zones, Healthy Schools Initiative and On Track. Some policies constrained joint working, however, and some criticism was made of education policies putting pressure on children within schools.

Impact, Advantages and Disadvantages

Impact on children

Overall many respondents, especially school staff, acknowledged that joint working had resulted in an increase in children's **happiness and well-being**. There was a measurable improvement in **children's behaviour** in two of the services, and better peer relationships were identified by workers. Although rarely measured, workers identified links to improved **academic attainment**, as children were able to learn and were developing learning skills. Education staff identified impacts on **exclusion** of children as their behaviour changed, or that they were allowed thinking space before being excluded. This was not being measured formally by the interventions. Some examples of work with school phobics showed improvements in school **attendance**.

Impact on staff

Working more closely **increased awareness and learning between health and education staff**. Education staff felt they had increased access to mental health services and a greater understanding of the services available. Health staff reported having a greater understanding of the school context and the impact it may have on children's mental health, staff, and educational resources.

Impact on service delivery

CAMHS staff felt that they were accessing children who would not normally be reached and identifying children's problems early. The services were felt by staff to be more accessible to parents and children as they were physically easier to get to, less stigmatising and within children's own environment.

CAMHS workers identified that they received more appropriate referrals. Some workers felt that services were improved as they could allocate more appropriately within teams and avoided duplication of work.

Disadvantages were seen to be that this way of working was more time consuming, the potential danger of duplicating work if it is not co-ordinated effectively, management problems, issues over information sharing and getting swamped with referrals. Also, practitioners working with schools felt pressured by high levels of expectation of the service.

Recommendations

National policy level

- To ensure that greater emphasis is given at national level and across Government Departments, to the provision of preventive and early intervention mental health services for children and their families within school based and other community settings.
- Within this, to ensure that the Children's National Service Framework, and particularly the CAMHS component of this, contains clear targets for the

development of multi-agency early intervention supports for children and their families within schools.

• To ensure that schools are given clear advice, guidance and support to promote children's mental health within school settings from both health and educational psychology services.

Training

- For joint training to be developed with CAMHS/Educational Psychologists and education specialists, and delivered on promoting children's mental health and effective early intervention work, within schools and community based settings.
- For there to be year career paths developed to enable all staff in schools to gain skills and confidence in promoting children's mental and effective early intervention work for those children most at risk of developing mental health problems. This needs to be developed in consultation and collaboration with the educational psychology service and local education authority.

Local strategic action for LEAs

- As part of the local CAMHS strategy, local education authorities should outline the strategy for work between CAMHS and education (including schools). This should include a specific statement of the objectives to be met and the roles of particular staff and organisations. In preparing this, Local Education Authorities should consider:
 - a) hosting Tier 2 CAMHS staff in relevant LEA teams such as behaviour support teams;
 - b) setting up joint budgets for this service across education and health;
 - c) listening to the perspectives of users including parents and young people;.
 - d) building on links with social services;
 - e) agreeing a joint strategy on confidentiality and convey this to parents and children.
- The plan should be reviewed every year.

Management at local level

- Local Education Authorities, school governors, head teachers and CAMHS staff to recognise that this joint working is a formal part of the job description for some staff.
- In recruiting Tier 2 CAMHS staff and teaching assistants, account to be taken of the competencies required to achieve effective joint working.

- Consider establishing secondments from one organisation to another.
- Allow time for building up an understanding of the different cultures of the education and health sectors.
- Try to ensure that CAMHS staff spend time working from a school location and or within LEA offices.
- For new relationships, a systematic and transparent approach to building mutual respect and understanding should be adopted and the induction of new staff should take this into account.
- Longer term contracts to educational support staff and CAMHS staff are more likely to result in successful recruitment of staff to work in school support teams.

Actions for Schools

- Ensure that within schools there are effective whole school approaches to promoting children's mental health, including good pastoral systems.
- Identify members of staff with responsibility for promoting children's mental health and provide protected time for this work to be undertaken.
- Appreciate that health staff may have different approaches to working with children, especially in relation to information sharing, confidentiality and discipline, and work out how these different approaches can work effectively alongside each other without one undermining the other.
- Help health workers to understand the culture of the school and be willing to adapt to their needs. Ensure that they are given opportunities to mix informally with teachers.
- Make physical space in schools for individual and group work for mental health staff which can be private and uninterrupted.
- Map together with CAMHS the services already available to schools and the responsibilities and remit of these to ensure CAMHS staff are used appropriately.

Action for CAMHS

• Consider basing Tier 2 CAMHS staff in small locality teams, in areas which match Local Education Authority, or school pyramid areas.

- Create formal integrated linkages with LEA staff including Educational Psychologists, Behavioural Support Services and EWOs to take advantage of multi-disciplinary working and co-ordination of services.
- When establishing a project in schools, ensure that the role of the project is communicated to all school staff. This should include the head teacher, SENCOs, all class teachers, SMT, heads of year and assistant heads for inclusion. This may need to be a continuous process where there is a high turn-over of staff.
- Be clear about the role of the project /project workers and identify a clear referral route. Be careful to set realistic expectations of the project. Ensure that there is a written agreement with the school about how the project will operate.
- Maintain strong links with CAMHS services with clinical supervision and remain part of the CAMHS team. Avoid placing a member of staff exclusively under one school management.
- Spend time in schools in order to make informal contacts. Recognise the tight timetable to which teachers work and be flexible about finding the best time for meetings.
- Ensure that interventions in schools are co-ordinated with other relevant initiatives.
- Have named person in CAMHS for schools to link into, and provide information about services and referral routes.
- Negotiate their role in collaboration and co-operation with other agencies providing services to schools to ensure coherent provision and access for all children and families to appropriate support and guidance.

1. INTRODUCTION

This is the report on research conducted by the Mental Health Foundation on effective joint working between schools and Child and Adolescent Mental Health Services (CAMHS) in England. The research was commissioned by the Department for Education and Skills, Westminster. It is hoped that this report will be of use to practitioners from both the health care services and education services working with children. It will also be of interest to a range of policy makers involved in providing services to children.

1.1 Background

There has been considerable interest over recent years on child and adolescent mental health. Research has shown an increasing prevalence of mental health problems in children. A ONS survey showed that 10% of children aged between 5 to 15 experience clinically defined mental health problems, for example, a psychiatric disorder (Meltzer and Gatwald 2000), and the prevalence of problems has been increasing over the past 50 years (Audit Commission, 1999). The provision of services for these young people has likewise received considerable interest (NHS Health Advisory Service, 1995, Audit Commission, 1999, Mental Health Foundation, 1999). Research by the Mental Health Foundation and others indicate that services, especially CAMHS, are historically determined and fragmented and in many areas lacking in key personnel (MHF, 1999, Audit Commission, 1999). It is increasingly recognised that to improve the ability of child and adolescent mental health services to provide effective care to children and young people, it is necessary to strengthen the support CAMHS provide to other services, such as schools. This requires multi-disciplinary teams and inter-agency working.

The issue of tackling mental health in early years settings (under 5s) and schools has been given priority by the DfES recently (DfES, 2001). It is becoming increasingly clear that children whose emotional and behavioural needs are being met are more able to apply themselves to learn (Goleman, 1996) and research has suggested that the environment of school may be more able to maintain changes received in treatment than contact with health professionals seen solely for referral problems (Kolvin et al, 1981, Roth and Fonagy 1996).

1.2 Research aims

This research project was commissioned by DfES from the Mental Health Foundation to explore joint working between schools and CAMHS in England and identify ways in which this might be improved. The research sought to:

- Identify models of joint practice between CAMHS and schools in relation to promotional work and early interventions for children experiencing mental health problems in school settings in England.
- Identify the theoretical, historical, contextual and other factors that have influenced these models.
- Explore the impact of local, social, cultural and economic factors on practice and the impact of local and national policy.
- Identify which factors contribute, and which create barriers, towards effective practice of joint CAMHS and schools work.
- Explore effective practice issues within different models.

1.3 Definitions and concepts

1.3.1 Mental health

The terms 'mental health' and 'mental health problems' have been used generically throughout this report to cover the range of types of problems that children may experience. It follows the definitions provided by the Mental Health Foundation where children who are mentally healthy have the ability to:

- Develop psychologically emotionally, creatively, intellectually and spiritually;
- Initiate, develop and sustain mutually satisfying personal relationships;
- Use and enjoy solitude;
- Become aware of others and empathise with them;
- Play and learn;
- Develop a sense of right and wrong;
- Resolve (face) problems and setbacks and learn from them.

(Mental Health Foundation, 1999, p6).

Mental health problems in children can be emotional, conduct, hyper-kinetic, developmental, eating, habit, somatic and psychotic disorders and post traumatic syndrome. The may be mild and transitory nuisances or have serious and longer lasting effects (Mental Health Foundation, 1999, p6).

It has been identified that definitions and terms can be confusing especially working across different professions. In schools, children experiencing mental health problems tend to be defined as having emotional and behavioural disability, although these are not synonymous (DfES, 2001).

1.3.2 Joint working

Joint working is a broad term which can encompass collaborative working between different professional groups, different agencies an/or different sectors. It may involve two or more parties and may be informal, such as liaison and sharing information and/or involve formal joint arrangements, such as joint committees, joint planning, funding and delivery.

Within the concept of joint working there is *joint agency working* and *multidisciplinary working*. *Joint agency working* is where professionals from different organisational departments work together, but they may well be from the same professional background, such as social workers employed by social services departments and the NHS. *Multi-disciplinary working* involves individuals working across different professionalisms, for example, clinical psychologists working with social workers or teachers. Most CAMHS teams are multi-disciplinary with a range of different professionals, as are many LEA support teams.

There is a long tradition of joint working within the public and voluntary sectors in England and across the UK, particularly in the fields of health care, social care and education. The outcomes for service users and communities are generally enhanced where services provided by different agencies are co-ordinated. Within England there

are a number of policies within the mental health and educational fields which encourage and guide joint working. These include:

- National Service Framework for Mental Health Services;
- Health Advisory Service Report, 1995 'Together We Stand';
- Behavioural Support Policies.

Despite commitment to joint working at national and local level, research and evaluation demonstrates that it is not always easy to ensure effective practice. This is due to a variety of issues including:

- Communication barriers often different professions and different organisations approach the same issue from a different perspective and use different terms;
- Organisational barriers different organisations may have different goals, priorities and structures;
- Resource barriers there may not always be sufficient money or time to support joint working.

This research, which focuses on more intensive, formal joint working practice, demonstrates that these generic challenges are shared by schools and CAMHS in England.

1.3.3 Child and Adolescent Mental Health Services (CAMHS)

Child and Adolescent Mental Health Services are the section of the NHS responsible for children's mental health. They vary in scale and organisational structure and service delivery (and name) in different NHS Trusts (Audit Commission, 1999, Day, forthcoming). Following recommendations from the NHS Health Advisory Service in 1995 most CAMHS are structured in a tiered model, with Tier 2 to 4 making up specialist CAMHS.

- Tier 1 services are the primary level of services including GPs, health visitors, school nurses, teachers, Social Workers and voluntary organizations.
- Tier 2 is made up of specialist professionals such as Clinical Psychologists, nurse specialists, Paediatricians, and Educational Psychologists, usually working individually.
- Tier 3 services represent a more specialist service for the more severe, complex and persistent disorders. Practitioners tend to work in teams in a community mental health clinic or child psychiatry out-patient service and will also include, psychiatrists and other therapists.
- Tier 4 services are highly specialized services such as residential in-patient facilities.

1.3.4 Education and school based policies and resources

There is a wide range of education based policies and services to support children with mental health difficulties and to promote mental health in schools in England.

• LEAs produce **behaviour support policies** which set out the support that schools and individual children with behavioural problems can receive. The LEA is required to consult with other agencies on these plans.

- Pastoral Support Programmes are developed for children with behavioural difficulties who are at risk of exclusion or of failure in school, which also draw on other services and agencies.
- Recent relevant initiatives within education are Connexions, Education Action Zones and Excellence in Cities which focus on areas of deprivation. The National Healthy Schools Standard is a joint DoH and DfES initiative funding projects to build on healthy schools initiatives and has evaluated eight pilot sites across England. Although they are focused on physical health, a key element is the school ethos of supporting emotional development. Other initiatives include the introduction of Learning Support Units in schools, a revised code of practice for Special Educational Needs, and the establishment of a new Advisory Group on Child Mental Health and Emotional Behavioural Difficulties (Hartley-Brewer, 2001).

The services to support children within LEAs, as with the CAMHS, vary in their structure and staffing from one LEA to another and from school to school but there are a number of common elements.

- Educational psychologists are mostly responsible for assessing children with difficulties affecting learning or access to the curriculum and school social environment. They may be responsible for initiating formal assessments that may lead to a statement of special educational needs for a pre-school child. They have a statutory role in providing advice to the LEA on the needs of school age children where these are the subject of a formal assessment. They also advise schools on working with children, staff training, school culture and psychological well being, provide advice and support to parents and carers, support children through group and whole class work and have a role in supporting and advising the LEA on such matters.
- The Education Welfare Service, also part of the LEA, has statutory responsibilities in terms of ensuring children's education provision and attendance. Education Welfare Officers also work with parents and carers at home to support the welfare and attendance of their children. Behaviour Support Services advise and support schools on managing children's behaviour. There are specialist teachers for looked after children and emotional and behavioural difficulties advisory teachers.

Schools themselves have pastoral systems responsible for the emotional and social development of pupils, usually comprising of a network of form and year head teachers. This may include curriculum work, such as the personal social health education curriculum, circle time (a form of classroom discussion), peer support and system of awards and sanctions. A key member of this support is the school special educational needs co-ordinator (SENCO), usually a teacher with special remit for SEN, who is often the link to other agencies. Children identified with an emotional, social or learning problem will be assessed and provided with support according to the SEN code of practice. School nurses and doctors play an influential role in promoting mental health, identifying concerns, and providing support.

Schools may also have learning support assistants, learning mentor and counsellors, as well as buying in services from voluntary organisations. However, a child with passive indicators of mental health need such as being withdrawn or anxious may not

come to the attention of any of these unless a teacher becomes concerned about him or her.

Although the focus of this paper is on education and health, there are many other policies which are relevant for children's mental health that involve both health and education in inter-agency working. Key examples of this are Social Services Policies, including Child Protection Policies and the National Framework for Looked After Children.

1.3.5 Models of service delivery

One of the research aims was to identify theoretical models underpinning the approach to work. This was explored in the literature review and to an extent in the case studies. It is useful to distinguish between the theoretical models of practice (such as medical, psycho-social), and models of practice delivery. For example, one practice delivery model identified in the literature is the ecological systems theory currently being developed in Flintshire, North Wales (Appleton and Hammond-Rowley, 2000). This has five defining features of population-based outcome measures, small area service focus, primary care based CAMHS specialists, primary care service and community engagement.

1.4 Summary of literature review findings

The literature review consulted over 50 publications mostly concentrating on work from the USA.¹ This is primarily because school based mental health services have been developed there since the 1980s and schools in the US are the major providers of mental health services to children. There are three key reviews identified as useful, Rones and Hoagward (2000), Oxford Health Services Research Unit (forthcoming) and Day and Wood (1999).

Rones and Hoagward (2000) looked at studies published between 1985 and 1999 which involved any intervention or strategy applied in a school setting that was specifically designed to influence students' emotional, behavioural, or social functioning, and which employed some aspects of quasi experimental control. This yielded a sample of 47 studies. The authors concluded that no right or wrong approaches emerged, but there were a number of factors that did have a positive effect on the success of the outcome, these being consistent programme implementation, inclusion of parents, teachers or peers, use of multiple modalities and the integration of programme content into general classroom curriculum, and developmentally appropriate programme component.

The Oxford Health Services Research Unit review considered those interventions that are designed to promote mental health and/or to prevent mental health or behaviour problems, and at least one of these outcomes should have been measured. The interventions being reviewed had to be based in school, and were aimed at the whole school population. The review itself provides a detailed account of nine studies, all in the USA and describes a further 63 studies which met a second level criteria. There is no clear division between those interventions that succeeded and those that did not,

¹ The literature review was conducted by Dr A Barron from Leigh and Barron Consultancy Ltd, and summarised here by the author.

however, the results do suggest as a general rule that "those interventions which had positive (promoting) aims, which included attempts to change the culture or environment within the school or class, and which were implemented continuously over a longer period, were more likely to demonstrate improvements in the outcomes measured" (p26).

The third review by Day & Wood (1999) for the North Southwark Education Action Zone looked at 'Evidence-Based Child Mental Health Practice in Schools' as part of the school based child mental health initiative 'Improving Learning and Wellbeing in School'. The authors concluded that the Family and Schools Together (FAST) Track programme developed by the Conduct Problems Prevention Research Group in 1992 was an intervention that particularly stood out. This was a multi-faceted approach with a number of integrated programmes including parent training, home visiting, social skills training, academic tutoring, and teacher-based classroom intervention (PATHS – Promoting Alternative Thinking Strategies). While the authors emphasised the value of collaboration between children, parents, and staff, they did note that few of the interventions specifically encouraged such collaboration.

Main issues that emerged from all the literature were:

Theoretical basis of initiatives are not discussed much in the literature, but one research project identified that a social work model of practice with an emphasis on intervention and social support systems was more helpful than the medical model with an emphasis on diagnosis and treatment (Pool, 1997).

Access to services Many of the school based programmes cite reaching children and young people who do not otherwise receive support services. This may be because school based clinics may be less stigmatising and easier to access. Studies comparing two groups of young people accessing school based mental health services and community clinics found that those in schools were less likely to have previous services, and in one study were more socio-economically disadvantaged (Armbruster, Gerstein & Fallon, 1997; Weist et al, 1999).

The need for *Co-ordinated services* is highlighted. Schools usually respond to concerns about mental health only when these problems are seen as direct barriers to learning (Adelman and Taylor, 1999). To avoid crisis intervention with fragmented programmes the research favours the model of 'full service schools' where community services and schools services are brought together, Taylor & Adelman (1996).

Collaboration Part of the challenge of working in a school based mental health service is the different practices and traditions in the fields of health and education Weist & Christodulu (2000). Research in the UK on teachers attitudes toward CAMHS services suggest that they utilise education-based services before referring to CAMHS and often try to resolve the problem in-house (Ford & Nikapota, 2000). Interdisciplinary dialogue and collaboration needs to be made an explicit priority (Porter, Epp and Bryant 2000, Sedlak, 1997).

Planning and implementing delivery Planning and implementing collaborative programmes which cut across different disciplines and departmental boundaries is a challenge. Success relies on co-ordinating different bureaucracies, selling the programme to middle managers, employing individuals who can span different boundaries using communication skills, and an understanding of organisational dynamics (Kastan, 2000).

Parental Involvement Many initiatives emphasise the importance of working collaboratively with parents and schools. Managing ethical issues such, as parental consent, are key. Evans (1999)

Cultural Diversity Services should be developmentally and culturally sensitive to the young poeple and families receiving them, which necessitates cross-cultural training so that staff are sensitive to race ethnicity, class and gender (Porter, Epp and Bryant, 2000, Weist et al, 2000).

Staff training and development is key when a number of professionals are working together. For example, a study in the UK looking at school nurses and CAMHS working together identified the impact of training and regular support sessions of school nurses (Richardson & Partridge, 2000).

Evaluation and Funding Evaluation of programmes is critical for the development of effective services, but many initiatives have not included such measures (Weist et al., 2000) and should include both process and outcome measures. This is often reliant on funding (Flaherty, Weist & Warner, 1996). The review emphasised that securing reliable funding is very important.

The literature review identifies key principles that could helpfully guide programmes in the UK:

- 1. Establish clear and positive aims and objectives that are achievable;
- 2. Programme designers to take account of the realities of day-to-day operations, i.e. to be realistic in what is being required;
- 3. Models of practice should focus on social work model of intervention and support systems rather than the medical model of diagnosis and treatment; the move from narrowly focused, problem-specific services to comprehensive general approaches;
- 4. The initiative should be multi-faceted, using a range of approaches where necessary;
- 5. Collaboration and inclusion of services, professionals, parents and children;
- 6. Communication between all parties to facilitate co-ordination through multidisciplinary team meetings; this could be supported by cross-disciplinary training and supervision;
- 7. Cross-cultural training so that staff are sensitive to race, ethnicity, class and gender;
- 8. Education of school staff on mental health issues, and provision of specialist support;
- 9. Evaluating programmes is critical for the development of effective services;
- 10. Effective and reliable funding of integrated programmes rather than fragmented programmes funded by unco-ordinated agencies, with possible use

of 'resource co-ordinating teams. The programme should be allowed to run and develop over a significant period of time.

1.5 Structure of the report

Chapter Two gives the details of the methodology, scope and limitations of the report.

Chapter Three reports on a questionnaire survey of CAMHS in England, and gives an idea of the scope and nature of the work conducted between CAMHS and schools. **Chapter Four** gives four detailed case studies of interesting joint working between CAMHS and Schools in Cornwall, Southwark, Portsmouth and North Shields. There is a detailed description of the structure and practice of their work and similarities and comparisons are made between them.

Chapter Five draws together issues coming from the literature review, case studies and survey. It highlights structural, practical and management issues.

Chapter Six outlines the outcomes, advantages and disadvantages of working in this way.

Chapter Seven summarises key findings, conclusions of the findings and makes recommendations.

A bibliography and a glossary of acronyms is provided in the **appendices**.

2 METHODOLOGY

The research aims and objectives covered a very broad remit. The focus of the research was on joint working in practice, the factors that facilitated joint working and the barriers to joint working. The research is grounded in the assumption that joint working is positive, and looks for models of practice, rather than questioning this assumption. As the focus was on the practice of joint working, the research relied on interviews with professionals and practitioners working in the field, and evaluations of this work, and some observation by researchers. Direct contact was not made with service users on ethical grounds and due to time constraints.

The research used a combination of methods to ensure coverage of the breadth of concerns. It was conducted in three stages: firstly a literature review, secondly a survey of existing practice and thirdly, four case studies. Additional material was gathered by key informant interviews.

2.1 Literature review

A literature review was conducted to identify models and learn from practice developed elsewhere.² It consulted over 50 publications, most of which concentrated on work from the USA. Three key reviews identified as useful were Rones and Hoagward (2000), Oxford Health Services Research Unit (forthcoming) ,and Day and Wood (1999).

2.2 Survey of existing practice

A survey of existing practice used a semi-structured postal questionnaire to CAMHS in England to scope the extent of practice, the models being used, and to help identify examples to be explored in the next stage of the research. The questionnaire was developed with the assistance of CAMHS managers. Unfortunately it turned out to be difficult to get an accurate sample frame CAMHS, since there is no centrally held information on CAMHS and there is huge variation in terms of size, location and services provided across the regions. This problem is in the process of being addressed by a mapping exercise which is about to be conducted by the Department of Health. Questionnaires were sent to 309 CAMHS taken from the Directory of Child and Adolescent Mental Health Services (Young Minds, 1998)³. Reminder letters were sent out and this was supplemented by telephone follow-up, at which point the researchers were referred to other agencies providing CAMHS services. Some of the larger CAMHS services sent in several questionnaires where their services are broken down into smaller geographical areas. For the purposes of this research, these are treated as separate CAMHS, as they report on different service activity. In total 171 usable questionnaires were r, eturned of 313 sent out representing a return rate of 55%.

2.3 Case studies

. . .

In order to explore some of the themes identified in the body of this report, four CAMHS were selected for in-depth study from the 83 respondents who expressed an interest in participating in further research. There was a huge range of interesting practice, and it was hard to narrow down the case studies. On the basis of factors

² Literature review was conducted by Dr A Barron, Leigh and Barron Consulting Ltd.

³ The YoungMinds Directory of Child and Adolescent Mental Health Services lists out-patient and inpatient services for the whole of the UK. It is available from YoungMinds – www.youngminds.org.uk.

identified from the literature review, two sets of criteria were used to select the case studies. They were:

For each case inclusion of:

- 1. their own evaluation of service;
- 2. provision of wide range of services and approaches;
- 3. using a multidisciplinary approach;
- 4. working in more than one type of setting (eg early years, primary, secondary).

Overall, the case studies should include:

- 1. rural and urban services;
- 2. a geographical spread across the country;
- 3. both core and project funding, and some projects that are not in receipt of substantial additional funding/ grants;

4. different lengths of time implementing projects, including some that had been running for several years;

- 5. a range of age groups covered;
- 6. experience of working with minority ethnic groups.

The respondent filling out the questionnaire (from the CAMHS service) was contacted, and information on the project was sent to them. They were usually the head of the CAMH service or service co-ordinator. They were asked to identify other individuals for interviews and schools to be accessed. Semi-structured interviews were designed, and reviewed after several interviews in consultation with a research adviser. The majority of interviews were one to one, with three group interviews and two paired interviews. A total of 59 people were interviewed from Health, Education and Social Services, including visits to at least two settings in each area. Interviews were tape recorded in most instances and transcribed or written up from notes. Interviewees were assured confidentiality, and information was not shared with other respondents. During analysis the interviews were coded. Case study details were checked back with the key contacts and further information collected by telephone.

Local literature was consulted, including Behaviour support plans, Ofsted inspections for the schools and LEAs visited, CAMHS strategies, and service evaluations.

Gaps in the findings from the case studies were filled by revisiting the questionnaire data and contacting other services. Four services were contacted about their work with minority ethnic young people, as these were felt to be under-represented in the research.

2.4 Analysis

The questionnaire data was inputted into an excel spreadsheet, and basic descriptive statistics were used to summarise, compare and analyse the data, including cross tabulation. Answers from open questions were transcribed verbatim and coded. The interview material was taken from interview notes, and where appropriate tape transcriptions, and inputted into an analytical framework (on a spreadsheet). Themes were compared across case study areas and professions. This data was analysed with the material from the questionnaires. Documentary materials (such as strategy documents, and evaluation reports) were noted and themed.

2.5 Steering group

A steering group was set up and chaired by the DfES. It included representation from the Department of Health, DfES, Home Office, Healthy Schools Initiative, Mental Health Foundation, and Leicester CBII Project and a Head Teacher. Comments were made on drafts of the reports and suggestions for additional materials and research findings. Further consultation at the design stage of the research was conducted with a voluntary organisation group.

Inevitably, any research will have its limitations which have implications for the findings. The questionnaires were sent to CAMHS, and the case studies were selected from these responses. The CAMHS workers identified the schools to be visited. This may have meant that more influence has come from the health perspective than schools or LEA perspective.

In general, the response to questions within the questionnaire was high. A few questions had a low response, including how many schools they worked with, open questions on the impact their work was having, evaluation details and the length of time they have been working in this way. The impact that this has had on the analysis is that it has been hard to gauge the scale of the work that each CAMHS has in it's own area – whether they are working, for example, with all schools in the area or focusing on a few schools (see section 3.4 below).

SCOPE AND NATURE OF CAMHS WORK IN SCHOOLS 3

3.1 Introduction

This section looks at the scope and nature of CAMHS work in schools in England, and reports on responses from a questionnaire survey. As discussed in the introduction, CAMHS have very different structures across the country. Up until March 2002 CAMHS are commissioned by Health Authorities, but with NHS reorganisation, on 1st April 2002 arrangements changed and CAMHS are now commissioned by the new Primary Care Trusts. The provision may be different in each NHS Trust, for example some NHS Trusts may not have a CAMHS service at all and commission services from other trusts, others may have a very large service which may cover a whole Health Authority Area, others may cover a local authority area. Some services are based in hospitals, others localised in community clinics or settings. A mapping exercise is being conducted by the Department of Health. For the purposes of this study it has meant that it is hard to get an accurate sample frame for analysing the scope and nature of CAMHS services working with schools. A questionnaire was sent to a list of CAMHS which had 309 addresses in England (the list came from the Young Minds Directory). This was supplemented by telephone follow up, at which point the researchers were referred to other agencies providing CAMHS services. Some of the larger CAMHS services sent in several questionnaires where their services are broken down into smaller geographical areas. For the purposes of this research, these are treated as separate CAMH services as they report on different service activity. In total 313 questionnaires were sent out and 171 questionnaires were returned, representing a response rate of 55%. The majority of the CAMHS (89% - 152) who responded were carrying out work in supporting schools.

3.2 Settings for CAMHS work with schools

(n=171, base = all responding CAMHS) Setting	Number of	Percentage
	CAMHS *	
Secondary schools	138	81
Primary schools	130	76
Special schools for children with emotional	123	72
and behavioural difficulties		
Special schools for children with learning	89	52
difficulties		
Early Years	68	40
Other special needs provision: including for	24	14
physically or sensory disabilities, language		
support unit, autism, delicate		
Pupil referral units, alternatives to schools**	25	15
Mainstream 16+ e.g. 6 th form, tertiary	9	5
colleges**		

Table 1: Settings for CAMHS work with schools

* respondents could mention more than one setting.

** respondents answered these in an 'other' category

The most frequent setting for the CAMHS work with schools was in secondary schools (80%), very closely followed by primary schools (76%). Early years work was much less frequent, at just under half working in this setting. The CAMHS seem to be well linked into special schools both for Emotional and Behavioural Difficulties and Learning Disabilities.

3.3 Type of intervention in mainstream schools

Of the CAMHS that supported schools, all but four offered some form of consultation to school staff, three-quarters worked directly with children and just under two-thirds worked with parents. There was a range of intensity of work in this area.

Table 2 Type of work for CAMHS with schools/ education

(n=152 - base = CAMHS working in schools – excluding 19 that were not working in schools)

	Number of CAMHS working in schools (n=152)*	Percentage
Consultation with school staff	148	97
Direct work with children	120	79
Direct work with parents	96	63
Working with the LEA	75	49

* respondents could mention more than one method of working.

3.3.1 Support to school staff

The majority (97%) of the respondents who were working in schools were consulting with school staff (see table 2) which makes up 87% of all respondents including those who do not work in schools. The description of the work given in questionnaires revealed a range of activities including:

- consultation, training, support and advice to teachers;
- consultation to school nurses;
- help with behaviour management;
- training for SENCOs;
- attending annual reviews for children with EBD;
- attending or running staff support groups;
- support to school counsellors;
- input into the personal social and health education curriculum (PSHE);
- supervision meetings with members of staff;
- joint meetings with staff and parents.

Consultation

'Consultation' covers a wide range of work with staff. Many of the respondents referred to consultation about an individual child who has been referred to the CAMHS by their family. The respondents mentioned observing and consulting on the management of the child's behaviour in school. This consultation may be on an adhoc basis, by telephone or with regular visits. For example one CAMHS team mentioned termly visits to primary schools by CPNs, others have regular monthly to six weekly visits. One CAMHS mentioned having a specific teacher in their

department who liaises with school staff over referrals. Another service provided monthly discussion groups in a high school on mental health issues and monthly meetings with the year heads.

Training – teachers, SENCOs, school nurses

46 of the CAMHS described training school staff.⁴ This training ranged from INSET days for teachers, conferences and running regular groups. For example a family therapy interest group which was attended by teachers and health visitors, or regular seminars through the year. Several of the CAMHS that were running specialist groups or health promotion packages included a training element for the school staff. Other training included presentations on the role of the CAMHS and training on specific mental health problems such as autism, ADHD, aspergers syndrome, deliberate self -harm and depression.

Support to school nurses

Support to school nurses was mentioned specifically by CAMHS (20) in addition to support to other staff. This support ranged from case by case consultation to training and direct supervision of their work.

3.3.2 Assessment and observation

Several of the CAMHS described conducted assessments (48) and observation (7) of children in schools or early years settings. This was either in response to the school's concern who wanted to make a referral, or when a child has already been referred to CAMHS and is assessed in a school or early years setting. This occurs more frequently in early years and primary settings than in secondary school settings. Several also mentioned contributing to SEN statements.

3.3.3 Working with parents

Just over half the respondents who were working with schools said that they worked with parents, although it was not clear if this is necessarily within a school. The work with parents was more common in early years settings and primary schools than in secondary schools. Parent support included directly running groups for parents in the school setting, and awareness raising on general mental health issues and about specific conditions. Parenting classes were run directly by CAMHS staff, or by education staff, with their support. This could be in the form of training Tier 1 staff in parenting (two mentioned a Webster Stratton parenting programme specifically) or offering ongoing supervision to staff running them. Some CAMHS mentioned providing home/school programmes. Other CAMHS mentioned liaison meetings at schools with parents and school staff about individual children. As with staff training, some of the specific intervention programmes with children and young people involved training for parents at the same time. Although work with parents in secondary schools was less common, one CAMHS mentioned attending parent evenings with an information stand, and running parent workshops.

 $^{^4}$ these figures come from descriptions of the work the respondents gave in an open question, which was then coded, rather than to a direct question (ie do you train staff – yes/ no, and thus may be an underestimate.

3.3.4 Direct work with children

Just over three quarters of the respondents described working directly with children. This involved individual and group work, running clinics in schools, social skills groups and anger management groups. There was a wider range of direct work with children and young people in secondary schools than early years and primary. Some of the individual work in schools was run in clinics, for example, having a one stop shop in a school – particularly where schools were inaccessible such as in a rural environment. For example:

(We provide a) one stop shop in 3 primary schools with an Educational Psychologist, the CAMHS and the school, with consultation for staff. Individual children are seen in school. (questionnaire)

Over 30 respondents identified running groups with children. In some cases, the nature of these groups was unclear – whether they were therapy groups targeting children with an identified mental health need, or whether they were social skills groups aimed at prevention and health promotion. In addition, 26 CAMHS identified that they were running social skills courses within schools, some as a rolling programme, others as one-off schemes. One CAMHS was involved in a peer mentoring scheme. Several of the groups were targeted at specific issues including children at risk of exclusion (16), anti-bullying (6) and others aimed at girls for eating disorders and self harm. Two services discussed art therapy groups and an under fives group.

For example:

(We run a) nurture group for 0-8 year olds at risk of exclusion including support to staff and training for parenting groups. (questionnaire)

(We run) a closed group aimed at supporting children at risk of exclusion is being run as a pilot project in one high school - 10 week group (questionnaire).

Four of the respondents mentioned working specifically with minority ethnic groups. Three of these were working with Asian young people, one working with Bengali boys and girls and one with Bangladeshi boys and girls, and one described work with refugees. *(questionnaire)*

In one boy's school (we run) individual work for pupils at risk of exclusion due to behavioural problems - a counselling psychologist works one day per week and administers a structured programme that focuses on behavioural problems. In other schools we provide a psychotherapy service for individual refugee pupils. (questionnaire)

(Primary school) weekly children's group run by art therapist for Asian children who school and community health service, were concerned about, and whose families were unable and unwilling to access (clinic). Main problems were elective mutism and severe anxiety symptoms. Parents are seen monthly alongside this. (questionnaire)

3.3.5 Mental health promotion

Only small minority (10) of the CAMHS specifically mentioned being involved in mental health promotion activities in schools, but these in themselves are interesting. These range from giving awareness-raising sessions to pupils, sometimes as part of PHSE to specific whole school projects. For example, a life skills education project run in conjunction with School Standards Funds in 20 settings:

(We run a) life skills education project and train teachers in its implementation. It covers managing emotions, stress, decision making, problem solving, communication, interpersonal relationships, critical and analytical thinking. (questionnaire)

Another example is a prevention and intervention model developed from a social growth programme which is a whole class approach targeted at improving emotional resilience which is being run in one primary school. It is planned to be extended to all primary schools in the area where there is serious concern about school inclusion. Similarly, another multi-agency preventative project (MAP) is being run by one CAMHS in secondary schools, and another setting is working with a school to develop the PATHS curriculum for year 1 and 2 in ten primary schools, and doing mental health promotion in year 11 in eight secondary schools.

3.4 Scale of the work

It is difficult to get an overall idea of the scale of the work from this survey, for example, in terms of how many schools each CAMHS is working with, since the CAMHS themselves differ so much in the areas they cover. For example, some may cover an area with over 240 primary schools, others may cover an area with only a few schools. This will be easier once the Department of Health mapping exercise is complete. The CAMHS were asked how many schools they worked with and the results can be seen in Table 3 below. Unfortunately there was a high non-response to this answer, which may indicate that it was a difficult assessment for the respondents to make. It was least common for CAMHS to work in early years settings and the majority of those who did (67%) worked in less than five settings, one CAMHS worked in 15 different early years settings. A third of the CAMHS working with primary schools were only working with five or fewer schools, and over half were working with less than ten schools. Although, one CAMHS was working with 240 primary schools. Nearly half the CAMHS were working with 94 schools.

Number of settings	Early Year	s	Primary Schools		Secondary Schools	
	Number	Percent	Number	Percent	Number	Percent
	of		of		of	
	CAMHS		CAMHS		CAMHS	
0-5 settings	26	67	30	36	41	46
6-10	7	18	13	16	18	20
11-20	1	3	12	14	15	17
21-30	0	0	6	7	4	4
31-40	0	0	1	1	1	1
41-50	0	0	1	1	0	0
51+	0	0	12	14	2	2
'All schools'	2	5	3	4	4	4
Other: many, some,	3	8	5	6	4	4
case by case						
Total	39	100	83	100	89	100
No reply	29		47		49	

Table 3: Number of mainstream settings covered by CAMHS

Clearly from the descriptions above there is a range of intensity of work within schools from consultation on individual cases which are referred to CAMHS to group work conducted on a regular basis with children in schools. Many CAMHS said they worked in all the schools in their area, and yet some of these reported conducting quite intensive work including running groups. Others selected particular schools to work with. Several targeted schools which they had identified as particularly needy with high referrals to CAMHS or areas with high levels of deprivation. One service ran a clinic in a primary school in a rural area where the families had problems attending a clinic which was several miles away. Another service prioritised a school with high referrals and poor pastoral care. In some areas, the CAMHS service allocated specific workers to groups of schools (see case studies). Several of the services described running pilot schemes, some of which were being rolled out to other schools and others had stopped through lack of resources. In terms of structures, some CAMHS had specific workers within their team responsible for liaison with schools. Others had secondments of staff to Education services (some of these are explored in the case studies in chapter four).

Three mental health specialists are based in 10 secondary schools in the borough providing direct clinical work for young people and families, and consultation and support to school staff. Also early identification of mental health problems. A project is currently being set up to cover all secondary schools in the borough. (questionnaire)

One (CAMHS) team member is linked to each of the secondary schools in our borough and is used more or less intensively by different schools as source for consultation referrals etc. Groups are run in 4 schools. (questionnaire)

3.5 Different settings for the work – mainstream early years, primary and secondary

As described in Table 1, the respondents were asked about the different settings that they worked in. The majority worked in mainstream primary and secondary schools, working in early years settings was less frequent. Working with parents, assessment and observation is more prevalent in the early years and primary schools. Direct work with children is more prevalent in primary and secondary schools than in early years settings, although this does occur.

3.5.1 Early year settings

68 respondents were working in early years settings. Most of this work consists of assessment and observation and support to staff, including consultation support and advice, training programmes and helping early years workers manage children's behaviour. Consultation is also given to school nurses. There is additionally support to parents and some direct work with children. For example:

'Direct liaison with local child development centre allows for consultation assessment and multi-agency management of pervasive developmental problems in the under 5s according to a multi-agency protocol. Health visitors and school nurses are trained in tier 1 CAMHS work by tier 3 CAMHS professionals who offer ongoing supervision', (questionnaire)

Nearly a quarter of these provided some form of treatment in early years settings, one of which ran a social skills group to assist children starting education.

'We run an under 5 groups work with nursery teachers, parents groups and individual work'. (questionnaire)

'Nursery group - year long psychotherapy group for referred children at local primary school consultation to local early years centre to staff and a psychotherapy group for children'. (questionnaire)

3.5.2 Primary schools

One hundred and thirty CAMHS responding to the survey said they work with primary schools, substantially more than in early years settings, and there was a wider range of services provided. Assessment and observation took place here but the main contribution was liaison, consultation and support to teachers. Some support was on a case by case basis of children who have been referred to the CAMHS. Teaching staff received consultation support and advice and training and assistance with managing behaviour, with some supervision. School nurses received consultation and training, as did SENCOs.

3.5.3 Secondary schools

The range of work in secondary schools was broadly similar to that in primary schools. There was less emphasis on assessment and observation, and meeting on individual cases. Support to staff involved consultation, advice and support, training,

advice on behaviour management training and advice to school nurses and SENCOs and counsellors.

There was a wider range of direct work with children and young people including individual and group treatment and social skills groups, anti-bullying projects, work with children at risk of exclusion, anger management classes and work with peer trainers and mental health promotion work and input into the PSHE curriculum. Three reported specific projects working with minority ethnic groups.

3.6 Special schools

123 respondents worked in schools for children with emotional and behavioural difficulties (EBD) and 89 worked in special schools for pupils with learning disability (84 worked in both). Most teams involved with special schools worked with relatively small numbers of schools – mostly one or two schools in their areas. Of these, 74 provided consultation to staff and 39 attended meetings on individual cases. Others provided assessment, made regular visits to schools, conducted training for staff, and some provided interventions. For example:

'We have three mental health specialists based in 8 special schools in the borough for Mild Learning Difficulties, Severe Learning Difficulties and autistic units, providing direct clinical work for young people and families, and consultation and support to school staff. Also, early identification of mental health problem..' (questionnaire)

'At an EBD school for boys we provide a psychotherapy service for pupils on an individual basis. A psychotherapist employed by this centre works at the school half time per week. We have worked with the school for eight years. We also provide support to the teaching staff. Similarly at Learning difficulties school a child attends psychotherapist one day per week. This is funded by grants from charitable trusts'. (questionnaire)

'We work alongside school health advisers to support young people in special schools. We are also currently discussing future support as the L EA are due to open a school for pupils with emotional and behavioural difficulties. The psychologists in the department link with the special schools to offer consultation. Other professionals link on a case by case basis.' (questionnaire)

3.7 Joint working

'We have a CAMHS/education support task group, reporting to CAMHS HIMP subgroup which delivers specific joint projects, e.g. referral guidance for schools; joint training events; protocols on specific clinical problems. Secondly, there is a Education Welfare Service /School Health/ CAMHS case liaison group which shares information and co-ordinates input on specific cases. Thirdly, there is an Education Psychology/CAMHS joint working group: specific local joint initiatives for the benefit of schools. We also input two staff regularly into SENCO training.' (questionnaire) The respondents were also asked whether they worked with the Local Education Authorities (LEAs) to get an idea of the kind of joint working they may do at a strategic level as well as the direct work with schools. Only 75 (44%) of the survey reported working with the LEA, although a further 22 went on to describe some work elsewhere. Key contacts with the LEA were with the education welfare service, the behaviour support panel, and the Educational Psychology Service. As with the schools work, there was a range of intensity of working with LEAs. The range of work included:

- liaison with LEA staff on a case by case basis,
- planning work jointly,
- running regular meetings with LEA staff,
- conducting joint training, interventions, research,
- developing shared protocol and strategies,
- secondments of staff from LEA to CAMHS (EBD advisers and teachers);
- secondments CAMHS to LEAs (primary mental health workers and CPNs);
- Interagency CAMHS groups;
- multi-agency management board for the CAMHS which involved LEA staff;
- multi-agency groups for specific conditions such as Autism and ADHD.

Working with education psychology

Working with educational psychologists was the most common form of liaison with just under 30 respondents participating in this. This involved joint planning work, attending meetings on specific cases and on particular issues. Some projects and service were run jointly between the two services and some described joint research projects. One CAMHS reported having an educational psychologist seconded from the LEA to their CAMHS team half time. The aim of this was to improve the quality of the relationship between the two services, to ensure that the assessment of educational factors was taken into account by the CAMHS workers, and to assist them in intervening effectively in educational settings. He also acts as a point of contact for educational staff who refer to the CAMHS team and co-ordinates contact with the LEA service. The educational psychologist has produced a joint protocol for working with education and participating in steering groups, offered a consulting service for CAMHS workers, and was involved in direct case work run jointly with other CAMHS workers.

Working with behavioural support team

Twenty one of the respondents mentioned working with the behavioural support team in the LEA. This ranged from liaising over individual pupils, giving consultation and advice, and training to attending the behaviour support team meetings. In some cases a member of the CAMHS team sat on the strategy group and others consulted on the behaviour support policy.

Working with Education Support Service

Fifteen of the respondents mentioned working with the education support service. As with the behaviour support service, this involved consultation, advice, attending meetings, working jointly on projects and occasionally providing supervision.

3.8 Staff conducting the work

A wide range of personnel are conducting this work. Clinical Psychologists and community psychiatric nurses are most often cited, followed by Social Workers, Psychiatrists and Psychotherapists. Relatively few had educationally trained staff in their teams with 22 Educational Psychiatrists, 11 teachers and 6 Educational Welfare Officers. Others include primary mental health workers, teachers, family therapists and occupational therapists.

Table 4: CAMHS Staff conducting the work

Staff	Number of CAMHS* (n=166 no replies =5)	Percentage
Clinical Psychologists	88	53
Community Psychiatric Nurses	81	48
Social Workers	60	36
Psychiatrists	57	34
Psychotherapists	33	13
Educational Psychologists	22	13
Primary Mental Health Workers	21	13
Family Therapists	19	11
Occupational Therapists	15	9
Teachers	11	7
Play or Art Therapists	8	5
Education Welfare Officers	6	4
Other (includes managers, school nurses, counsellors, health visitors, other therapists and EBD support workers)	31	19

* respondents could mention more than one group.

Respondents were asked how long they had been working in these settings. The average time spent working in this way was six years for all settings, and very few had worked in this way for more than 10 years. See table 5 below.

 Table 5: Length of time working in this way

	Early Years (n=68)	Primary schools (n=130)	Secondary schools (n=138)	LEA (n=75)
Average number of years	6	6	6	6
less than 2 years	5	18	12	10
2 - 4 years	16	24	30	23
5 - 10 years	18	26	30	17
more than 10	6	7	8	4
Many	5	3	3	2
Total	50	78	83	56
No reply	18	52	54	19

3.9 Resources spent on working with schools

In the questionnaire, respondents were asked to estimate the proportion of their resources spent on working in schools. Many commented that this was difficult but 107 (70%) did make estimates. Just over half of these CAMHS spent less than 10% of their resources on work in schools, and the average is 15%. This is higher than found in studies elsewhere (Audit Commission, 1999).

Percentage of resources spent on work in	Number of
schools	CAMHS
0-5	29
6-10	26
11-15	14
16-20	14
21-25	5
26 +	19
Total	107
Average	15
No response/ unable to estimate	45

Table 6: Resources spent on work in schools

Many of the respondents highlighted resource issues as a problem, especially those that are a small service. The main reason cited for not working in schools was not having the time or funding to do so. One respondent commented that working on projects in schools had detracted from their core work and had led to an increase in waiting list, and low morale within the service.

79% of the CAMHS who reported working in schools are using core funding 28% are using project funding (12% are using a combination of both). Many were linked to other initiatives including Sure Start (52), Health Action Zones or Health Improvement Strategies (30) Education Action Zones (24) and Healthy Schools (22), Connexions (18) and Excellence in Cities (5). Other initiatives mentioned were CAMHS modernisation (5), On Track (3), Quality Protects (2), SRB and social inclusion.

3.10 Summary of key findings from chapter 3

CAMHS structures are very different across England, and it is hard to get an overall picture of the scale and pattern of the work they are doing with schools. For example, they cover different sizes of geographical area, may be based in clinical or community settings.

The majority of CAMHS services which responded to the survey did some work with schools (89%). Within this, was a wide variety of practice and structures. The most common form of work was **consultation and support to school staff**, often on a case by case basis with children who had been referred to their service. Other support to school staff was consulting on behaviour, training and supervision to a range of school based staff, and contributing to health promotion activities.

Direct work with children and young people was conducted by 70% of the services which included individual and group work in schools and contributing to whole school mental health promotion. Many worked with parents in school settings, especially with early years and primary age children.

Only just over half the CAMHS who responded worked with the LEA. This included work with the educational psychology service, education welfare service and behaviour support services. The structure of the work varied significantly, from one extreme of a joint integrated service, to secondments from health to education and vice versa.

Clinical Psychologists, Community Psychiatric Nurses and Social Workers were conducting the majority of the work from the CAMHS teams, and surprisingly few education staff were included in the CAMHS teams.

Of those respondents who could estimate the proportion of their resources spent on working with schools, just over half spent less than 10% and the average was 15%. This is higher than findings from elsewhere (Audit Commission, 1999) but should be viewed with caution as those who did work with CAMHS were more likely to respond. The majority who responded were using core funding.

This chapter reports on the questionnaires sent out to CAMHS to describe the work they have been doing with schools. It has given a broad overview of the work being conducted across the country. The next chapter goes on to explore in more detail four case studies of work with CAMHS and schools.

4. CASE STUDIES

In order to explore some of the themes identified above, four CAMHS were selected to study in depth from the 83 respondents who expressed an interest in participating in further research. There was a huge range of interesting practice, and it was hard to select case studies. On the basis of factors identified from the literature review, two sets of criteria were used to select the case studies. (See chapter 2 for criteria used for identifying the case studies). Much of the work conducted below is innovative, and has not been operational for long: it should be seen as work in progress. The aim of investigating these structures and practice is to learn from their experience to date.

The following sections provide detailed descriptions of the structure and practice of the case studies individually. The chart below summarises the structure and context of the case studies.

	Compary of case		Dortamouth	North Typogida
<u></u>	Cornwall	Southwark	Portsmouth	North Tyneside
Structure	Joint service	Specialist	Secondments	Secondment of
	between NHS	schools team	of NHS staff	NHS staff
	and LEA	within	(primary	(Community
		CAMHS tier 2	mental health	Psychiatric Nurses)
		service	workers) to	to Education
			Education	Department
			Department	(Behaviour and
			(Educational	Attendance
			Psychology)	Support Service -
				BASS)
Location	Based in six	Based across	Based in four	One based in an
	locality teams	four locality	locality teams	LEA team, one
	5	teams	5	based in a
				secondary school
Tiers (see	Using tier	Tier 2	Tier 2/3	Tier 2/3
Chapter 1)	structure – Tier			
· ····································	2 but			
	increasingly			
	locating Tier 3			
	services to			
	locality teams			
Management	Teams co-	Managed by	Line manager	Line manager of
management	ordinated by	Clinical	for the day to	CPNs by head of
	health worker.	Manager of	day	BASS team,
	Professional	Tier 2 service.	management.	professional
	supervision by	Links with	Supervision	supervision by
	education or	education via	and appraisal	CAMHS team.
	health as	EAZ Director	from	CAIVILIS ICalli.
		EAL DIRECTOR	-	
	appropriate		professional	
			discipline.	

Table 7Summary of case studies

Rural/ Urban?	Rural	Urban	Combination of rural / urban	Rural, in close proximity to large city
Geographical location	South West England	London	Southern England	North East England
Funding	Mostly core funding, some Innovations fund for specific projects	Mostly EAZ funded with some core funding	Combination of funding: some core, On Track, EAZ	CPNs funded by HAZ and EAZ
Length of time working in this way	6 years	3 years	2 years	2 years
Age groups covered	Early years, primary and secondary	Primary and secondary	Primary and secondary	Early years, primary and secondary
Experience of working with minority groups	Very low experience	High experience	Very low experience	Low experience but developing work with asylum seekers and refugees.

4.1 Cornwall

4.1.1 Context

Cornwall is a rural county, the most sparsely populated in England, with a population of roughly half a million. 20% of the school population are on the SEN register and 4.5% are statemented, which is higher than the national average. There are no special EBD schools in the county, and the mainstream school provision is highly integrated. There is a very small ethnic minority population with a small number of gypsy / travellers. Key problems facing the community are rural isolation, relatively high unemployment and rural poverty.

4.1.2 Structure of CAMHS

Cornwall's CAMHS structure is radically different from most CAMHS and education services. It is a joint service formed in 1995 by bringing together the staff of the Cornwall Health Care Trusts, the Child and Family Psychiatric Services and the LEA county psychological service called the 'Child and Family Services'. This structure was implemented following a Health Advisory Service Inspection in 1994 and follows a tiered model. The Tier 2 service are made up of six locally based multi-disciplinary teams made up of Educational and Clinical Psychologists, Community Psychiatric Nurses, specialist Social workers, advisory teachers for behaviour support, Education Welfare Officers, Child Psychotherapist and Creative Therapists. These teams provide assessments and a range of therapies and act as a filter system and onward referral point to Tier 3 services. Constructing a fully integrated childrens services for children with mental health problems, with pro-active joint management and pooling of budgets and resources is a specific aim of the CAMHS, and is also reflected in the Local Authority's Children's Service Plans. The teams have a locality co-ordinator –

mostly community psychiatric nurses, but line management for each professional is through their respective departments. The Chief Psychologist manages the Education Department staff, and the Clinical Service Director line manages the health staff. There is a joint service Director in Education who is responsible for inter-agency coordination and strategic management of the service. The service works with all schools in the county -31 secondary schools and 240 primary schools.

4.1.3 Practice

This is a joint Education and CAMHS service and their work is highly integrated. So for example, all the work that LEAs routinely do for children with educational and behavioural difficulties are conducted by the joint team, although there are divisions of labour within the teams. For example, the assessments that educational psychologists do with children in schools could be included as part of CAMHS work. Some key areas of project development described by the schools and other staff are identified here. Two schools were visited, one primary and one secondary, and group discussions were held with two locality teams. One joint inter-agency project, Scallywags, is investigated in more detail below.

Direct work with students

Children can be referred to the teams through a wide range of avenues. School staff with concerns about a child, most often refer through the members of the team who most frequently visit schools, for eample, the Education Welfare Officers, Advisory teachers or Educational Psychologists or specialist social workers. They will talk to parents and the child and if there are issues beyond education – particularly problems at home, they take it back to the team co-ordinator and the multi-disciplinary allocations meeting of the team. They may then work with the case themselves, with support and consultation with their health colleagues, or work jointly with other colleagues. Rather than actually having to formally refer the case across the team, they can just hand the file over to another member of their team. One example given was a bulimic girl who was being seen by the family therapist in the team but also occasionally supported by the EBD advisory teacher in school. In some circumstances where families are reluctant to work with health service directly but are willing to be seen in schools the EBD adviser or specialist social worker may see them in schools, with advice and support of their health colleagues in the team initially, but involve the health colleagues more directly if the intervention is not being effective. A child may have already been referred to the team by the parents or GP, in which case the team co-ordinator will already have notes on what services they are already accessing. A similar process would be followed for assessing problems such as ADHD with the Advisory teacher or Educational Psychologist working with the school and passing on to the health professionals in their team.

The children may receive an anger management programme, counselling, or social skills groups or be referred to an activity project. In the primary school visited, several children with behavioural problems had been referred to an activity based project called Dreadnought for art therapy sessions by the advisory teacher in consultation with the SENCO and head teacher. This had been funded by the 'Individual Solutions Budget' – a joint health, social services and education pool of funds.

Support to school staff

The way the teams liaise with and support schools varies across the different locality teams. The two teams interviewed both set up regular meetings with the secondary schools in their areas to discuss children that the schools are concerned about (involving the EWO, Educational Psychologist and advisory teachers). In one team the Specialist Social Worker runs the meetings every month, in another it is termly. The schools discuss with the team the children they are concerned about and the team decides if they need to be involved and take the referral then. The cases then get discussed at the regular meetings in the team. The staff linked closely to the school such as the EWOs will attend the meetings, even if they are not directly involved, which means that they can feedback regularly to the schools about what is happening and keep them informed. In one area the team co-ordinator (mental health worker) also attends the meetings at schools.

The teams were also involved in training school staff in behaviour management issues and mental health issues, although this varied across the different schools. The secondary school visited had INSET days from the child and family team, and training for lunchtime supervisors and learning support assistants.

Mental health promotion

Several mental health promotion activities were mentioned by the locality teams and the schools. Two examples were Trailblazers and the Pyramid Trust. In the primary school visited, Trailblazers was being used in two ways; targeting a group of 16 children who had self esteem issues, and a wider mental health promotion approach using it across a whole year group. In the secondary school visited Trailblazers was also being run with the assistance of the EBD adviser from the Child and Family Team. It is jointly co-ordinated by Cornwall Outdoors and the Behaviour Support Service. and offers schools a number of activity based experiences which help raise children aware of the importance of rules and discipline in other aspects of life. Teachers take responsibility for running the scheme and work with groups of approximately 16 children at a time. The children on the scheme are assessed before and after the scheme on their emotional and behavioural development and self esteem on the Coopersmith/ Gurney self esteem inventory.

'Scallywags'

Scallywags is an interagency project provided by Cornwall Social Services, the Local Education Authority, Health Authority and NHS Trust and is funded by DoH CAMHS Innovation fund. It is an early intervention project based on cognitivebehavioural intervention and focused on co-ordinated agency responses. It is aimed at three to seven year olds who are experiencing behaviour and emotional difficulties either at home or school, and is delivered in three local communities chosen on the basis of high levels of social need and poverty. Referrals are made jointly by parents and professionals, primarily school staff (45%), social workers (14%) and health staff (30%). Once the child is referred, the project leader has a planning meeting with parents, school/ playgroup, and the support worker. They set targets, for example, compliance targets, children over five years old will do as asked 75% of time at first word. Parents pick a particular area of problem, for example, bedtime or reducing tantrums when shopping. The support worker focuses on children's emotional intelligence and dealing with anger, co-operativeness and social skills, sharing and problem solving, and to ensure that each child has an individual programme. The aim is to change the interaction between parents and children and they may do some small group work in schools. Support workers work with four children at a time and come from a variety of professional backgrounds including teaching and nursery childcare. They are given two weeks initial training and ongoing training.

So far, 83 children have been supported by the scheme, 79% of whom are boys. The children are seen for eight hours per week for a period of six months, by support workers. They will be seen both in school or early years settings and at home depending on where the need is most. For example, if problems are exhibited at bedtime, the support worker may observe and support the parent at this time in the home, and help trouble shoot. Parenting groups are run as part of the intervention.

4.1.4 Evaluation and outcomes

The overall impact of the joint CAMHS / LEA service is not being systematically evaluated although the team is currently looking at ways of evaluating the service. Specific elements of the service have however been evaluated already. The team has worked with young people to get feedback, for example, by working with voluntary organisations and youth clubs (providing a video of the discussion of the impact of the residential services, for example). Specific projects set up methods of assessment, for example, Trailblazers which assesses children before and after the scheme on their emotional and behavioural development and self esteem on the Coopersmith/ Gurney self esteem inventory. However, there is not a centralised system for collecting this information at present.

Scallywags is being extensively evaluated by looking both at the impact on the children and parental stress and the impact of inter-agency working. The evaluation is drawing on interviews with parents, project staff and professionals and standardised pre and post intervention measures. The measures used are the Eyberg Child Behaviour Inventory, and the Abidin Parenting Stress Index. The evaluation is not yet complete, but interim reports analysing material of 83 children have shown a reduction in parental stress, improvement in difficulties of children's behaviour and parent's ability to cope. The project has been successful in establishing interagency approaches and has been particularly successful with working in schools (Lovering, 2001). It highlights the importance of clear roles and responsibilities of members of the different agencies involved, to have an agency with a lead and manager who has responsibility to drive work forward, and that the agencies feel ownership of the project (Lovering, 2000).

4.1.5 Feedback from interviewees

Members of the locality teams also gave feedback on the impact of this way of working. They emphasised the increased co-ordination and communication between themselves, and an improved service to the children and families as well as their own professional development: 'That's one of the good things in working in this way. We don't have odd people working with children in their own little boxes - somebody doing a lot of anger management in schools and someone else doing something else. We do actually discuss them at opt- in meetings and work out who's working with who.' (Educational Psychologist)

'It's improved a lot. I used to be a SENCO. I remember you had to keep phoning to get your child's file nearer the top of the pile. There was a lack of system. The psychiatrist used to say that problems breed into crises on (his/her) desk. Pile of files – totally overwhelmed because all referrals went to the psychiatrist. There was no route.' (EBD adviser)

Feedback from schools was also positive. The SENCOs and heads of pastoral support were clear about the referral routes to Child and Family service and were aware that they could access via the educational staff (EWOs, Educational Psychologists and EBD advisers), and almost all referred via this route. One head teacher was not clear that she/he could refer directly to child and family, and would prefer to go via EBD advisors first who then may refer on. One SENCO discussed working with parents to refer to child and family – especially if the problem wasn't a school based one.

'I always refer directly to child and family and I would get an acknowledgement letter from [co-ordinator] saying that it's been set up. That's with the parent's permission. I put in a referral with the parents. I get a letter back and they are added to list. Or I give the parent their brochure and say you can do it. If it's impacting on the school they are quite happy to work with me and [EBD adviser]. It's all in the same office and sometimes they will pass papers to and fro because [EBD adviser] might have picked up the child.' (SENCO)

'The advisory teachers are extremely good and recognise issues across more than one school and borrow ideas and strategies.' (Head teacher)

4.2 Southwark

4.2.1 Context

Southwark is an inner-city borough in the South of London. It is characterized by high levels of poverty and inequality. It is one of the bottom five most disadvantaged Local Authorities in the UK, with pockets of affluence. The borough has a very diverse ethnic and cultural community. In the parts of the borough, for 50% of the population, English is not their first language, and there are over 70-80 different languages or dialects spoken. The population includes West African, South American, Bangladeshi, Vietnamese, Turkish and Afro-Caribbean people as well as White British and Irish people. There are also a number of asylum seekers in the borough. The borough is characterised by having poor housing – there is a high level of local authority housing much of which is poorly maintained. Interviewees identified child health problems, crime, drugs, racism and teenage pregnancies as problems. They also referred to huge community resourcefulness in tackling porticularly hard in terms of the relationships between adults being verbally abusive with much violence in the home and the community.

4.2.2 Structure of CAMHS

The focus here is on the Tier 2 services in Southwark which are within the South London and Maudsley MHS Trust. The overall structure of the CAMHS comprises five clinical units (one for each of four boroughs Lewisham, Southwark, Croydon and Lambeth) and a specialist/ national unit. The borough services provide Tier 2 and Tier 3 services. Tier 4 services are provided by the national/ specialist unit. All of the work of the Tier 2 services in Southwark is conducted in community settings - GP surgeries, in schools and in homes across three of four localities within the borough. The most highly developed locality services are in the north of the Borough. Strategic plans are in place to develop similar services for areas where they are not currently available. Southwark LEA has been taken over by a private company. They shadowed the previuos management a year before taking over.. Liaison across Health, Social Services and Education occurs at various levels. At a strategic level, there is the Children's Partnership Board which links Health, Social Services and the LEA. There are a series of working groups at a practitioner level including a school network which meets once a term involving SENCOs, school pastoral staff and CAMHS staff.

The aims of the Tier 2 services in Southwark are:

- 1. To provide direct help to children and their families that is accessible and in acceptable locations;
- 2. To train and support Tier 1 practitioners;
- 3. Promote emotional and behavioural well-being and where possible, to prevent difficulties arising;
- 4. To network with other services and practitioners involved in working with children and young people to create more integrated services;
- 5. Service evaluation and research.

There are a considerable number of area based initiatives in the borough including two Education Action Zones, Health Action Zone, six Sure Start programmes, Single Regeneration Budget (SRB), On Track and New Deal for Communities many of which have funded community based CAMHS initiatives. One element of the schoolbased work outlined here is funded by the North Southwark Education Action Zone. This school based project is known as the Kaleidoscope Project. The overall aim of the Kaleidoscope Project is to improve learning and well-being in schools. The idea is that by addressing the emotional, behavioural and family difficulties of pupils as early as possible, children will be able to make the most of their learning opportunities provided by education. The work of the Kaleidoscope Project complements, and is integrated with, other Tier 2 services.

4.2.3 Practice

Support to students

The Tier 2 services have link practitioners visiting schools regularly, to provide school based services and advice, information and consultation to teaching staff, and to attend key pupil planning meetings (Day, 2001). As outlined above, the funding is a mixture of mainstream, EAZ and HAZ funding. Some more intensive services are provided by an EAZ project which has two and a half full time staff working in three schools.

Child mental health specialists run outreach clinics on school sites. These staff are experienced CAMHS staff from clinical psychology, social work, psychotherapy, nursing or other relevant backgrounds. The locality team works with 8 primary schools and 4 secondary schools, offering individual work with children and their parents, and involving other school and education practitioners where appropriate. The referrals can come from the schools via the head teacher or from the SENCO or from the families themselves. Workers are at the school site for a minimum of once a week and may identify need themselves by watching children. The children using the outreach clinics experience a range of emotional and behavioural problems which vary in severity and intensity. Many referrals tend to be boys with behavioural difficulties including conduct disorder. Workers like parents to be informed of the potential involvement of the outreach staff, and their involvement in sessions is essential. Children and their parents receive family support, counselling, parent advice, as well as a variety of therapeutic interventions. The locality service also offers parenting courses in small groups based at the school sites: some parents prefer to be seen in venues other than their child's school. The workers also have regular sessions with the teachers about how they deal with the behaviour in school. The outreach staff facilitate communication and understanding between families and school staff where this is an issue. In the primary school visited, there were about eight children who participated - for about an hour per week each. Strategies to change their behaviour were discussed, as well as methods to cope with their feelings.

In addition, working jointly with a voluntary organisation, workers conducted a drop in service at one of the schools. This was advertised in school and led to further work and support to the pupils involved.

Support to staff

Support to staff includes formal training and liaison and consultation concerning the work of school staff with individual children. The CAMHS team offer supervision to the school counselling service. Training has been given to the learning support team, INSET days and contributions to the LEA behaviour policy. One particular initiative has been to give support to meal-time supervisors. This has given them a chance to learn about the impact of shouting and negative behaviour towards children. The service has also provided training for teachers on strategies for dealing with mental health issues and ADHD in some schools. One of the secondary schools expressed a need for support in conflict management and general support to heads of year eight.

The parent adviser training has been offered to all Tier One local practitioners school nurses, learning support staff, learning mentors, early years staff and, offers on going support for those who take it up.

Mental health awareness / promotion

In one primary school two members of the CAMHS team are conducting a Webster Stratton social skills programme with the whole of the year one class called Dinosaur School. Puppets are used to make the presentation of material fun and interesting. Video tapes, group discussion and activities including role plays are used to rehearse and reinforce the social skills taught in the classroom sessions. The class teacher observes and participates in the sessions and then reinforces the use of the skills and techniques advocated in the programme throughout the school day. The programme has been evaluated elsewhere as effective in groups and is currently being evaluated in classroom settings. The programme covers how to behave in the classroom, listening and paying attention, problem solving, anger management and making friendships. The aim is that the whole class, and eventually the whole school, can share a language where problem solving can occur. The course is run over six months at two sessions per week for 45 minutes per class.

4.2.4 Evaluation and Outcomes

The principles behind assessing the effectiveness of the service delivery is to adopt a comprehensive outcome model to take account of clinical outcomes but also ecological, consumer and economic and needs related outcomes. Thus a number of different approaches to evaluation are being taken. The direct client work of the Community Child and Family Service (CCFS) which includes work in school setting, is being evaluated to assess who is using the service, what kind of treatment they received, outcomes in terms of the changes in severity of child mental health problems and parental stress and to assess client's expectations and assessments of the service. This includes both parents and adolescents. Service evaluation packs made up of standardised measures and questionnaires are used to collect information from children, parents and teachers before, and four months after the intervention, and a year after for a sub sample (Attride-Stirling et al, 2001). Unfortunately it is not possible at this stage to disaggregate the figures for the children seen in school settings. The overall service clinical outcomes (including work not in schools) were very positive, showing clear improvements in child problems and parental coping after the intervention and that the improvements were enduring over a year after the intervention. Parents reported high satisfaction with the service, especially with the location of their appointment (the majority within 30 minutes walk from home). Interestingly, teachers reported less positive change in children's behaviour than clinicians or parents and adolescents themselves.

The support of the Tier 2 services to Tier 1 services and multi-agency approaches were evaluated to identify whether the introduction of a Tier 2 service affected the perceived quality of CAMHS in terms of service access, working relationships and satisfaction (Day et al, in press) with Tier 1 workers (which include GPs, nurses, health visitors, head teachers, deputy heads and SENCOs. The findings were that there had been improvement in the knowledge, access and quality of working relationships with CAMHS. This was stronger when there had been direct contact with CAMHS Tier 2 staff, for example, when referrals had been made.

4.2.5 Feed back from interviewees on impact

The staff providing the service identified positive outcomes of both the Kaleidoscope project and the 'Dinosaur School' in terms of the peer relationships, academic attainment, behaviour and exclusion; one felt that she could really see a difference even just over the eight months of her work. CAMHS staff identified that it was more difficult to work in secondary schools (see discussion in section 5.4.5).

The primary school staff were very positive about the project. The difficulties reflected working with secondary schools, outlined above, were reflected in the

feedback from them, where the interviewees were less able to identify direct outcomes related to the CAMHS work, although the staff felt more supported.

'Some children have come close to permanent exclusion and have been supported by Kaleidoscope project: it takes the edge off and gives them a breathing space. Gives another door before exclusion. Children feel that are being looked after by the school. (Head teacher)

'Training for staff – we have the feeling of having back up, help is immediate or nearly immediate from CAMHS' (School counsellor)

4.3 Portsmouth

4.3.1 Context

Portsmouth became a unitary authority in 1997, and is one of the most densely populated district authorities in the UK outside London. Unemployment is low, but there are pockets of severe deprivation. The proportion eligible for free school meals is in line with national average. The population is mostly White British, with a very small population from minority ethnic groups (2.6% in the 1991 census) who are mostly from Bangladeshi, Chinese or Indian heritage. (Ofsted, 2000). When discussing the context of their work, interviewees identified low levels of academic attainment, young carers, disengaged pupils who are disaffected materially and emotionally deprived as key issues. The two schools that took part in the research were located in the Paulsgrove area, and the roll intake is particularly from a large council estate. Both schools have secured On-Track funding and there is a range of related initiatives in the area including Sure Start and National Healthy Schools Initiative.

4.3.2 Structure of CAMHS

The Portsmouth project covers three NHS Trusts, Portsmouth Health Care, Portsmouth City Primary Care Trust (from April 2002) and East Hants Primary Care Trust. Since April 2001, they are within a new larger strategic health authority which combines two previous health authorities. The CAMHS was previously part of the Portsmouth Health Care NHS trust and the service has moved from a combined community and hospital based service to a totally community based service over 10 years. It has recently been transferred to the three primary health care trusts to enable better links with primary care, and to support enhanced interaction with local social services department education and voluntary organisations. There is a joint Tier 2/3 service which is based in three locality teams, and a district wide Tier 2/3 specialist team for the under 12 age range. Tier 4 services are commissioned from a regional unit on a service agreement level. There is a specialist youth mental health team to provide clinical advice and support for more complex cases. However, this team is in the process of re-organising and expanding, with a focus on joint working with social services and education. Each PCT area has a multi-agency CAMHS strategy group.

The locality teams are multi-disciplinary and receive referrals from health, education and social services. They work with ten primary schools, eight secondary schools, in two early years settings, two EBD schools and one learning disabilities school. There is a primary mental health worker team attached to each locality team as well as GP surgeries and social services and education provision. The service manager manages the locality teams and the primary mental health worker team. In Portsmouth City PCT one primary mental health worker (PMHW) is attached to the joint school and family support team and managed by educational psychology service. They are based within the education team, but maintain supervision and case-management links to the CAMHS team. The Portsmouth and City team has another primary mental health worker who works in schools as part of On Track beside having the normal GP attachment work. In the Fareham and Gosport Primary Care Group (PCG), a primary mental health worker who, apart from doing the generic GP attachment work, receives referrals from social services and education. The East Hampshire primary care team operate an integrated team model which has primary mental health workers who provide a GP attachment service, as well as a PMHW attached to schools by linking with school nurses and the Educational Welfare Officers who make the referrals, and a PMHW attached to the Social Service Reception and Assessment team, with the duty social workers making the referrals. There are four Primary mental health workers (PMHW) for a population of just over 37,000 children and young people, and referral rates are approximately 48 per month (Flemming, 2002).

4.3.3 Practice

Referrals come to the teams either from schools, from GPs or from other colleagues in the teams and from Tier 3 CAMHS. How the schools refer varies – sometimes via the head, the SENCO, the school nurse or the Educational Welfare Officer. The work of the primary mental health workers is slightly different in each of the localities. In one area there is 'On Track' funding, which is mostly preventative work. Another area has referrals only from school nurses and EWOs and social services, and in the third area they accept referrals from educations and social services. The primary mental health worker role in schools provides attachment and liaison, consultation and training, and direct work with children.

Support to staff

The primary mental health workers offer support and consultation to teachers about children who are referred to them, often offering consultation over the telephone in the first instance, followed up where necessary with face to face consultation in school setting. Support and training is given to teachers on managing pupils with behavioural problems, on mental health issues such as ADHD and anxiety. They also train support workers such as learning support workers and meal time supervisors. Other training has been to develop the PATHS curriculum (Promoting Alternative Thinking Strategies) as a core curriculum subject for Key Stages 1 and 2 by the Education Psychology and Behaviour Advisor service in one area. The PMHW supported this developmental work and provides additional mental health consultation. Other work with teachers involves training primary school teachers on running social skills and anger management groups, and the teachers are now running the group with supervision offered by the PMHW or Educational Psychologist.

Direct work with children and families

Direct work with children and families is targeted at those children with mild to moderate mental health needs who are unable to access usual routes for mental health services. Individual time limited therapy is given to children and their families for up to six sessions. A rolling programme of social skills groups and anger management groups are run in several schools, covering issues such as divorce and separation (Splitz), and transitions. The workers identify and refer on cases such as ADHD. Much of the work is with families and mediating between families and schools.

In the Portsmouth City PCT the work is focused on supporting children at Key Stage 2 (children aged 11) who are emotionally distressed and who have potential mental health problems, focusing on children who are not necessarily excluded but ones who may be introverted. The model forms a referral, telephone contact with the school to either refer on or discuss strategies with the school and then (where relevant) direct work with pupils and family. There are review meetings including school staff and parents, with follow-up consultation meetings afterwards.

4.3.4 Evaluation and outcomes

The project and model of working is being reviewed and evaluated as it progresses, although it is at an early stage of the project's development. An evaluation is currently being conducted on the problem resolution programme from the client's perspective. The framework for evaluating the project looked at who was using the service, how it was being used, what changed as a result of the service, and whether it made a positive difference. The evaluation found that the team was successful in improved working relationships, opportunities to discuss cases, and agree the most appropriate referrals. The evaluation also identified that the team was responding to mental health issues at an early point of intervention: 27% of referrals had a one to two per cent probability of developing a mental health problem, 28% an eight percent probability, and 12.5% were 20% more at risk.

Reports from the teams identified that this model of working raised the profile of children's mental health in schools, provided direct and appropriate access to support for children, and built networks to provide a co-ordinated service. The consultation role enhanced knowledge and confidence in detection and management of mental health problems, supported more appropriate referrals and opportunities to learn from each other's systems and pressures.

4.3.5 Feedback from interviewees

The outcomes for these projects are being evaluated (see above). The CAMHS staff identified advantages of shared knowledge, experience and expertise, learning across the different organisations, and better services to children and parents as there is greater clarity about who is doing what.

Feedback from school staff was mostly positive especially those directly involved with children with mental health problems or emotional and behavioural difficulties such as SENCOs and learning support assistants. Some teachers identified that there was a plethora of initiatives to support children and did not especially distinguish this programme of work from other interventions. (Advantages of this approach) 'everybody knowing what is happening with specific student, having the whole picture, families not having to meet lots of different professionals with different approaches to their problems' (SENCO)

'Addressing problems early, dealing with problems, helping to change the child's environment so they can come to school and benefit' (Learning Mentor)

4.4 North Shields, Tyne and Weir

4.4.1 Context

The area covered by North Tyneside local authority has a mixed socio-economic profile, ranging from poorer estates to more affluent coastal resorts, and some rural areas. This is reflected in the contrast in schools, with four particularly disadvantaged wards (Ofsted, 2001). The population is predominantly White British with only 1.4% of school children from minority ethnic groups which is fewer than the national average. Recently there has been an increase of refugees and asylum seekers in the area. One school visited was in a 1960s New Town, which was described as predominantly working class. Workers drew attention to problems of family dysfunction and poverty, and a high proportion of single parent families.

4.4.2 Structure of CAMHS

The CAMHS visited is the Child and Family Psychiatry, part of the Northumbria NHS Trust, child health directorate. This is a joint Tier 2 and 3 service which is split over two sites. It is resourced by two psychiatrists, psychologists, CPNs, specialist social workers and a range of therapists including an art therapist. It is co-ordinated by a service co-ordinator, who is also a CPN. Tier 4 services are provided in specialist units, for example, the Nuffield Unit and young people's unit, NewCastle -Upon -Tyne. The main work with schools is via the Behaviour and Attendance Support Service (BASS). This was set up in 1999, amalgamating education support services, and includes specialist support teachers and assistants, Education Welfare Officers, family support workers and two Community Psychiatric Nurses (CPNs) seconded from the CAMHS service. It has a multi-agency management group and has staff seconded from children's services (SSD) and health. The two nurses are funded by a Health Action Zone. They are managed on a day to day basis by the head of the BASS and have clinical supervision from the Child and Family Psychiatry (CAMHS). Initially, the psychiatrist and psychologist from CAMHS spent one day per week on site at BASS as a resource to the team, but this was found to be under-utilised. One of the CPNs has recently been seconded further to work exclusively in one secondary school and its feeder primary schools (funded by Education Action Zone for 30 hours a week spending the remainder of time in the BASS). This link with the school predated the BASS team, and had originally been set up by the head teacher who contacted the CAMHS team directly. The Educational Psychology Unit is based separately from the BASS. Both units are managed by the Pupil Support Manager and meet on a weekly basis.

4.4.3 Practice

Referrals come to the BASS team from schools – from head teachers, heads of years or SENCOs. A teacher from the BASS team visits to make an assessment and the referral is reviewed and allocated at a BASS meeting at which point they may be passed to the CPN. The CPNs also conduct joint assessments with other members of the BASS team. Referrals may also come via Child and Family Psychiatry from the child's doctor.

The CPNs conduct a range of interventions the vast majority of which take place in school settings (an estimated 10% would be in the home). These consist of individual work with pupils and their parents, and group work with children with identified problems. They also conduct joint home visits with EWOs. The BASS team covers 11 secondary schools and their feeder primaries and the two CPN based in the BASS (one post currently vacant) cover half of the area each. The interventions are normally time-limited to a weekly session over six weeks, but can be extended when necessary. Individual interventions include art therapy, cognitive behaviour therapy, work on self esteem, and counselling. Parent groups were set up and run jointly with school nurses initially in schools, but have subsequently been moved away from schools. The group work involves social skills training and anger management training and teachers are given support in terms of managing children's behaviour.

One CPN who is based in a secondary school is able to provide more intensive support. This includes running six week long social skills groups (for up to eight children at a time) for each year group. Special support assistants and learning mentors are involved in running these groups.

Other CAMHS support to schools includes training school nurses, including in cognitive behaviour therapy, and regular supervision meetings with the CAMHS team. A nursery nurse based in CAMHS conducts social skills training for children in early years settings.

Asylum seekers.

Although this area is predominantly White British, there has been a significant number of asylum seekers moving in to the area in recent years, and estimates vary between 80 and 130 asylum seeking children are in the County. A CPN and an EWO have been working together to provide a service for this vulnerable group and proposals for enhanced support have been integrated into the most recent Behaviour Support Plan (still in draft form for consultation). They found that asylum seekers do not know what help is available or how to access it and that many are reluctant to come forward as they are often wary of professionals. They realised that pro-active work needs to be made within the refugee community to break down barriers and raise awareness of services that are available, and have been conducting outreach meetings with groups. One of the main issues that they have identified in the community is that of serious trauma.

4.4.4 Evaluation and outcomes

This service has not set up a system of formal evaluation. The main impacts of the project as reported by interviewees were better and smoother access to services, better understanding of both teams of the resources available, so that the families and children get a better service; an earlier intervention and being able to understand the pressure that children are under in school settings.

4.4.5 Feedback from interviewees

Feedback from the school staff were positive in terms of the impact the intervention had on children, the faster access to mental health support and the overall support provided to children, teachers and parents.

'I think it works very well...I'm a great believer of working in this way. Before we had no service at all, it was either put up with the children or exclude them. I can refer straight away to come and get sensible advice.' (Head Teacher)

'Ffast route for me - open door to services. The CPN comes at (the issue) clinically and gives it another perspective.' (SENCO)

'It is more effective working in tandem. Teachers can do damage without meaning to. they can't tackle the range of different problems that a nurse can help with. The staff trust and rely on (the CPN). They can see successes with groups and individuals.' (Head Teacher)

The case studies described above give an idea of the range of services and structures provided. The report goes on to discuss some of the issues that were brought out in the research.

5. ISSUES IN JOINT WORKING

This section explores the key issues raised by interviewees in the case studies, respondents from the survey and findings from the literature review on factors that helped or hindered the process of joint working. They range from structural and management issues, to cultural difference and practice issues.

5.1 Structural and management issues

Key points from this section:

- shared location;
- good links to LEA;
- commitment of chief officers and middle management;
- tradition of working together;
- joint training;
- values and ethos of service;
- different expectations and referrals;
- having clear aims and objectives which are shared amongst the teams, planning time;
- adequate resources and reliable funding;
- avoiding protectionism over budgets;
- relationships with social services departments.

5.1.1 Structure of service

The structural arrangements for each case study area were presented in Chapter 4. The key structural issues which related to joint working are summarised below. The case studies had a variety of different structures. Some were based in locality teams, some had both LEA staff and NHS staff located in the same offices. They were all using a tiered approach to their CAMHS structure, and services to schools were mostly made up of Tier 2 and Tier 3.

They had different **relationships with the LEA support services**. In Cornwall they were a joint service between the CAMHS and LEA service. In Portsmouth and North Tyneside, CAMHS workers were being managed on a day to day basis within the LEA; by Educational Psychology or from the head of the BASS service. In Southwark, other than occasional joint agency meetings and consultation on the ground by workers, there was no structural link with the LEA. The Education Action Zone was playing a key role in resourcing CAMHS work with schools and facilitating the partnership. It played a key role in identifying schools to work with, and negotiating access into the schools. The close linkages with LEA support services facilitated access into the schools. In Cornwall, schools were most likely to refer to the CAMHS service via their existing contacts such as the advisory teachers, Educational Psychologist or EWOs.

One important element of the structure appeared to be **joint location and shared offices**. All those who were in shared offices between health and education

emphasised the importance of this, as it led to better communication, especially informal communication.

'I can catch (CPN) as he walks down the corridor. I'm a huge believer in multidisciplinary teams. Everyone has limited expertise. Children have multi- disciplinary needs and we have here multi disciplinary knowledge.' (LEA manager)

One of the advantages of sharing offices with people from other professions was that it increased learning. Although this might seem simple, creating joint teams in the same location also had its difficulties (often about allocating space) and could be hindered by external policies. For example, in one case study an EBD advisor talked very positively about sharing an office with a clinical psychologist, and the learning experiences this gave him. This was disrupted when budget allocation meant that phone lines could not be shared between the two services, and they were subsequently relocated for administrative reasons. Simply putting people together in the same office is not enough in itself however.

Linked to being in joint teams was the issue of having the **same geographical boundaries** for the CAMHS service and the LEA or school pyramids. This was identified as helpful in Portsmouth and Cornwall. In North Shields, this issue was resolved by placing staff in the LEA support service. Having teams based in area localities also facilitated a closer match to school catchment areas or pyramids.

In every case study, the work conducted with schools has been a **Tier 2 or Tier 2/3 service**. This tiered structure has facilitated this work and made appropriate CAMHS staff accessible to schools. In Portsmouth and Cornwall these tiered approaches had been applied to other services in the area (Education and Children's Services Plans respectively).

In all case study areas the importance of having **strong commitment to the process by senior managers** was stressed, needing chief officers committed to joint working. This was facilitated by certain national policies pushing towards joint service provision (Together We Stand., HAS, 1995). In three of the case study development plans (either CAMHS strategies or Behaviour Support Plans) there were stated aims to work jointly with other services.

Joint training was also important to facilitate joint working.

'If we were to do this again I think we should have put more emphasis on helping people define what they do and what's unique about their role and how it differs from others so that we're all really clear who does what.[.... Joint training helps – for the whole service once a term'. (EBD adviser)

Three of the case studies identified the **tradition of working together** in their regions as being important. This meant that staff had experience of joint working themselves and a personal commitment to it. Working jointly is facilitated by a better understanding of each other's priorities and pressures.

'Working in multi-agencies you have a better understanding of the challenges the others are faced with. Health workers have definitely enhanced the provision and broadened the experience within context of education.' (LEA senior manager)

In North Shields, there had been staff exchanged across the sectors – the previous head of pupil support in the LEA had moved on to be Head of Children's Services (SSD), and the current head of pupil support had worked for the health service. Staff in three areas also identified that being quite a **small service** helped staff to get to know each other.

Workers also stressed the importance of **the values and ethos of the service**. This mostly revolved around commitment to helping children, and putting the child at the centre rather than the needs of the service.

5.1.2 Management arrangements

Management arrangements were highlighted as key problems, especially in the three areas where there was management across the different organisations (Cornwall, North Shields and Portsmouth). The two different agencies, health and education, have different traditions of management style, salaries and terms and conditions. In North Shields and Portsmouth health staff were seconded to education departments , and in Cornwall, health and education staff were in locality teams jointly managed by health and education. In Southwark, mental health staff were a specific schools team within the Tier 2 CAMHS, and were linked into the EAZ. These structures are complex to manage, and several managers identified this as a problem. In the first three situations workers had two managers – day to day line management in their locality teams, often from the other service, and professional (clinical) supervision from their own organisation. Where services have been brought together, there was some controversy about different salary scales, and terms and conditions between two organisations. Having joint working as part of people's job description and assessment process is also important if it is to be a respected part of their job.

5.1.3 Different expectations of the service and appropriate referrals

Different expectations and understanding of the services provided seemed to be an issue on various levels in each case study area. Almost all interviewees discussed the issue of expectations of the service and inappropriate referrals. Two of the services in the case study areas (Cornwall and North Shields) had the experience of launching themselves as a new service, when in fact they were simply re-organising the existing provision, and adding one or two members of staff. This had raised huge expectations amongst schools and clients.

Health workers became inundated with referrals, many of whom were referred for being disruptive in a classroom, but were not necessarily in need of therapy. Some workers who regularly went into schools felt that they were prone to be used as a 'sin bin' where naughty children were sent. Mental health workers also described being asked to talk to children who seemed upset, but without the worker having a proper referral or a chance to contact the parents or work with the family. From the school's perspective, some were uncertain of what they could actually expect from the services, and having referrals turned down left them feeling let down and frustrated at having to turn to other sources of advice and help.

What can seem like intensive level of support to a health worker (weekly sessions over 6-8 weeks with a child and family) with six of seven children in any particular school, may seem like a drop in the ocean to a class teacher or head teacher who has over a thousand children. This was reflected in different perspectives between some teachers and health workers about the level of provision. For example, one deputy head in a school where the health team felt they were doing very intensive work felt that there was very little input.

These problems are not necessarily a feature of working in this way, and indeed they are more likely to be resolved in this approach. The methods that the workers found for resolving this were good communication with the school staff at all levels in terms of what they could offer, clear referral routes and criteria for the service. This was also assisted where there was a range of support for children, not just the mental health worker, for example, with learning mentors and learning support units within the school, and where support was well co-ordinated across the LEA and health service, and alternative ways of assisting the child or school could be established.

5.1.4 Planning

All staff emphasised the importance of planning services and having clear aims and objectives of what is intended. In Cornwall, two senior members of staff were seconded to research and plan the new service for several months. It is a difficult balance to strike between being rigid in terms of direction and policy making and yet being flexible enough to adapt to working on the ground. Much of the good practice develops organically from workers and this needs to be allowed to happen. It is important to develop existing structures rather than overwhelming workers with dramatic changes. It was stressed that having regular reviews of the aims and objectives of the service and particularly the joint working element was important.

5.1.5 Resourcing

Resourcing was also felt to be a key issue, in terms of level of funding, sustainability of long term funding and methods of allocation of budgets. From the questionnaires, the reasons given for not working in/with schools were mainly resource constraints – either that they are a particularly small team, or that they were over stretched dealing with their existing case loads. Estimates of the proportion of resources spent in working this way by questionnaire respondents were quite low – over half were less than 10% and the average was 15%.

In the case studies, many services felt under serious pressure of restricted resources, especially when their service was becoming more accessible to clients. Many health workers felt overwhelmed with the numbers of referrals and disillusioned when they saw the level of need in the communities they were working with. One service identified that being in a well resourced Mental Health Trust facilitated their ability to work in this way.

The positive impact of flexible approaches to funding and pooled budgets was identified. In Cornwall, there is a relatively small pooled fund called Individual Solutions. This is a joint fund from education, health and social services and workers can access it for specific cases if they can demonstrate that there is a joint health and education need. This process in itself enhances working across the two sectors. In contrast, protectionism over budgets is seen as one of the major barriers to joint working. One senior manager pointed out the negative impact on front line workers ,who are working collaboratively, to see senior managers disputing over budgets.

The findings from the literature review emphasised that securing reliable funding is very important. In the case studies, the issue of short term funding was raised as a problem in terms of sustainability of the work and recruitment. One short term funded post had to be made permanent before anyone could be recruited to it.

5.1.6 Relationships with social services departments (SSD)

The focus of this research is joint working between health services and education. However, in every area the importance of joint linkages with Social Services was stressed, and interviews were conducted with senior members of social services departments (SSD). All interviewees said that they had links with social services, and several mentioned the importance of Quality Protects and Child Protection Policies (see below under section 5.5). The structural linkages with Social Services varied across the case studies. In one area, the SSD was nominally part of the joint team and provided funding for a pooled budget, but staff had not joined the service. In another area, SSD seconded family support staff to the Behaviour Support Team. Some of the projects visited were joint projects with social services. However, many of the interviewees described working with SSD as being the most problematic area. The problems were described in terms of the enormous pressure social services departments were under, the seriousness of the cases that they were dealing with, and the level of crisis intervention. Staff again emphasised the importance of contact with individual named workers, and this was seriously undermined with the very high turn over of social workers experienced in these areas. Similar issues of joint working were raised in terms of protocols for sharing information and confidentiality.

5.2 Different working cultures

Key points in this section:

Identifying difference between schools and CAMHS ethos, the implications and possible solutions across:

- relationship with children;
- understanding of mental health issues;
- understanding of other resources available to schools;
- attitude towards children's behaviour;
- working with families;
- information sharing and confidentiality;
- management arrangements;
- expectation of service;
- accessing service;
- policy aims/ pressures;
- length of intervention.

The literature review identified that it is exceptionally challenging working across different sectors and different cultures of organisations. These challenges have been raised in every case study area. The chart below outlines some of the differences between the two organisations ethos, context, aims and priorities of the services. These have implications for joint service delivery, and many of the issues identified in this section such as different expectations of the service can be understood by these differences. This has been drawn from the interviews and documentation. Both health staff and education staff explicitly identified working cultures, attitudes and practices that were different across the organisations, and what they had done to overcome them. Other material has been identified by the researchers' analysis of the data. It is not the intention to polarise different positions, and clearly these are generalisations within which there is great variation, nor to imply that one approach is preferable to the other. Most of the interviewees had identified and overcome these problems in the course of their work, and may have been reflecting on past practice or experience.

Issue	Schools Ethos	CAMHS Ethos	Implications	Potential solutions
			1	
Relationship with children	Works with large class sizes, role is to educate. Has to balance the needs of the whole class with those of individuals.	Work with individuals or small groups. Role is to address individual children's needs within the context of their family.	Recommendations from health workers can be unrealistic for teachers or school. Teacher's priority is to find a way of including the child within the context of the classroom.	Health workers in schools can get a better understanding of the context that the child is in. Closer links between health services and LEA / school support services, such as Educational psychologists help bridge this gap. Work together to identify ways of managing children's behaviour and identifying structural problems such as teacher/ pupil interaction
Understandin g of mental health issues	Teachers are more likely to identify and respond to externalising behaviour in children than internalising, which may not be picked up on. Tend to understand mental health problems in terms of SEN Code of Practice.	Interventions are individually or family focused and may emphasise working on internal and/or external processes.	Harder to identify early intervention and internalised problems.	Better collaboration between health services and teacher support services – better understanding for teachers. Teachers can express concerns informally to school based staff without referring to health services. Health workers in school can identify and assess children.
Attitude towards children's behaviour	Discipline is important to maintain. Disruptive behaviour presents enormous problems. Strict rules and high expectations of behaviour (no swearing, dress code, respect).	Intervention focus is on attempting to understand why children are challenging rather than controlling their behaviour. Rules during intervention may be different – emphasis on self expression. For example, children may be allowed to swear.	Conflicting ideas on how to address children's behaviour. Health staff may be seen to be rewarding bad behaviour which undermines the teacher's authority. Health staff may feel that teachers have too high expectations of the child in difficult situations. Children may be confused by different rules applied (especially if both on school grounds)	Working together – health staff can explain childrens' behaviour to teacher and explain / consult with the teacher about the strategies that they are giving the children, so teachers can use them too. Teachers can work with health staff to show implications of their strategies on classroom. Work together to find ways for teachers to manage response of rest of the class to special treatment

Table 8 Different working cultures between CAMHS and Schools

Issue	Schools Ethos	CAMHS Ethos	Implications	Potential solutions
Working with families	On going relationship with parents is important and delicate. (Schools may worry about upsetting parents). Parents may have had bad experiences at school, and a poor relationship with school. Boundaries about what parents will tell school. Teachers may attribute children's problems to parents.	Ethos of interventions is that engagement with the family should take place when possible, particularly with younger children. Parental consent is required for work with children, except where adolescents are seen as "Gillick competent" and able to consent themselves. Interventions may include family therapy or may be focused on individual work with child or young person or work with parents.	Schools may be reluctant to refer in case they are jeopardising their relationship with parents. Teachers feel frustrated if they persuade the parent to refer to service, and then the parents decide not to attend; the child is not getting the service.	More immediate access to service for parents Home / school mediation role by mental health staff – seen as independent Parents see co-ordinated attempt to help the child. CAMHS staff can help the child by supporting school staff.
Information sharing and confidentiality	Variety of attitudes towards confidentiality. It may not be a high priority.	Strong ethos and legal requirement of confidentiality. Under the Data Protection Act 1998, information can be shared as long as the parent/carer or their child has given their informed consent. Will only discuss cases with other professionals with child/ family's consent, unless there is a child protection issue or there is a serious risk to the child's health.	Schools feel that they contribute by referring pupils but then feel frustrated that they are not informed of outcomes. Health workers fear passing information back to schools as it may jeopardise confidentiality.	Greater trust built up between workers, school and parents. Joint meetings. Negotiation of consent with parents and school. Joint protocols for information sharing. Increased understanding of each others policies and practices in relation to information sharing
Management	Tradition of day to day management by own profession – e.g. Educational Psychologist managed by Senior Educational Psychologist.	Management roles are often separated with day to day management by team manager and clinical supervision.	It is complicated to establish joint management.	Secondments.

Issue	Schools Ethos	CAMHS Ethos	Implications	Potential solutions
Expectation of service	High expectations of the service - that a child can be 'cured' by drugs or intervention. Often want child to see psychiatrist. Want to see improvement in external behaviour.	Often identify a different problem to school. Has different expectations, and won't necessarily focus on behaviour – might emphasise self esteem or unhappiness of child. For example a child's behaviour may become more challenging. They may identify systemic problems with school ethos or teacher-child interaction.	School is disappointed in service as they do not see noticeable improvements in behaviour. Inappropriate referrals to health worker, who get overwhelmed.	Better communication. More information about referrals and kind of therapy available. Health staff explaining what to expect from intervention.
Accessing service	Schools are compulsory. EWOs have statutory authority re school attendance. Sanctions if a child doesn't attend (e.g. a class)	Opt-in service. Philosophy is that interventions are only effective if the child or family are willing to engage. No sanctions if child doesn't come to a session.	Children who are particularly at need at risk of slipping through the net.	EWO supported by health worker can facilitate engagement (joint visits).
Policy aims/ pressures	National curriculum academic output, best value	Clinical governance, duty of care.	Policies pulling in different directions.	Joint working at strategic level, so can understand each other's priorities and pressures. Identify joint areas of working.
Length of intervention	Long term intervention – statementing tends to be for a period of a year at a time, often for longer. Files may remain open on a child over the whole period of their school career	Emphasis on time limited intervention. Close file after intervention.	School may need more on-going support for the pupil	Multi-agency approaches can identify a range of different support for children.

5.3 Practice issues

Key issues in this section:

- personal and professional skills of staff and the importance of knowing individuals;
- features of schools;
- good communication within teams, between different agencies and with clients;
- sharing information and confidentiality issues;
- spending time in schools;
- working in different contexts early years, primary and secondary;
- working with parents;
- services for minority ethnic groups.

5.3.1 Key role of staff

'What you're looking for is people with clinical skills but also open to systems change and institutional responses, and teachers who recognise kids have needs beyond the process of learning - realise the emotional social issues that the kids bring to school that block their learning. Getting a form of service delivery that transcends existing boundaries between agencies' (EAZ manager)

Interviewees were asked what were the things that helped or hindered joint working and the intervention they were involved in. The importance of individual members of staff came up in two main ways, firstly, the personal and professional skills of staff and, secondly, knowing people personally and being able to refer to them by name. The personal and professional skills mostly referred to the health staff who were implementing the projects, partly because they were the ones crossing the boundaries into the schools. The school staff were also discussed, but to a lesser extent, rather the ethos and attitude of the schools was highlighted.

Personal and professional skills of CAMHS staff

Throughout the research, the importance of staff's professional and personal skills was highlighted. This was emphasised in the findings of the literature review and stood out in the case studies as people continually referred to particular individual health staff's skills and abilities. Good professional skills and a good understanding of mental health issues are important, but the skills that were emphasised for this kind of working were working creatively and flexibly. The skills of health staff that were outlined were:

- the ability to work flexibly and creatively;
- a commitment to helping children (rather than focusing on the needs of the service);
- confidence in their own skills and experience;
- to be able to work in unfamiliar environments and adapt their way of working;
- professional respect;
- being able to pool professional territory and to recognise that they have different but complementary skills;

- being friendly and approachable;
- being self motivated and tenacious;
- not being arrogant and willing to listen to other ideas;
- experience and commitment to working in a multi-disciplinary way.

'Being open to resolve barriers and struggles, not being too precious, being sympathetic and not arrogant or fixed on what you are offering but being confident, professional but friendly.' (Mental health worker)

It clearly is not an easy task:

'Tolerate being treated badly. It takes a long time to build up relationships. You need to realise that experience and training should inform that'. (Mental health worker)

Both sets of professionals, health workers and education staff, need to feel that their work is respected and valued, and where it works successfully this clearly has been the case. Many interviewees discussed their co-workers by their first name and talked about their approaches as personal attributes.

'She's the right kind of person. She's very skilled working with young people, not all cpns are like her. They (children) all like her... I considered getting counsellors but I'd rather have her.'. (Head teacher talking about mental health worker)

Some interviewees compared the current working relationships they had to poor working relationships they had in the past. In these examples, they are talking about poor approaches from health staff working with schools.

'Working with(cpn) is best. S/he's got good links into the medical side. 5 yrs ago I'd given up on every psychiatrist I know. Health whisk a child away and do something confidential, no information comes back as to what is happening. But the (cpn) is not like talking to a brick wall. Two psychiatrist now ask me how it's going and ask me to monitor rhetolin and actually listen to me if I make suggestions. The cpn is part of that process - halfway house fast route for me - an open door to the services.' (SENCO)

'Schools have a history of professionals coming in arrogantly and feeling they know it all. All schools want services like us but maybe too many problems to have the time to allow us to come and meet.' (Mental health worker)

Knowing individuals

In addition to staff skills and methods of working by staff, knowing the relevant person by name was important. Building up relationships with individuals across departments seems very important. Teachers and SENCOs lamented frequent changes of support staff (this was particularly aimed at social workers with whom there seemed to be a fast turnover). Some interviewees emphasised the importance of social contact in non-work time to allow people to get to know each other. The importance of staff continuity has significant implications for retention and recruitment of staff and of short term funding. 'You need long term funding and the same people on an on-going basis. Some people move on but they should minimise re-organisation. It depends on personalities, you need trust and respect... you need social contact, if you know someone you are more tolerant of their ways.'. (Deputy head)

5.3.2 Features of schools

When asked what facilitated joint working, many of the health professionals in the case studies identified key features of schools that helped them work effectively. Many made reference to the ethos of the school being very important, and the attitude of the head teacher was vital.

Key factors were:

- that the school was open to other professionals and value the external input;
- had good communication systems within the school about pupils;
- prioritised pastoral issues and children's well being;
- that could make private office space available for one to one sessions with children, and space for groups;
- clear coherent management structure;
- size is important: it is easier to work with smaller schools to get to know the staff group;
- ability to allow teaching staff to meet with health professionals to discuss children.

Other important, but less clearly tangible issues, were about the attitudes of teachers. Some identified schools where teachers seemed under so much pressure they are too stressed and busy to be able to focus on children's welfare.

'I've been in a staff room where people are unable to talk because they feel so pent up and are in tears' (CAMHS manager)

Health and education staff both talked about the importance of differences between schools and the attitudes of school staff, although they were discussed less often than the attributes of health staff. For example, one health worker attributed much of the success of a health promotion package to the particularly good teacher who integrated the terms, rules and problem solving aspects of the sessions in the rest of her teaching and listened to the children. Staff of the schools visited (who had been selected as positive examples by health staff) emphasised the priority they put on their ethos of pastoral care. Some health workers valued teachers' ability to acknowledge the progress that children may have made and not labelling a child early on. Health staff also emphasised the importance of being welcomed by other members of staff, such as the school secretaries, and being welcome in the staff room.

5.3.3 Communication

Good communication was deemed as essential for good practice. This was on many levels, good communication within teams, communicating clearly between health and education staff and communicating with clients.

Good communication within teams when taking on a new way of working – was emphasised, that the vision and rationale for this way of working needed to be

communicated well to all the members of service. This was especially important when new multi-disciplinary teams were being created, when roles and skills needed to be clarified.

Communications between health and education staff were stressed as very important. It was stressed by both health workers and teachers that they needed to know what was available from the service and the role of the workers. It was emphasised that it was important to try and communicate this to all levels of school staff, and not necessarily only relying on the SENCO or head teacher for referrals but to have discussions with the entire staff group. This was particularly important if there is a high turnover of teaching staff. The importance of informal chatting and networking was raised, and for health staff to become part of the staff room, for example. Schools emphasised needing feedback after a referral was made, and to know what input is happening to the child or their family. Likewise, feedback from the teachers about how children are progressing in class was seen as important. One school facilitated this by giving school staff, particularly class teachers, time out of lessons to discuss issues.

Communication with children and young people is also key, letting children and young people know what is available, providing open access and drop-ins. Mental health staff felt it was important to show that they are not necessarily part of the school and will not take on a teacher's role. The term psychiatric for the nurses was felt to be an impediment as it is off-putting to the children and parents, and in danger of labelling the child for teachers.

5.3.4 Sharing information

A key issue raised was that of sharing information about individual cases. Although in general, this practice was felt to facilitate better service provision, there were sensitivities for parents and children who may not wish information to be shared across the services. There is a difference between health and education services cultures of approaches to information sharing and confidentiality. This is also an issue with social services who have different approaches again. This requires a build up of trust in terms of staff.

Different ways that this was resolved were having shared files, with separate confidential sections in them for health materials or getting consent from the parents for a specific list of people who might have access to the information.

5.3.5 Spending time in schools

Mental health workers stressed the importance of spending time in schools and the value of informal communication. Being part of the staff room facilitated a greater understanding of the health worker's role for the teachers and allowed for informal discussions about the work. Health workers stressed how important it was to recognise the rigid timetable and structure that school staff are subject to and the need to be flexible themselves, for example, by catching them as they are using the photocopier, or in the corridor. This close working and spending time in the school also gives health staff a better understanding of the context of children's, and schools staff's lives in schools.

The issue of whether to actually be based in schools or not is another relevant debate. To be effective, health workers need to be accepted in the school and vet retain the support and clinical supervision of the CAMHS team. The importance of being part of the health team and getting clinical supervision and support, was emphasised very strongly. It is a difficult balance to maintain, especially when they have different working cultures. One service had started out with staff individually based in schools, but found that this was not effective. This was changed to teams of two staff working together across two schools. This facilitated mutual support and provided more sustainability in the case of staff turnover or sickness. In another service, one CPN has started to work based in one school full time. This is at the early stages and she has worked with this particular school as part of the joint behavioural support system for three years previously. Although it is at an early stage, she has found that children are slightly less willing to visit her as she becomes more known in the school and is identified as a member of staff. There is concern that meeting with her might be come more stigmatising and children have asked her if she is going to start behaving like a teacher (e.g. tell them off). To counter this, she is ensuring that she remains casually dressed, insists on being called by her first name and ensures that she does not instil discipline.

5.3.6 Working in different contexts

Whilst the majority of the CAMHS who returned the questionnaires were working in secondary schools, the case study participants felt that working in primary schools was easier and more accessible. This was attributed to the more nurturing environment in primary schools with a higher priority given to children's emotional well being, the importance of early intervention and the restrictions of the school curriculum in secondary schools. In addition secondary schools are larger and have a more complex management system which can make relationships harder to build. Working with parents was harder in secondary schools where parents seemed reluctant to attend parents groups. One case study area tried to set up a parents group and failed. On the other hand, it was pointed out in one case study that in secondary schools it was important to have a service that young people could access independently of their parents, and that this was particularly key for rural areas. Many interviewees stressed the importance of supporting the transition from primary to secondary schools, and some CAMHs teams ran groups specifically to meet these needs.

5.3.7 Working with parents

The relationship with parents was a key issue. Schools and education authorities and the CAMHS tend to have different relationships with parents, and most of the case study interviewees were sensitive to these differences. School staff emphasised the importance of the relationship they had with parents, and the delicate balance that this could represent. They all acknowledged that there was information that parents and children would want to keep from them and respected this. However, most teachers also stressed the huge impact that home life had on the mental health of children and the likely effect they would have on children's ability to participate fully in school.

Mental health workers have a strong ethos that parents need to be involved in any therapy or intervention with a child. In many cases the model of working closely with the school provided a useful bridging and mediating opportunity for parents and schools where there had been a breakdown in communications. However, the issue of confidentiality and information sharing was raised.

There were different experiences and opinions on whether services in schools were more accessible to parents. On one hand, the school is local and easy for parents to come to, particularly in rural areas. Both health and school interviewees felt that school based services can be less stigmatising as they can say they are going to the school for a meeting rather than going to a clinic. On the other hand, many workers found it very hard to engage parents and several had tried to run parents groups and failed. Some parents groups were deliberately re-located away from the school to other community facilities. This was a greater problem in secondary schools than with early years and primary schools.

5.3.8 Services for minority ethnic groups

Few respondents to the questionnaire gave examples of specific work with children and young people from minority ethnic communities. A few examples are:

'assessment of individual children, attend SEN reviews, school based intervention, regular consultation with SENCO at 1 school, developing and managing school based project for Bengali girls and boys' (questionnaire)

'part of 2 multi-agency projects working with Bangladeshi boys and girls. Individual and group work directly with children and young people' (questionnaire)

Findings from the literature review highlighted the need for training with staff on issues of working with minority groups. In the case studies, few of the interviewees had been given training on specific issues of working with minority groups, although many expressed awareness of the make up of the community they worked in and the impact of their own background might have on their work. The manager of one service with a high minority population stressed the importance of ensuring that mainstream services are appropriate and applicable for all members of the community the more accessible they would be. Although making mainstream services as accessible as possible was a priority, the service did recommend Black young people to a specialist project run by a voluntary organisation. This project ran a drop in counselling service in schools and ran out of school education and counselling. Mental health assessments, where necessary, are made by an Afro-Caribbean child psychiatrist.

Other respondents from the questionnaire outlined specialist provision for minority groups. One example is the Map project, which is a joint enterprise between SSD, Schools, Mental Health Service, youth service and the voluntary sector. It is run by a multi- disciplinary team of social workers, youth workers, and psychologists. Its aims are to offer an early preventative intervention service to adolescent Bangladeshi boys and their families, support at-risk boys to use schools and social surrounding and to

offer a culturally appropriate service. It provides outreach and early intervention work. It is developing a service that gives due regard to issues of race, religion and culture through regular staff training and development and use of appropriate resources and close liaison with representatives from the Bangladeshi community.

Last year it piloted a solution focused short term group to develop confidence, selfesteem and social skills of vulnerable and failing pupils. Youth workers are involved to engage young people in activity groups to develop self confidence. Many of the reasons for referral were education related, for example, non school attendance, persistent lateness and risk of underachievement (highest – 74%). The schools contributed space for individual and group work and staff time. Link workers are given time to discuss referrals and give feedback on the project's development.

A recent interim evaluation of the project found that the structure and organisation of the project within the framework of apposite understanding of race and ethnicity was useful and that this specifically targeted service was meeting the needs of difficult to access young men (Barn et al, 2001)

5.5 Impact of national and local policies

Nearly all the case study areas referred to the HAS policy 'Together We Stand' and using a tiered approach (HAS, 1995). In two of the case study areas this had influence beyond the health service. In one, the Children's Services Plan had adapted it for all services in the area, and in the other the Education Service had adopted it for its pupil support services. Other policies that had positive impact on this work were cited as Quality Protects, Social Inclusion Agenda, and the Children's Fund Grant Processes. Although Quality Protects was mentioned, the Children in Need Assessments was not, which may be related to the problems raised about working with Social Services (see section 5.1.6). Almost all the areas had benefited from an initiative (see below) such as Health Action Zone, Education Action Zones, Sure Start etc. Several managers described the importance of support of national policies to back up this kind of structural change.

'It is useful to have directives to push people to work together. It means people can give up power without looking out of face. From our perspective - mental health the National Service Framework means we just have to get on with it together. If it had to be worked out on a local basis it would be more difficult.' (CAMHS manager)

However, there are policies that constrain this joint working when priorities are different or administrative issues. For example, the Best Value process meant that budgets had to be disaggregated so that health and education had to account for everything separately. One LEA working jointly with health service was about to be inspected by Ofsted which meant that they were concerned about the number of hours the LEA staff spent in school, rather than the work they may have been doing supporting health workers.

The pressures that schools were under in terms of academic performance, league tables and the national curriculum received criticism as being a contributing factor of some of the mental health problems in children. This was seen as the pressure on children to achieve high results, and staff being too overwhelmed to offer adequate pastoral support for children who need it. Teachers had to balance the value of the input that the health professional could offer a child against the need to have them in the class for their academic progress.

'The national curriculum has a lot to answer for; it forced children into sitting behind a desk doing Science and French. It doesn't suit many kids.' (Head Teacher)

'One of biggest restrictions has been the severity of the curriculum. We have to make the choice of how important is it for the child to complete the curriculum and what (worker) can do for them. Greater flexibility is needed. There is pressure on schools for exam results - key stage 3 or 4 even. Teacher won't want to lose them from the class. As long as schools are only judged on their academic achievement it is less easy for schools to work in this way.' (Deputy Head)

'There are changes in education system. Teachers are skilled but the whole ethos has changed - performance tables, league tables - schools are more of a pressure cooker. You've got literacy hour and I've seen children sitting on the carpet who cannot sit still in such a high state of anxiety. And they are expected to sit there for an hour. Kids need playtime.' (Advisory Teacher)

There is significant restructuring going on in both NHS and education services. All the case study services were either in the process of boing, or had just recently been, restructured into Primary Care Trusts. In education a key change is the increased devolution of budgets to schools rather than in LEAs, and schools bidding into the support services.

Although the policies were not referred to explicitly, at least three schools visited in the case study areas were accessing support to work alongside the CAMHS workers. In a secondary school in North Shields, the CPN based in the school was being linked to an onsite Learning Support Centre which was linked to Excellence in Cities initiative. This provided learning mentors for students. In a secondary school in Cornwall they had set up a Social Inclusion Support Worker, called a partial support worker, who runs a small unit to teach children who exclude themselves from lessons by disruptive behaviour or missing classes. This is funded by DfES Social Inclusion funding, and this worker has been providing one of the key links to the Child and Family Service (joint Education/ CAMHS service). In one of the Portsmouth Schools, there were Excellence in Cities learning mentors who worked closely with the Ontrack CPNs working with the school, and had Healthy Schools Initiatives in the area. The linkages with these initiatives is clearly strong. However, there was some signs of confusion and overlapping roles with these different workers.

Interviewees also identified the problem of **short term funding and sustainability**. Many of the case studies did have some form of input from various initiatives including Education Action Zones, Health Action Zones, On Track, SureStart, Standards funds and modernisation funding. These were providing funding for staff and a facilitating role in setting up new projects. Some workers and managers expressed concern about the longer term sustainability of the work.

Concerns were also expressed about the number of Tier 1 services being set up and overwhelming Tier 2 resources to respond (from the health side) and lack of co-

ordination between the initiatives. The expansion of the initiatives was also causing recruitment and space problems.

Other issues about sustainability and funding were how to roll out intensive programmes to other schools. In the case of mental health promotion, some were doing this by training teachers and school support staff and providing supervision for the work to continue. In addition, there is the dilemma of how to allocate resources across different schools. Some approaches were to work with the schools that were most willing and open to support – asking schools to opt-in. However, these may not be necessarily those in greatest need. Other respondents in the questionnaire had targeted schools with highest levels of need, for example, high referrals to CAMHS, or in areas of high deprivation).

5.6 Evaluation

The literature review identified that evaluation is crucial to the development of services, especially with the prioritisation of evidence based practice. Evaluating this type of work, it can be argued is more complex than other ways of working as it entails measuring not only outcomes on children but also the impact of joint working. From the questionnaire, approximately half of those working in schools (75/152) either had evaluated this practice in the past (44) or were currently evaluating (51) or both. Only 30% of the CAMHS are currently evaluating their services, and this appears to cover a wide range of methods and intensity of evaluation.

Evaluation methods we found were:

- traditional pre and post intervention standardised scales for clinical work and group work;
- specific research projects by outside agencies (such as universities, Audit Commission, Ofsted);
- satisfaction ratings for liaison staff, other service providers, and clients. evaluation of the process of setting up a multi-agency project and indicator scales of improvement in behaviour in under 5s;
- monitoring rates of referrals;
- appreciative enquiry (a qualitative action research process);
- less formal approaches such as regular review meetings or informal feedback from staff ;
- specific research projects evaluating primary mental health worker role.

Few of the evaluations asked for children's own perceptions. Some services were working with young people to get feedback, for example, by working with voluntary organisations and youth clubs. As with the principles of joint working, it is important for evaluations to take into account the priorities of all the services. For example, most health driven evaluations would not necessarily include outputs in terms of academic achievement or attendance at school or exclusions unless they are a specific aim of the project.

6 IMPACT, ADVANTAGES AND DISADVANTAGES OF JOINT WORKING

"The work in schools, particularly the discussion groups for staff, are having a very powerful and positive impact on the school environment. Resources are targeted at the most needy and at risk pupils while the staff groups enable a culture of sharing, discussion and reflecting with each other to be developed. This impacts on the way teachers think and react to challenging and worrying behaviour." (questionnaire)

Case study interviewees were asked about the impact of the joint work they were doing and the advantages of working in this way. In addition, 74 respondents to the questionnaire commented on the impact of their work with schools. Many felt it was too difficult to comment on the impact as the resource input was too small, or that it had been running for too short a time. The interviewees may have been referring to particular practice, or to the impact of the structure of joint working. This research is not an evaluation of the effectiveness of CAMHS' role in schools as such, although any evaluations available have been referred to. The advantages of joint working are grouped together in two main sections - the improvement in service delivery and the impact on children themselves. The impact on service delivery includes:

- increased understanding of mental health issues and services;
- early recognition of problems;
- improved access to CAMHS services;
- more appropriate referrals especially for hard to access children.

The impact on children themselves relate to:

- their happiness;
- behaviour;
- academic achievement;
- exclusion and attendance.

Disadvantages explored are:

- greater time investment required;
- management difficulties;
- information sharing;
- getting swamped with referrals;
- keeping professional identities.

6.1 Increased awareness and learning between health and education staff

One of the most important advantages for staff working in this way was an increased understanding of each other's professional role. CAMHS staff learnt about the context of education staff and their work. The CAMHS staff identified an increased awareness of mental health issues, and services among school staff. This includes relieving anxiety about mental health issues, and about accessing services. Both education staff and health staff who worked closely together talked about the opportunities to learn from each other, especially if they worked together on a regular basis. For example an advisory teacher and an education welfare officer felt able extend their role to conducting some behavioural therapy with young people with the back up of the health workers in their teams. This was recognised by senior managers:

'Education Welfare Officers are an interesting case- giving them professional support has brought out skills they didn't know they had. They are involved in counselling and training which they wouldn't have done before if they had kept within the tramlines of their work. Wider network allows greater professional development.'. (Senior LEA manager)

A class teacher who had health staff coming into the classroom on a weekly basis doing a social skills class talked of the break it gave both the children and herself, and the opportunity to learn from the approach of the health staff. In another area, health staff identified that joint visits enabled education staff to learn what kinds of questions to ask to identify potential mental health problems.

'CPNs know more about health services and resources. I know more about education. It has been useful. It is always good to have a second opinion of a case. Our work can be very isolating, you can pick things up that the other one misses.' (EWO)

Health staff also discussed learning about working in a school setting, which gave them a greater understanding of the stresses that teachers were under and the pressures that children were experiencing.

'We can't advise teachers on behaviour in class - we don't know how to deal with it ourselves. We can work jointly. It's been quite humbling - we work through ideas together. I had never worked in school before and it is useful to learn what is really happening in schools.' (Mental Health Worker)

'It has been helpful to understand difficulties schools are encountering and support the teachers.' (questionnaire)

Increased joint working and communication also made staff aware of the resources available. Health staff learnt about education resources, and education staff were more aware of what was on offer from the CAMHS.

'We are learning the education systems - we know what they are entitled to, and understand what they mean by individual education plans. People get better services because we all know what resources are available.' (CAMHS staff)

Teachers identified that health staff brought a different perspective on problems and enabled them to learn different approaches to dealing with difficulties.

'It gives a teacher time out from children and new ways of dealing with issues.' (Class teacher)

'I can refer straight away and get sensible advice. It gives us something to offer parents - we run out of our own tricks and they respond to other professionals.'

'You get completely different insights - see things in a different way. For example I was trying to get child to behave well before allowing him to move to another class. The CPN tactfully pointed out that the relationship with the teacher had broken down so badly that he should be moved. They have a trouble shooting role and gives a lot of help and advice and alternative plans.' (head teacher)

These findings were re-iterated in the evaluations. For example both in Southwark and Portsmouth, having linkages between tier one staff (including schools) and CAMHS, Tier one staff felt more confident about mental health issues (see Chapter 4).

6.2 Impact on children

This section draws on the evaluation materials available from the case studies, comments on the questionnaires and interviews from the case studies. Unfortunately ,not all evaluations were complete and outcome data is not available for all areas. All interviewees were asked about the impact of the work and were prompted for impact on peer relationships, behaviour, academic achievement, school ethos, attendance and exclusion. Some described the impact by giving examples of individual children.

6.2.1 General impact on children

Many interviewees described the positive impact that the work had on the children in general – their happiness.

'We and the schools have witnessed great changes in young people using the group facility. The groups give young people a sense of identity, support and a place of safety. The young people value their group, and many have developed new skills in terms of communication, developed greater insight into others and formed healthy attachments to adults.' (questionnaire)

'Other children know they are getting special treatment and know that they aren't being left high and dry. You see children smiling - desperately unhappy children smiling and you can't measure that. Children who are violent, trying to do something about it and using strategies.'. (Head teacher)

6.2.2 Children's behaviour

The majority of those who were asked said that they saw positive impact on children's behaviour and their peer relationships. Evaluations of Scallywags showed improvements in children's behaviour and parental stress on standardised measures, as had the clinical work in Southwark. In the latter, the improvements were seen to be sustained over a one year period.

'The project meets them, counsels them and gives strategies to change their thinking and what to do if they are upset. Sort of thing we do all the time at school but this has a cognitive feel to it. It hasn't stopped the behaviour, but children now understand why they do it. They don't fly off the handle when challenged by someone.(...) I find that now children are more willing to talk. One child had got worse since the project.' (head teacher) 'Within the group you see them behaving like that on a very high level. They'll be building fires, cooking sausages. Those more withdrawn are really coming out. For example a child suddenly for the first time taking part in an assembly. People just fell over with surprise.' (Head teacher)

'I would say 85% of interventions have made an impact in behaviour relating to other children and anger management. Most have changed and, most have sustained that change. Definitely avoiding exclusions.'. (Head teacher)

One Head teacher questioned whether the children on a social skills and self esteem programme did use the strategies learnt in other areas of their lives (citing them cycling along the road dangerously after the session).

6.2.3 Academic achievement

Mental health and academic achievement are linked, but it was harder to identify a definite link between the interventions and academic achievement, as few services were evaluating this and data was not available. However, responses to this were that if the children were happier they were, the better able to learn, and were better able to concentrate on their work. For example, one deputy head teacher felt that the children's thinking skills were being developed by the approach of the intervention and that this would impact later on their learning. Another head teacher identified that the children out of the classroom described the positive impact that this had on the achievement of the others in the class as well as their own. However, another teacher expressed the anxiety of children missing time in classes to be with the worker.

'If pupils are not overloaded with emotional problems and distress they are more able to attain'. (Mental health worker)

'One girl in yr 1 (S) bashed other children and was socially isolated. Mum would come in and scream at the teacher in front of class. The EWO initially and then the CPN together worked with S and her mum. It worked... The CPN doesn't look like a teacher and is willing to listen. Afterwards S got grade 2 in SATs, had more friends, looked happier and was smiling. Unfortunately they got driven out of the estate so moved on, but apparently doing well at new school'. (Head teacher)

'Children are getting work done which impacts on their output.' (Head teacher).

'I hope to get academic achievement but can't tell. It avoids exclusion and gets them to come to school.' (Head teacher)

6.2.4 Exclusion and attendance

Many of the education staff were particularly interested in preventing exclusion and some of the projects were exclusively targeted towards children who were vulnerable to exclusion. Again this was not being formally evaluated, but the impact on exclusion seemed to be in several ways. Firstly, some children with the support of the intervention adapted and controlled their behaviour. Secondly, the interventions themselves allowed them time out from the situation they were in to give them space, and another opportunity before exclusion.

'Exclusion yes - some children have come close to permanent exclusion and have been supported by the project – it takes the edge off and gives them a breathing space. Gives another door before exclusion. Children feel that they are being looked after by the school'. (Head teacher)

'A girl (N) lashed out at anyone in her way. At the end of school year she was excluded but glad that we kept her there that long. They offered her father support – he was on his own and really struggling.' (Head teacher)

'I saw an impact on the students straight away. Both the group work and the individual work. For example one lad in year 11, when he was in year 9 we nearly had to throw him out. Temper tantrums, totally unmanageable and would blow up in very strange circumstances - couldn't tell when. He's still here. Limited academically but will finish school. He can now cope with school'. (Head teacher)

Attendance was not prioritised in the same way by education staff as avoiding exclusion. The only link was made that the children tended to enjoy the sessions and therefore attendance on the day that it was happening was high. However, with school phobics, clearly there were some examples of an impact:

'One boy had high anxiety - so anxious he wouldn't leave the home and wasn't coming into school. I have worked with him. He's now in twenty out of thirty lessons. I worked with teachers and with him. I would have worked with him in the CAMHS but I wouldn't have got him back into school without support of the teachers. They wouldn't have got him back in without intensive work from me.' (CPN)

6.3 Accessing children who would not normally be reached

Many health professionals described the way this approach meant that they could access children and families who needed help, but who would not normally be reached. This is both in terms of earlier identification and intervention, and accessing those who would not make it to clinical settings. This was recognised by one evaluation that found that young people picked up by the joint working (CPN linked to schools) had relatively high risk factors of leading to further mental health problems. This might be the earlier recognition of problems in children and young people by supporting teachers and education staff to recognise mental health problems, or by physically being in the school, and being able observe and make assessments themselves. For example, one mental health worker talked about watching a child in the playground spinning round and round a pole all through break on his own. This was something that the school staff had not picked up on but she could identify straight away as a problem.

'addressing problems early, dealing with problems, helping to change the child's environment so they can come to school and benefit' (School Counseller)

Beyond the identification of children with mental health problems, children are accessing a service who would not for various reasons come to a clinic.

'reaching children you wouldn't normally at an earlier stage. Being more accessible to children and parents, easier for them to make contact. In secondary a lot of advantages as teenagers wouldn't use any of these services but teachers are aware of them and refer the pupil before it is too late'. (Mental health worker)

'children who would not ordinarily access the service (parent fears of stigmatisation or other priorities) are able to have emotional behavioural needs met to an extent.' (questionnaire)

Some used the examples of high uptake of the service by both parents and children as evidence for this:

'parents are involved happily - clinic normally gets 33% drop out and 45% do not attend. Never had a cancellation yet.' (Mental health worker)

One of the reasons that the services in school are more accessible was attributed by staff to the lack of stigma attached to it. Almost all the staff interviewed mentioned that the service was less stigmatising both for the children and for parents. In a rural context, the importance of the service being physically accessible was stressed.

'having therapy in school is much more accessible. Not as challenging spending half a day going to town and leaving the other children. The parents can drop the kids off, have a cup of tea go and see the therapist. There's so much scope in the school were there to be space and time to support'. (Head teacher, primary school)

'It is not stigmatising - it is the opposite, they know its for their good and other children were moaning that they weren't going.' (Head teacher)

Several mental health workers identified that it also enables the child or young person to be seen on their own territory which they felt was empowering for them. This also gives the health worker some understanding of the context that the child is in, and also allows for attempting to change the education situation if that is the problem.

'problems addressed in the place the children are used to being in. If it is the system that is the problem, that can be sorted out - in the school. Less stigma - its part of the school.'. (CAMHS staff)

The sharing of information and resources mean that there is improved access to the CAMHS service for children and families. Many education staff described having a 'direct route to health' or a 'seamless service'.

'families get better service, CAMHS staff can draw on other service and share responsibility with school and families.' (CAMHS worker)

(it gives us) a fast track to child psychiatry via the community psychiatric nurse (CPN). The child could have been permanently excluded by the time we get through the system.' (Senior manager, LEA)

'everybody knowing what is happening with specific student, having the whole picture, families not having to meet lots of different professionals with different approaches to their problems, different assessments etc'. (SENCO)

6.4 More appropriate referrals to CAMHS

The implications of the greater accessibility of CAMH service is of increased referrals, and indeed in some case study areas (and some responses from the questionnaires) referral rates had increased, especially from schools. However, the main finding from the case studies is that more appropriate referrals were coming to CAMHS. For example it was stressed that multi-referrals (a child, for example, being referred by their GP and by the school SENCO at the same time) were being avoided. Working in joint teams with shared information means that it avoids different people working with a child without knowing it.

'I just closed one (case) today and it was a young man who came via the health route. I'm not suggesting that his problems were only school problems but the immediate things to do to relieve the situation were school based. That was done very quickly in the first meeting and that was because the relevant education welfare officer was sitting next door and I could say "can you see this child?", and set various things in motion which took care of three quarters of the problem.' (CAMHS Co-ordinator)

One manager where there were joint teams described the rationale for the structure was to prevent the whole concept of 'referral' where responsibility of the case is passed on from person to person. Rather, there is a joint responsibility within the team for the case.

Other workers identified that if a referral was inappropriate, they would find that out straight away rather than having to wait.

'If it is an inappropriate referral we know straight away rather than waiting to get to top of waiting list and then finding out.' (EWO)

6.5 Supportive network for school staff

It was identified that a supportive network was provided for primary care workers, including teachers, which equipped school staff to deal with issues. Findings from the Southwark and Portsmouth evaluations identified increased understanding and confidence in health issues among Tier 1 staff (school staff in Portsmouth). Interview findings supported this from both the health service staff and the education staff. Teachers spoke of knowing who they could go to for support. This led to staff feeling more supported and confident in their role. Other teachers mentioned the impact on their staff when they knew that children with behavioural problems were being seen to be addressed. Several teachers identified the space it gave them when certain children with behavioural problems spent time out of the classroom with health staff for work or therapy. It enabled teachers to concentrate on teaching. Also it allows teachers to discuss problems and 'off load' onto health staff.

'Working together enables really difficult situations to be tackled. If you are on your own you wouldn't tackle it. Families are reluctant to talk about issues it requires huge skill – you get bravery in the team.' (EWO)

'(*We*) got excellent feedback on evaluation, working relations much improved, tier 1 more confident re mental health problems in children and adolescents.' (questionnaire)

6.6 Link between home and school

A further impact mentioned by both health workers and education staff was the improvement in relationships between parents and the school. Many of the workers saw some of their role as mediating between school and home. As they worked with the family, they were in a privileged position to have information to understand the children's behaviour. They represented a neutral person, for both the school and the family to discuss issues with. School staff identified that often parents had difficult relationships with teachers, they may have had a bad experience in school themselves or feel threatened because they have problems with their children. Parents may be more willing to trust and listen to CAMHS workers rather than teachers. On the other hand, the teachers felt that by having this service, they felt that they had something that they could offer to the parents.

'Parents in the community trust her. Her relationship with them is really good. She has access to families in a way we couldn't – the kind of things they won't tell the school for example problems at home - we never get details.' (Head teacher)

'Credibility with families and children is much improved by a multidisciplinary approach. Schools contribution to behaviour strategies and therapeutic work is invaluable.' (Questionnaire)

6.7 Disadvantages

When asked about potential disadvantages of working in this way, many interviewees replied that they could not see any disadvantages, or couldn't imagine working in any other way. However, some disadvantages were outlined:

- greater time investment required;
- management difficulties;
- information sharing;
- getting swamped with referrals;
- keeping professional identities.

Most interviewees agreed that joint working was more time consuming. Some felt that this was the case for managers rather than workers, but they too need to find time to attend more meetings and networking.

'(More time consuming?) Oh yes, quickest way of working of all is to get a referral and deal with it or pass it on and that's the end of it. We don't allow that. You have to

get together and talk about what you're going to do. What the customer wants is immediate response. To say to them" to answer your question I'm going to have several meetings with my fellow professionals to decide what's best" - they don't want to hear that.' (Mental health worker)

Management issues were the difficulties of matrix management, this created potential problems of accountability and responsibility (although no incidences of these were specified). One manager referred to the feeling of having a foot on two horses as he maintained the joint linkage between the two services. It does lead to a more complex management structure.

A further concern raised was the issue of staff dealing with higher order problems than they are able to deal with, specifically Tier 2 level staff dealing with Tier 3 problems, and the need to bring in specialisms. In one case, the Tier 3 staff are being brought into the localities. (See chapter 1 for definitions of Tiers)

A core problem seems to be information sharing – both the practicalities of creating shared databases and files, and the issue of different levels of access and traditions of using files between different agencies.

One anxiety expressed by several workers is that they were becoming swamped with referrals, as they were becoming better known. This was partly that they were becoming more accessible, but also that they were picking up inappropriate referrals .In this case, ones that should have been going to social services.

'we are victims of our own success - we take on a bigger role, take on much of social services work... If you built a service like this people use it – everyone. It's seen as a quick fix solution.' (EWO)

Managing expectations:

'I suppose the demands that schools put on you - they are demanding and you have to fight off unreasonable requests like 'I demand that this child sees a psychiatrist now.' (Specialist advisory teacher in multidisciplinary team)

This ended up putting increased pressure on their resources.

'increased work in schools and projects is draining resources of team - we have had the first waiting list in our history over the last 3 years (4-5 months). No increase in resources to manage this work' (Questionnaire)

Another problem identified was professionals losing their identity and feeling deskilled, or becoming absorbed into the other agency's organisational culture.

7 CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusions

This section draws together the conclusions from the literature review, case study research and the survey, some of which have already been highlighted in other sections of the report.

It is widely accepted that joint working is a preferred model of service delivery for CAMHS and that support to Tier 1 services are very important. School staff and the education service provide a substantial part of these Tier 1 services. This research investigated the scope and nature of joint working between CAMHS and schools and looked in depth at some of the structural and practice issues of this way of working by investigating case studies.

CAMHS structures are very different across England, and it is hard to get an overall picture of the scale and pattern of the work they are doing with schools. For example, they cover different sizes of geographical area, may be based in clinical or community settings.

The majority of CAMHS services which responded to the survey did some work with schools (89%). Within this was a wide variety of practice and structures. The most common form of work was **consultation and support to school staff**, often on a case by case basis with children who had been referred to their service. Other support to school staff was consulting on behaviour, training and supervision to a range of school based staff, and contributing to health promotion activities.

Direct work with children and young people was conducted by 70% of the services which included individual and group work in schools and contributing to whole school mental health promotion. Many worked with parents in school settings, especially with early years and primary age children.

Only just over half of the CAMHS worked with the LEA. This included work with the educational psychology service, education welfare service and behaviour support services. The structure of the work varied significantly, from one extreme of a joint integrated service, to secondments from health to education and vice versa.

Clinical Psychologists, Community Psychiatric Nurses and social workers were conducting the majority of the work from the CAMHS teams, and surprisingly few education staff were included in the CAMHS teams.

Of those respondents who could estimate the proportion of their resources spent on working with schools, just over half spent less than 10% and the average was 15%. This is higher than findings from elsewhere (Audit Commission, 1999). The majority were using core funding.

No particular model of work, or theoretical basis, could be found from the survey or the literature review. The case study participants tended not to be explicit in their theoretical model, although most identified using a psycho-social approach. Other similarities of approach could be identified. All of the CAMHS in the case studies were based on a tiered structure and were influenced by the approach of Together We Stand (HAS, 1995). This reflects a commitment to inter-agency working and supporting Tier 1 services. Other theoretical bases that were drawn on were the American total service approach and a psycho-social method of intervention, and basing practice on evaluated approaches (evidence based practice).

The reliance on evidence based practice emphasises the importance of evaluation of interventions. With a joint working approach it is important to not only to measure outcomes but to also the processes and impact of joint working. In fact relatively few of the CAMHS surveyed evaluated their work.

The advantages of joint working were assessed by looking at outcomes of evaluations, and discussions with practitioners. Some of this was supported by descriptions of particular examples.

Overall many respondents, especially school staff ,acknowledged an increase in children's happiness and well-being. A measurable improvement in **children's behaviour** could be seen in two of the case study sites which had undertaken their own evaluation, and better peer relationships were identified by workers. Although rarely measured, workers' opinions identified links to improved **academic attainment**, on the basis that children were better able to learn and were developing learning skills. Linked to improved children's behaviour, education staff identified that the interventions had an impact on **exclusion** of children as their behaviour changed, or that the intervention allowed thinking space before being excluded. This was not being measured formally by the interventions. Some examples of work with school phobics showed improvements in school attendance.

The impact of working in this **way increased awareness and learning between health and education staff**. Working closely together facilitated learning from each other both about the resources and services that were available to children and adolescents, but also learnt about approaches to work. Education staff felt they had an increased access to mental health services and a greater understanding of the services available. Health staff reported having a greater understanding of the school context and the impact it may have on children's mental health and on education staff, and a greater understanding of the resources available in the education setting.

CAMHS staff felt that they were accessing children who would not normally be reached, and identifying children early representing a preventative or early intervention model. Reason for increased access was that they could identify children themselves. The services were felt by staff to be more accessible to parents and children as they were physically easier to get to, less stigmatising, within children's own environment, and could tackle structural issues for children.

CAMHS workers identified that they received more appropriate referrals to their services, although overall referrals were increasing. Some workers felt that services were improved as the joint teams could allocate the case more appropriately within teams and avoided duplication of work. Practitioners working with schools closely felt pressured by high levels of expectation of the service, and strategies were needed to be put in place to manage referrals.

Joint work with parents was felt to facilitate an improved relationship between the school and parents where this was necessary.

There was no single structure of services that was seen as crucial to joint working. Factors within structures that were useful were having a tiered approach and being located in small localised teams, and a tradition of joint working. Secondments of staff were positive in two of the case studies. Smaller services allowed people to get to know each other well. Shared offices with members of the team of different disciplines were felt to be particularly useful as they facilitated learning and informal communication. A strong commitment to the joint working by all levels of management was also key. Chief Officer level was very important and middle management who often had more difficulties in managing this approach, especially dealing with budgets.

Joint working was helped by the skills of the individuals. As well as professional skills, additional skills needed were confidence in their own abilities and profession, being flexible and able to work in a different environment and having experience of joint working. Knowing individuals was felt to be important which has implications for staff continuity and funding.

A key issue in joint working is overcoming cultural differences between organisations. These impacted on almost all levels of work from the approach to children and families to management structures and information sharing. This became particularly apparent when working in schools. Many of these approaches and case studies had identified effective ways of overcoming these issues. Good communication was a key feature of effective joint working.

Presence in schools by health workers was deemed to be very important to the work, but so too was close working with the LEA. In three of the case studies, health staff teams were based in or with the LEA services. This facilitated learning across the disciplines. School staff tended to approach individuals whom they knew and had working relationships, and those who spent time in schools. This was often the EWO, Educational Psychologist or EBD Advisory teachers. When the health staff were included in these teams they benefited from the education staff's experience of working in schools. In the other case study, the EAZ was key in facilitating these links.

As with any methods of working, there were dilemmas that occur. These dilemmas can be seen as:

- the role of specialist Tier 3 services;
- how to roll out this kind of service to other schools;
- potential duplication of work;
- complex management systems;
- increased identification of need with limited resources.

The majority of the case-studies had a structure of Tier 2 service based in small locality teams. Some workers expressed anxiety that Tier 3 level problems were being addressed by Tier 2 workers. This may have been due to Tier 3 services being less accessible. This was being tackled in one area by further devolving the specialisms to area based teams.

A strong ethos that came through from the case studies was that of working with those schools which are interested and committed to working in this way, and of it being an 'opt-in' service. However, these may not be the schools that are in most need of the service; and there is an issue of how to roll out the service to other schools (or whether to target particularly needy areas).

Although joint working is designed to improve co-ordination of services, this may not always prevent duplication of work. Currently, there are a lot of resources going into schools and there were some examples of schools being overwhelmed with other agencies coming in. Ways of co-ordinating this need to be identified and potential overlapping roles need to be explicitly clarified, for example the role of the EWOs, Educational Psychologists, and learning mentors with the Primary Mental Health Workers or specialist Social workers. Examples of good practice show that these can be effectively negotiated with joint working.

Managers expressed concern that this way of working was more complicated and more difficult; with complex lines of accountability. This made it a more time consuming approach, especially for middle management, but also sometimes in service delivery.

Most respondents identified that the increased accessibility of the service and earlier identification of problems meant an increase in referrals. This presents an increased demand on the service, and problems of resource constraints.

7.2 Recommendations

Recommendations for action have been drawn from the literature review, survey and case study research. This includes recommendations from survey respondents and case study interviewees for others wishing to develop effective joint working between CAMHS and schools. These recommendations could be usefully explored by policy makers and planners within key government departments – education and health- and by those involved in local CAMHS and education provision.

National policy level

- To ensure that greater emphasis is given at national level, across Government Departments, to the provision of preventive and early intervention mental health services for children and their families within school based and other community settings.
- Within this, to ensure that the Children's National Service Framework, and particularly the CAMHS component of this, contains clear targets for the development of multi-agency early intervention supports for children and their families within schools.
- To ensure that schools are given clear advice, guidance and support to promote children's mental health within school settings from both health and educational psychology services.

Training

- For joint training to be developed with CAMHS/Educational Psychologists and education specialists, and delivered on promoting children's mental health and effective early intervention work, within schools and community based settings.
- For there to be year career paths developed, to enable all staff in schools to gain skills and confidence in promoting children's mental and effective early intervention work for those children most at risk of developing mental health problems. This needs to be developed in consultation and collaboration with the educational psychology service and local education authority.

Local strategic action for LEAs

• As part of the local CAMHS strategy, local education authorities should outline the strategy for work between CAMHS and education (including schools). This should include a specific statement of the objectives to be met and the roles of particular staff and organisations. In preparing this, Local Education should consider:

a) hosting Tier 2 CAMHS staff in relevant LEA teams such as behaviour support teams;

- b) setting up joint budgets for this service across education and health;
- c) listening to the perspectives of users including parents and young people;
- d) building on links with social services;

e) agreeing a joint strategy on confidentiality and covey this to parents and children.

• The plan should be reviewed every year.

Management at local level

- Local Education Authorities, school governors, head teachers and CAMHS staff to recognise that this joint working is a formal part of the job description for some staff.
- In recruiting Tier 2 CAMHS staff and teaching assistants, account to be taken of the competencies required to achieve effective joint working.
- Consider establishing secondments from one organisation to another.
- Allow time for building up an understanding of the different cultures of the education and health sectors.

- Try to ensure that CAMHS staff spend time working from a school location and or within LEA offices.
- For new relationships a systematic and transparent approach to building mutual respect and understanding should be adopted and the induction of new staff should take this into account.
- Longer term contracts to educational support staff and CAMHS staff are more likely to result in successful recruitment of staff to work in school support teams.

Actions for Schools

- Ensure that within schools there are effective whole school approaches to promoting children's mental health, including good pastoral systems.
- Identify members of staff with responsibility for promoting children's mental health and provide protected time for this work to be undertaken.
- Appreciate that health staff may have different approaches to working with children -especially in relation to information sharing, confidentiality and discipline, and work out how these different approaches can work effectively alongside each other without one undermining the other.
- Help health workers to understand the culture of the school and be willing to adapt to their needs. Ensure that they are given opportunities to mix informally with teachers.
- Make physical space in schools for individual and group work for mental health staff, which can be private and uninterrupted.
- Map together with CAMHS the services already available to schools and the responsibilities and remit of these to ensure CAMHS staff are used appropriately.

Action for CAMHS

- Consider basing Tier 2 CAMHS staff in small locality teams, in areas which match Local Education Authority, or school pyramid areas.
- Create formal integrated linkages with LEA staff including Educational Psychologists, Behavioural Support Services and EWOs to take advantage of multi-disciplinary working and co-ordination of services.
- When establishing a project in schools, ensure that the role of the project is communicated to all school staff. This should include the Head teacher,

SENCOs, all class teachers, SMT, heads of year and Assistant Heads for inclusion. This may need to be a continuous process where there is a high turn over of staff.

- Be clear about the role of the project or project workers and identify a clear referral route. Be careful to set realistic expectations of the project. Ensure that there is a written agreement with the school about how the project will operate.
- Maintain strong links with CAMHS services with clinical supervision and remain part of the CAMHS team. Avoid placing a member of staff exclusively under one school management.
- Spend time in schools in order to make informal contacts. Recognise the tight timetable to which teachers work and be flexible about finding the best time for meetings.
- Ensure that interventions in schools are co-ordinated with other relevant initiatives.
- Have named person in CAMHS for schools to link into, and provide information about services and referral routes.
- Negotiate their role in collaboration and co-operation with other agencies providing services to schools to ensure coherent provision and access for all children and families to appropriate support and guidance.

Bridget Pettitt on behalf of the Mental Health Foundation June 02

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Glossary	
ADHD	Attention Deficit Hyperactive Disorder
BASS	Behaviour and Attendance Support Service
CAMHS	Child and Adolescent Mental Health Services
CPN	Community or Child Psychiatric Nurse
DNA	Did not attend (clients not attending an appointment)
EAZ	Education Action Zone
EBD	Emotional and Behavioural Difficulties
EWO/ EWS	Education Welfare Officer/ Service
GP	General Practitioner (Doctor)
HAS	Health Advisory Service
HAZ	Health Action Zone
HIMP	Health Improvement Plan
INSET	In - service Training (for teachers)
Key stage 2	Stage in the National Curriculum for children aged 11.
LA	Local Authority
LEA	Local Education Authority
NHS	National Health Service
Ofsted	Office for Standards in Education
PATHS Curriculum	Promoting Alternative Thinking (a health promotion package)
PCT	Primary Care Trust
PHSE	Personal health and Social Education
PMHW	Primary Mental Health Workers
SATs	Standard Achievement Tests
SEN	Special Educational Needs
SENCOs	Special Educational Needs Co-ordinators
SRB	Single Regeneration Budget
SSD	Social Services Department
Statement	Statement of special educational needs

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