Anna Freud
National Centre for Children and Families
annafreud.org

MENTAL HEALTH SERVICE AND SCHOOL LINK PILOT

Workshop findings and feedback

Dr Melissa Cortina
Felicity Saunders
Jaime Smith
Dr Miranda Wolpert

This project was funded by NHS England and the Department for Education. The training was developed and delivered by a consortium of experts in partnership with Anna Freud National Centre for Children and Families.

Acknowledgements

With thanks to the local authorities, CCGs, teachers, school staff, CAMHS staff, nurses, educational psychologists, and mental health providers who took part in the pilot workshops and who completed the surveys.

With thanks to NHS England (NHSE) and the Department for Education (DfE) for liaising with the team throughout the project and providing information and support.

Contents

Figures

Tables

Executive summary

This report provides an overview and internal evaluation of the Mental Health Service and Schools Link Pilot. The pilot, funded by NHS England and the Department for Education (DfE), was developed to improve joint working between school settings and CYP mental health services, to test the concept of implementing a 'single points of contact' for each area and to develop and maintain effective local referral pathways.

As part of this pilot, Anna Freud National Centre for Children and Families developed and delivered workshops to 26 CCG areas and led a consortium of a mental health and education experts. These workshops were broken down in to three phases, where the two full-day workshops (Phases I and II) aimed to achieve a shared view of strengths and limitations of capabilities and capacities of all target groups, improve attendees knowledge of resources to support mental health of target groups, make effective use of existing resources and improve joint working between target groups. These workshops were then followed by two national events, where all of the pilot areas and attendees from the workshops were invited to share their learning and achievements as a result of the workshops (Phase III).

A final summative account of the evaluation is due to be completed and published by Ecorys, an external research company employed to evaluate the success of the pilot, in November. The findings presented in this report are those collected by Anna Freud National Centre for Children and Families during and following the workshops as an internal evaluation.

Findings indicate that all pilot areas improved their joint working according to the CASCADE© framework; a tool designed by the Centre to enable stakeholders working with CYP to identify where they are on a number of key domains of effective joint working. No area considered themselves to be at 'Gold Standard' on any of the CASCADE© domains at either Phase, indicating that there is still progress to be made. Areas made the most progress on identifying an agreed point of contact and clarifying the role in schools and CYP mental health services. Areas made the least progress in regards to evidence based approach to interventions.

Additionally, three key themes emerged from the attendees' feedback survey, indicating that they found the workshops helpful as a forum for sharing knowledge, facilitating relationships, and increasing their sense of agency.

As a result of the workshops, areas were able to organise regular meetings with other professionals, maintain the relationships made in the workshops, and improve referral protocols. Schools in particular allocated a named link worker.

Although improving the relationships and collaborative working between educational and mental health settings is a large undertaking that will not be solved instantaneously, the findings contained in this report indicate that some important progress was achieved as a result of the workshops. There was variation in regards to the level of joint working attendees indicated on the CASCADE© framework. The engagement of the CCG lead, the enthusiasm and turnout of the attendees, the information on the workshops provided to the attendees beforehand, the previous history of the relationship between CYP services and schools, the communication skills of the group, the starting point on the framework, and the size of the area were all contributing factors to the progress of each area.

Although improvements are evident, challenges remain in regards to joint working. It is crucial for the areas to continue to develop the relationships between schools and CYP mental health services in order to better support CYP, particularly in light of funding limitations across the country and a continued reduction of services.

Background

Over 10% of children and young people (CYP) in the UK have a diagnosable mental health disorder (Green, McGinnity, Meltzer, Ford, & Goodman, 2005), only 25% of whom access specialist treatment. However, the estimated UK prevalence data is over a decade old, with new data not available until 2018 (Frith, 2016). It is expected that there are higher rates of CYP experiencing elevated levels of difficulties that are not captured by this data, and even higher levels for those experiencing difficulties but do not necessarily meet the thresholds for treatment (Fink et al., 2015). For example, nearly one in five CYP report high levels of anxiety (Office of National Statistics, 2015) and an average of 3,051 referrals are received by CAMHS per 100,000 population (ages 0-18; *Benchmarking and analytics for CAMHS*, 2016). The level of need, particularly for girls with emotional problems, is also rising (Fink, et al., 2015) meaning the demand on CAMHS is ever increasing with median maximum waiting times for routine appointments being 26 weeks in 2014/15 (NHS Benchmarking Network, 2016).

Alongside this rising need, there is an ongoing reduction in services, (Young Minds, 2015) making it harder for CYP to access treatment. Of those CYP who do access treatment, at least a third are likely to remain with significant difficulties even after the most evidence-based intervention (Warren et al. 2010). Even when CYP are receiving treatment, many are still in the school environment, placing increasing pressure on teachers to manage student difficulties, which are sometimes considerable and persistent, and impact on the classroom environment. Teachers are commonly contacted by CYP for advice for mental health issues (Ford, Hamilton, Meltzer, & Goodman, 2007) and are ideally placed within schools to encourage help-seeking among CYP and implement evidence-based prevention and intervention programs (Dishion, 2011).

Although the majority of teachers believe that they should play a role in supporting CYP mental health (Reinke, Stormont, Herman, Puri, & Goel, 2011), they often perceive that communication and ongoing support from mental health services on how to recognise and manage mental health difficulties is limited (Ford & Nikapota, 2000). These long term challenges in the relationship between schools and mental health services are well established (Masten et al., 2005; Weare, 2000) and include schools' access to services, confidentiality, staff training and development and protectionism over budgets (Pettitt, 2003). Alongside this, services are facing increasing budget cuts and an ever rising demand for treatment. Therefore, in order to better support CYP, it is crucial to establish and improve joint working between schools and CYP mental health services, within the limited resources available so that the systems can work together more effectively and collectively deal with the challenges being felt across the sector.

'Future in Mind' ("Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing," 2015), a Department of Health led report, highlights that joint working between schools and mental health services for CYP can be improved considerably, particularly around communication and

access. The report recommends the identification of named points of contact in specialist mental health services (or CAMHS) and specific leads responsible for mental health in schools. Consequently, a joint pilot programme with NHS England and DfE for named leads in schools and mental health services was developed, in the shape of the Mental Health Service and Schools Link Pilot, to promote shared understanding and support effective communications and referrals.

Methods

The Mental Health Service and Schools Link Pilot comprised a two-Phase workshop delivered at least 5-weeks apart per CCG area. The two full-day workshops (Phases I and II) were followed by two national events (Birmingham and London), where all of the pilot areas and attendees from the workshops were invited to come together and share their learning and achievements as a result of the workshops (Phase III).

Purpose of the workshops

The purpose of the workshops (often referred to as CASCADE© workshops), was to develop and test the approach of implementing single points of contact and offering training to improve joint working. They aimed to bring together representatives from schools and their local CYP mental health services in order to build stronger links and communication between these professionals. An educational professional, whose area was involved in the pilot, highlights the need for the workshops:

> *"Anyone at CAMHS who is working under the conditions they are working under and dealing with their impossible tasks on a day to day basis deserves our complete admiration and respect. CAMHS is doing the best that they can with the very limited resources that they have - we now don't even bother referring to CAMHS unless we can justifiably say there is clear and present risk of significant harm to either themselves or others around them. The chronic funding shortage is just storing up problems for the future. It is the untold scandal in education of our generation."*

Aims of the pilot

- To improve joint working between school settings and CYP mental health services to enable CYP to access timely and appropriate specialist mental health and wellbeing support
- Develop and maintain effective local referral route ways
- Test the concept of a 'Single Point of Contact' for each area

Aims of the workshop

- Shared view of strengths and limitations of capabilities and capacities of education and mental health colleagues.
- Increased knowledge of resources to support mental health of children and young people.
- More effective use of existing resources.
- Improved joint working between education and mental health colleagues.

Participants

NHS England and the DfE invited proposals from Clinical Commissioning Groups (CCGs) to become a 'pilot area', from which they selected the 26 CCG areas to participate in the pilot.

Schools were asked to identify a mental health (MH) lead to attend the workshops as well as another member of school staff. As it was important to get senior leadership buy in from the school, the MH lead was generally a head teacher, deputy, SENCO or pastoral lead. The leads from at least 10 schools (including: primary, secondary, special schools, colleges, alternative providers and social, emotional & mental health (SEMH) schools) within the CCG area and the CYP mental health service leads were required to attend.

A range of professionals attended, including the Clinical Commissioning Groups (CCG) lead, educational professionals, educational psychologists, independent providers, local authorities, NHS statutory CAMHS, school nurses and voluntary sector providers.

Content of the workshops

The workshops were developed and delivered by an Anna Freud National Centre for Children and Families led consortium of a number of mental health and education experts from the Evidence Based Practise Unit, CORC, University of Exeter Medical School, Tavistock and Portman Foundation Trust, South London and Maudsley Trust, University of Oxford, Psychology Consultancy & Training, University of Leicester, Manchester Institute of Education, Common Room, MindEd, UCL Partners, Cernis, Youth Access and In Our Hands.

Each of the three Phases of the pilot focused on different aims of the project as seen below:

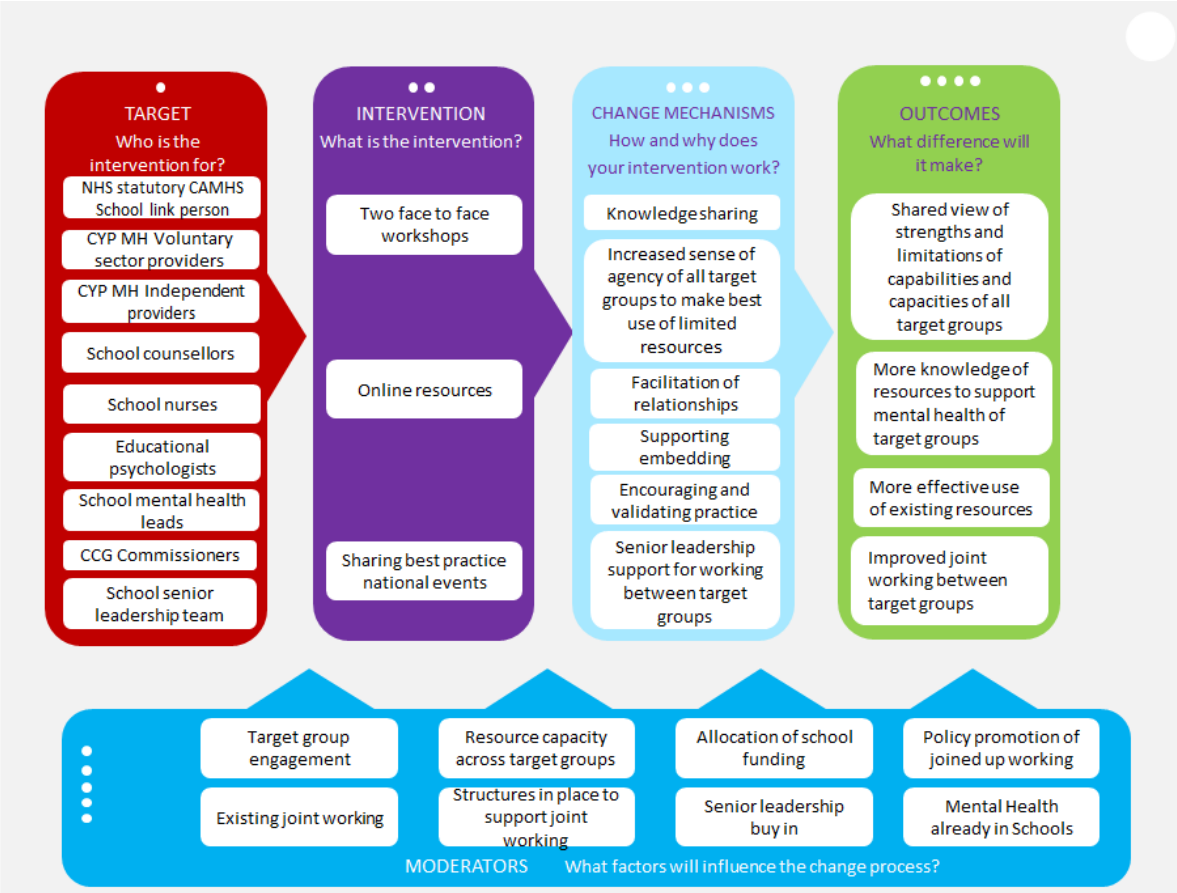
- Phase I: Forming School and CYP Mental Health Partnerships
    - Phase I aimed to achieve a shared view of the strengths and limitations of capabilities and capacities of education and mental health colleagues. In achieving this, a clearer picture of how to

improve joint working emerged and attendees had the opportunity to suggest ways in which it could be implemented. Phase I also provided professionals with more knowledge of resources to support mental health of CYP and an opportunity to discuss more effective use of existing resources.

- Phase II: Embedding Partnerships and building sustainability
  - Phase II aimed to give attendees an opportunity to reflect back on what new or developing methods to improve joint working had been successfully implemented since the last workshop and share ideas on further improving joint working locally. There was also an opportunity to review CYP case examples and for the CCG lead to discuss their local area planning with the attendees.

- Phase III: Supporting ongoing learning and development of best practice and ensuring on-going sustainability
  - Phase III gave areas an opportunity to share their key achievements as a result of the workshops and hear examples of good or developing practice across different regions.

The programme's EBPU developed logic model© (Figure 1), provides details in terms of the target group(s) for the Phased intervention, what the intervention comprised, the possible change mechanisms, intended outcomes, as well as any potential moderators.



The CASCADE© Framework

Figure 1. Logic model for the workshops.

The CASCADE© framework is a tool developed by Dr Miranda Wolpert for use with stakeholders working with CYP to identify levels of joint working across of seven key domains of effective joint working. The framework was used as a central component of the workshops where attendees were asked to rate themselves across each of the seven domains. An initial group CASCADE© was completed for each pilot area in Phase I and then re-visited in Phase II workshops. Responses from both Phases were recorded for all areas.

	Major challenge	Good elements of practice	Widespread good practice	Gold Standard
Clarity on roles, remit, and responsibilities of all partners* involved in supporting CYP mental health	No shared knowledge of the range of support available and poor links between partners	Some shared knowledge of the range of support available some links between partners	Shared knowledge of the range of support available and good links between partners	Full mapping of all sources of support kept up to date and accessible with strong links between all partners
Agreed point of contact and role in schools and CYP mental health services	No identified points of contact	Some identified points of contact with some partners	Agreed and shared points of contact with most partners	Agreed and shared points of contact with all partners that are kept up to date as staff change
Structures to support shared planning and collaborative working	No structures to support shared planning and collaborative working	Steering group/partnership agreement or other structure to support shared planning and collaborative working but membership attendance patchy or frequently cancelled	Steering group/partnership agreement or other structure to support shared planning and collaborative working but not fully linked to other groups	Steering group/partnership agreement or other structure to support shared planning and collaborative working, embedded well with other relevant groups
Common approach to outcome measures for young people	No shared outcome measures and no sharing of information	Some overlap of outcome measures, but no shared information	Most shared outcome measures and limited sharing of outcomes	Routine use of shared outcome measures that are routinely shared
Ability to continue to learn and draw on best practice	No forum for shared learning	Some sharing at joint events with some partners or access to good practice networks but limited	Widespread sharing of best practice with most partners but not always acted upon	Widespread sharing of evidence based best practice with all partners that drives initiatives
Development of integrated working to promote rapid and better access to support	Little to no integrated working and complicated and/or slow path(s) to support	Some integrated working with partners to improve access despite complicated and/or slow paths to support	Widespread integrated working with most partners to improve access with clear path to support	Widespread integrated working with all partners to improve access with clear and/or rapid path to support
Evidence based approach to intervention	Little or limited training available to support intervention, and not grounded in evidence.	Some routine training available, but not always evidence based. Some interventions in place	Most staff accessing regular targeted training with interventions in place	Clear training programme for all staff with some joint training alongside interventions

©Miranda Wolpert

Figure 2. CASCADE© Framework detailing seven key domains for collaborative working and categories of working across the domains.

Findings

NHS England and the DfE employed Ecorys, a leading European research and consultancy company, to externally evaluate the success of the pilot. A final summative account of the evaluation, including evidence from the case studies and

follow-up surveys, are due to be completed and published by November 2016. The findings presented below are those that Anna Freud National Centre for Children and Families collected during and following the workshops as an internal evaluation.

The CASCADE© framework findings

A group CASCADE© was completed for each pilot area apart from one in Phase I (N=25). All areas completed a follow-up framework as part of the Phase II workshop (N=26).

Phase I

At Phase I, the all areas rated themselves as either 'major challenge' or 'good elements of practice', across the seven domains, with the majority indicating they fell under 'major challenge'.

At Phase I, areas felt they were strongest on the domain of 'Agreed point of contact and role in schools and CYP mental health services', where nearly 70% (N=17) of areas scored within 'good elements of practice'. The weakest indicated domain across all areas from Phase I was 'Structures to support shared planning and collaborative working' with nearly 90% (N=22) of areas scoring this as a 'major challenge'.

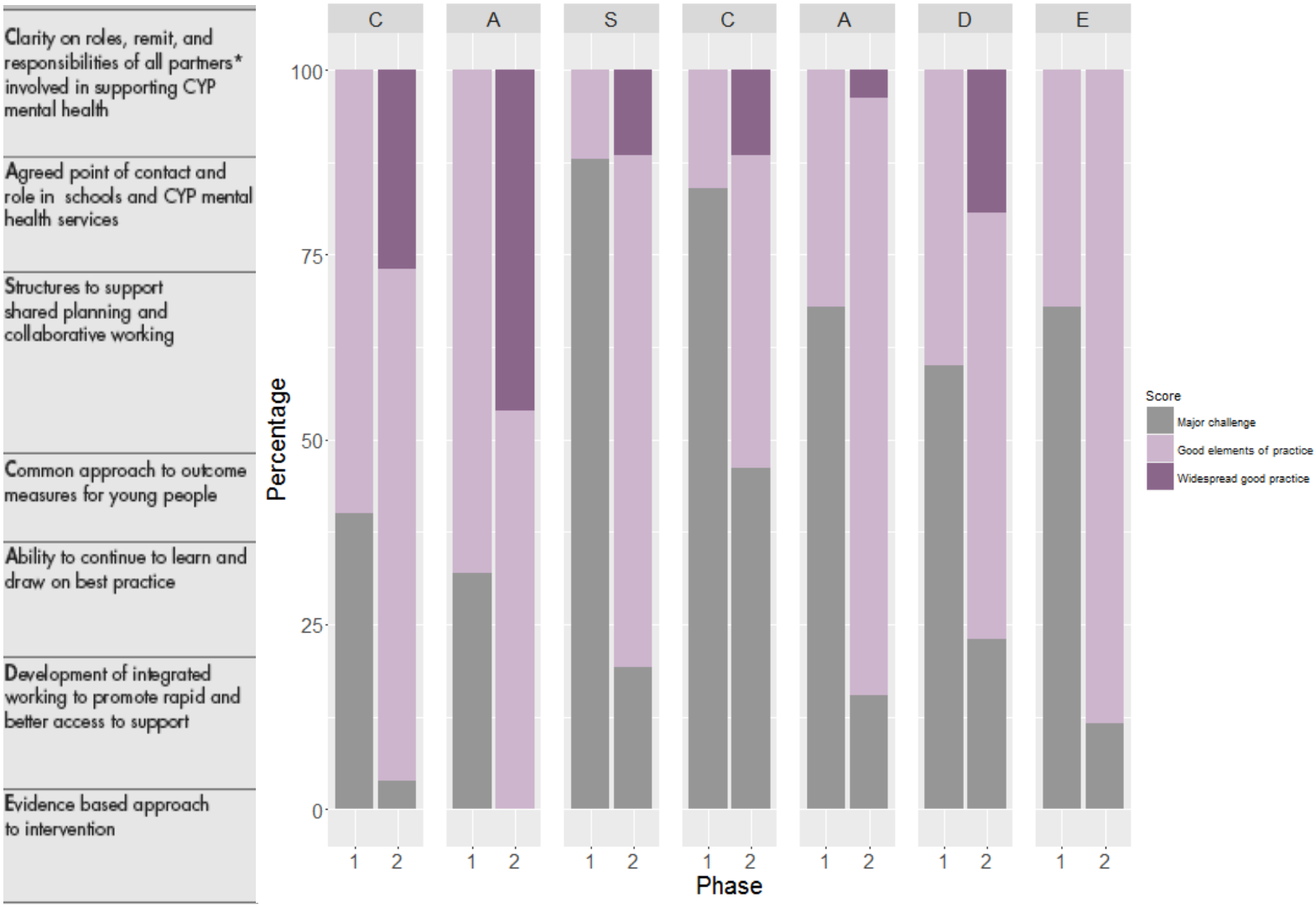


Figure 3. Plot of ratings on the CASCADE© framework.

Phase II

During the Phase II workshop, attendees were given an opportunity to reflect on what new or developing methods to improve joint working had been successfully implemented and the CASCADE© framework was revisited.

There was an improvement (ranging from 9.2% to 57.2%) whereby the majority of areas moved from 'major challenge' at Phase I to 'good elements of practice' at Phase II across the seven domains.

As well as a shift to the majority of areas identifying themselves as having 'good elements of practice' at Phase II, some areas scored themselves within the 'widespread good practice' category, with improvement ranging from 3.09% to 46.2%. This shift was evident across all of the domains except for 'Evidence based approach to intervention'. With this domain there was a shift of 56.5% of areas moving from 'major challenge' to 'good elements of practice.' However, 11.5% of areas still categorised themselves as a 'major challenge'. Although no areas scored themselves in the 'gold standard' category in Phase II, all areas showed improvements from Phase I to Phase II.

The domain of 'Agreed point of contact and role in schools and CYP mental health services' showed the most improvement. At Phase I, 32% (N=8) of areas scored within 'major challenge' and 68% (N=17) in 'good elements of practice'. At Phase II, this shifts to 0% identifying themselves in the 'major challenge' category, 53% (N=14) in 'good elements of practice' and 46% (N=12) scoring 'widespread good practice'. The percentage of responses across the domains at both phases can be found in Table 1.

Table 1. Ratings of aspects of joint working on the CASCADE© framework (percentages).

		Major challenge	Good Elements of Practice	Widespread Good Practice	Gold Standard
Clarity on roles, remit, and responsibilities of all partners.	Phase I	40.0%	60.0%	0.0%	0.0%
	Phase II	3.9%	69.2%	26.9%	0.0%
Agreed point of contact and role in schools and CYP mental health services	Phase I	32.0%	68.0%	0.0%	0.0%
	Phase II	0.0%	53.9%	46.2%	0.0%
Structures to support shared planning and collaborative working	Phase I	88.0%	12.0%	0.0%	0.0%
	Phase II	19.2%	69.2%	11.5%	0.0%

Common approach to outcome measures for young people	Phase I	84.0%	16.0%	0.0%	0.0%
	Phase II	46.2%	42.3%	11.5%	0.0%
Ability to continue to learn and draw on best practice	Phase I	68.0%	32.0%	0.0%	0.0%
	Phase II	15.4%	80.8%	3.9%	0.0%
Development of integrated working to promote rapid and better access to support	Phase I	60.0%	40.0%	0.0%	0.0%
	Phase II	23.1%	57.7%	19.2%	0.0%
Evidence based approach to intervention	Phase I	68.0%	32.0%	0.0%	0.0%
	Phase II	11.5%	88.5%	0.0%	0.0%

Qualitative analysis

Attendees provided feedback about the workshop at the end of each session. Responses were coded and analysed using thematic analysis software NVivo. The word cloud below (Figure 4) depicts to what participants liked about both Phase I and II workshops. A larger word size indicates higher frequency of feedback.

Figure 4. Word Cloud representing what attendees liked from phase I and II workshops.

Further review of attendees responses revealed three key themes in regards to the usefulness of the workshops: knowledge sharing, facilitation of relationships, and increased sense of agency. These are discussed below.

1. Knowledge sharing

Attendees reported that they found the workshops helpful to learn and share knowledge regarding a variety of factors such as, each other's roles, the difficulties that each organisation faces, the resources available in the local areas, the pathways available for CYP, and the referral process. Examples of this feedback can be seen below (Figure 5).

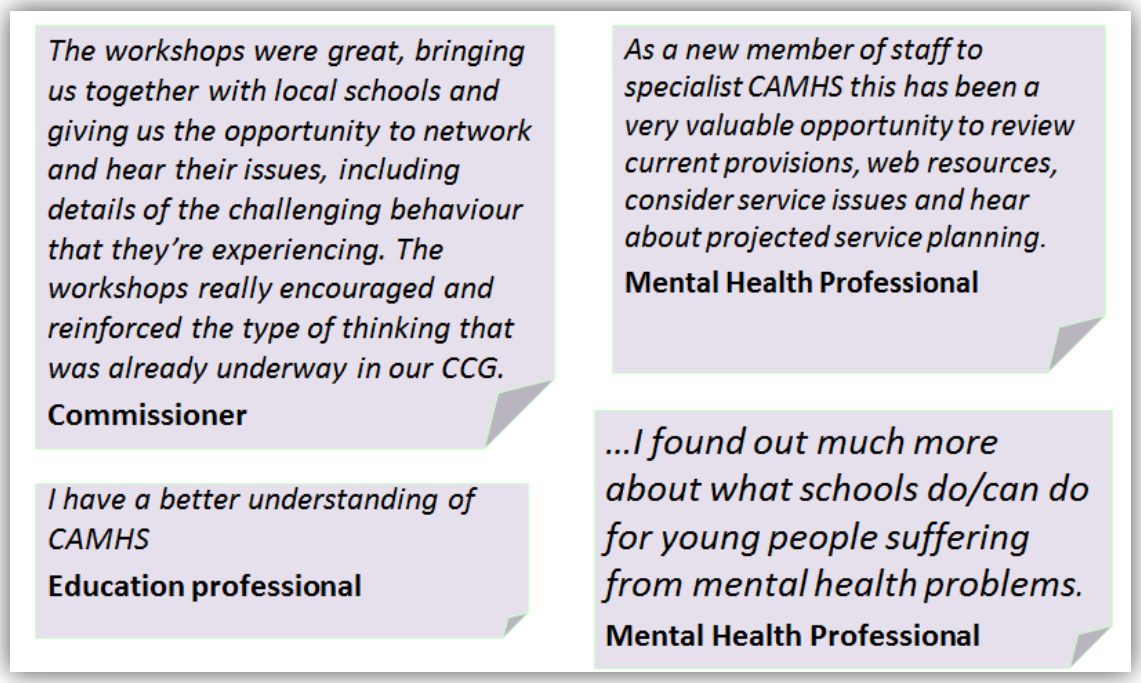


Figure 5. Example feedback from phase I and II workshops around knowledge sharing.

2. Facilitation of relationships

Attendees found the workshops helpful to facilitate relationships between other professionals that they had perhaps spoken to but never met before or in some cases, never knew existed. Attendees' comments on how interesting it was to hear from other professions and their ways of working in order to build a mutually focused relationship. Examples of this feedback can be seen below (Figure 6).

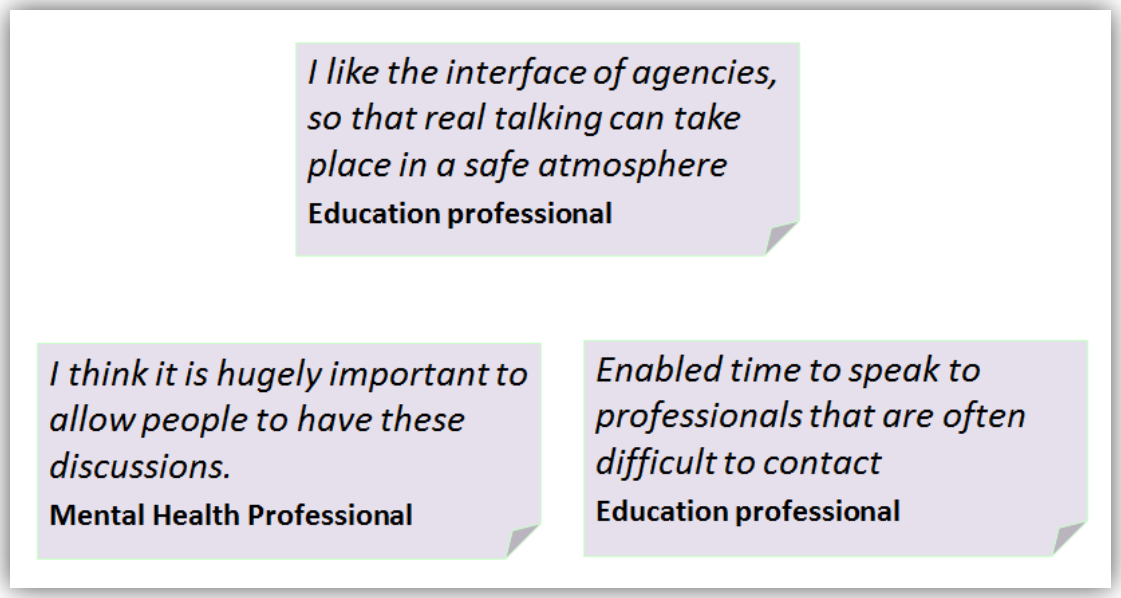


Figure 6. Example feedback from phase I and II workshops around facilitation of relationships.

3. Increased sense of agency

Attendees indicated that the workshops allowed them to hear about other services in their local area and to understand the services that they provide. It was evident that the educational professionals found this increased sense of agency particularly valuable. Examples of this feedback can be seen below (Figure 7).

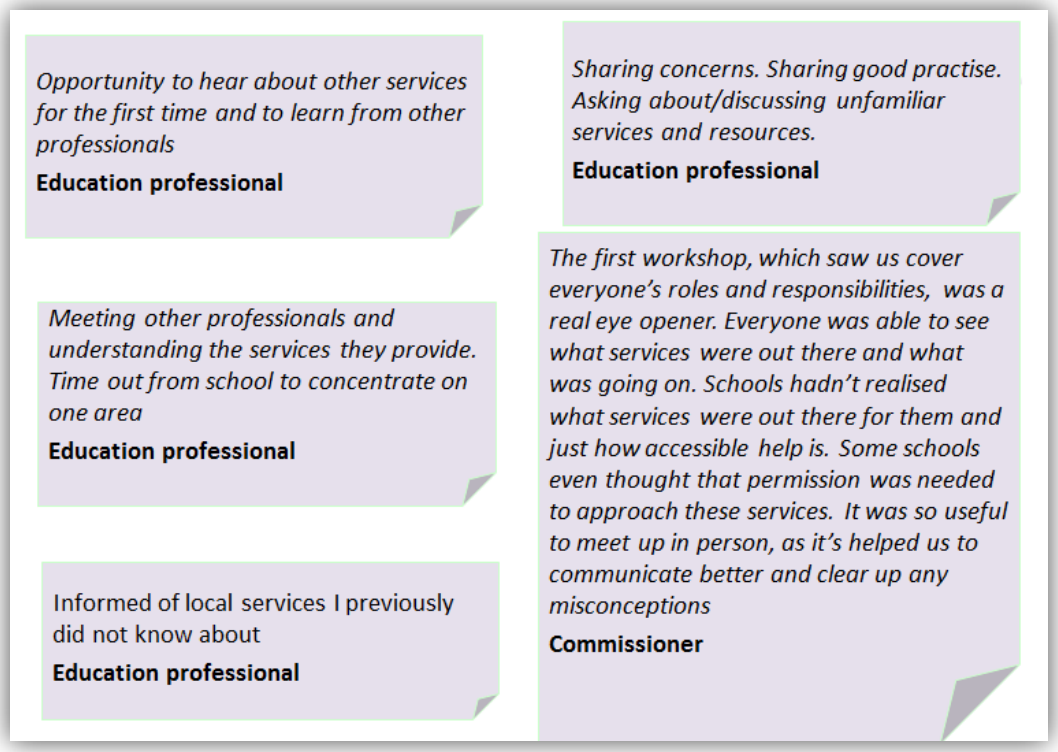


Figure 7. Example feedback from Phase I and II workshops around increased sense of agency.

Phase III and key achievements

All areas were asked to provide information on their key achievements following Phase I and II workshops. Table 2 provides an overview of key achievements provided by area. Some of the key themes found within these achievements were:

- Organising regular meetings with other professionals;
- Maintaining the relationships made in the workshops;
- Schools now having an allocated named link worker;
- Improvements made to referral protocol.

From the feedback it appeared that pilot areas made considerable improvement in joint working to support mental health as a result of attending the workshops. Phase III was therefore used to give areas an opportunity to present and share their key achievements so that attendees could draw on examples of good or developing practice from across different regions and share learning.

Table 2. Achievements by CCG following Phase I and Phase II.

CCG area	Key Achievements
A	• Development and circulation of clear guide for referrals and link working. • New CAMHS triage service with the ability for schools to ring up and get assistance. • Piloting a decision support tool. • Additional educational psychology time built in to develop link working for the schools. • Improvement in CASCADE self-assessment tool by schools attending training.
B	• Development of improved joint protocols. • Implement and test a school direct referral protocol into CAMHS services from the 10 pilot schools. • CCG have identified funding to run Phase II of the pilot with up to additional 20 schools. • Full-time CAMHS School Link Post appointed to support the pilot.
C	• 10 pilot schools will now receive a joint CAMHS/EP offer. • A dedicated CAMHS lead for each school. • Termly multi-agency consultation, assessment and interventions for children the school have concerns about. • Pilot Schools will receive Specialist training from CAMHS and Educational Psychology. • The creation of a personalised CAMHS feedback report for each school. • Dedicated CAMHS and Educational Psychology support with carrying out a whole school Emotionally Friendly Schools audit.
D	• One school trialling other programmes from MINDEd to consider the need for a dedicated pathway for school professionals. • CAMHS contact sheet supplied to each school. • CAMHS have ensured that each school within the pilot know their named CAMHS Practitioners.

E	• CAMHS is in the process of developing a protocol with schools for making appropriate referrals to the service. • Formed a joint forum of school representatives, CAMHS provider, CCG and Local authority. This forum has met twice and meetings are scheduled quarterly. This forum will work as an advisory role as part of CAMHS transformation plan.
F	• Student notice boards have been put up in schools. The boards are colourful and focus on positive mental health whilst providing contact details for support-including voluntary agencies. It also highlights self-help materials and informs young people where they can go for support if their mental health is deteriorating. • The Pilot has promoted the Emotion Coaching Course and a number of Pilot Schools are now enrolled onto the course which will be run over the next 12 months. • The CAMHS Duty line is now open to all schools participating in the Pilot. This means that all Pilot Schools have access to a qualified CAMHS Clinician between 12-2 Monday to Friday to get advice or to discuss a potential referral. • Currently working towards the development of a common Social, Emotional and Mental Health Policy for schools. Working alongside the Educational Psychologists and our Colleagues at the Local Authority to support the development of this.
G	• Healthy Minds Champions have been established in all schools in order to embed student voice in the activity of the pilot. • Mental Health Audit (MHA): a series of questionnaires for staff, parents and students have been developed to understand the mental health needs of specific school communities. • Development of whole school evidence based mental health interventions - trial of peer mentoring development, CBT group work, Theraplay groups. • Trial of the Mental Health passport in schools.
H	• The CAMHS team have also been able to support some additional initiatives in some of the pilot schools. These have included supporting a primary school in their development of a Mental Health Policy and the implementation of emotional wellbeing coffee mornings for parents. • Primary school relaxation packs have now be offered to all primary schools. Many of the schools report to have begun to implement the exercises routinely within their day to day lesson plan. The aim of this offer was to reduce 'Exam Stress' for the year six students in the run up to the May SAT's examinations • Following a recent meeting with the 14-19 service, it was agreed in principle to provide training for the alternative provides with regards to mental health awareness and what support the could offer. The plan will be to deliver this a joint programme alongside some of the 14-19 service staff. • Via collaborative working, CAMHs have liaised with wellbeing enterprises and proposed an intervention that would result in school staff joining in the delivery of an 'anxiety support group' for year 10 and 11 students. The aim being that this model would build skills and capacity within the school system itself, the longer term aim being the support group would be a self-resourced sustainable model of early intervention.
I	• Identified an admin link who is able to circulate information to all schools in county, which we are hopeful with increase system wide communication between schools and health services. • More schools have been made aware of the mental health/emotional wellbeing forum hosted by one of the schools and there is increased awareness and circulation of the EWB newsletter produced by Public Health with information updates.

	• All schools in county except independent schools have a link worker assigned and have received contact from them.
J	• Pilot schools are now aware of the CAMHS duty line as a source of immediate advice. • Engagement work with young people, both users of services and non-users (focus groups in school) to inform how to take forward a model of support for mental health needs with CAMHS and school staff. • School staff completed MindEd modules. • The pastoral staff in the six secondary schools have started receiving monthly reflected learning sessions with their CAMHS link.
K	• All pilot schools are being funded to hold a Youth Mental Health First Aid course for their school staff. • A further training day is being organised for July 2016 to address some of the issues raised by schools and to celebrate how they have spent their funding. • The Primary Mental Health Worker who is taking responsibility for providing the schools / CAMHS link came in to post in January 2016 and has made appointments with the schools and will be visiting them at least twice between now and July. • Schools have viewed the new online CAMHS referral form which is to be launched shortly. • Schools were given copies of the Royal College of Psychiatry book “Mental health and growing up” to enable them to access quick reliable information about different mental health conditions and also to give them copies of the leaflets contained to parents and young people. They also received further copies of the pink “CAMHS Current View Tool” book providing information on determining risk, referrals and signs and symptoms • Multi-agency local training day in February 2016 “if not CAMHS, what?” – developed in response to schools asking who should be referred to CAMHS and where else they should suggest if they didn’t reach the threshold for CAMHS. A number of agencies took part.
L	• Development of a training directory that includes training that will be rolled out during the summer and autumn school terms. • 23 Choice appointments (initial assessments) being conducted within pilot schools that reduces waiting times to access services. • 34 Training sessions conducted with school staff on specific conditions. • All schools have an allocated named link worker who have developed local plans to support the schools to access support from CAMHS • Sessions with young people regarding managing stress and anxiety as part of wellbeing day.
M	• Updating of contact lists for both schools and CAMHS workers and discussions around protocols for various situations (for example if a CAMHS worker is off sick). • Sharing of information about existing training and support for schools and identification of needs and a ‘wish list’. • Schools sharing good practice about how they have developed a clear flow chart with contacts (often for all joint agency working, not just CAMHS) to enable effective and efficient joint working • A number of schools have worked with their CAMHS worker to develop tailored training around mental health for some or all staff within their schools, such as on attachment or specific issues of relevance to particular cohorts (e.g. anxiety). • Convened a mental health in schools working group to oversee actions, and they are also responsible for next steps from the CAMHS and school link pilot.

N	• CAMHS schools pilot leads are embedding themselves within the schools on agreed days. On these days they provide a mixture of consultation, assessment and training. • Training programmes have been developed in consultation with staff and are provided following the school staff meeting to maximise levels of attendance. Neighbouring schools outside of the pilot have also been invited to attend. • Training has been provided to approximately 250 staff on self-harm and young people; 43 on overcoming mental health difficulties and 23 on recognising anxiety and supporting young people
O	• Maintain the list of MH Links in Schools and expand it to other Schools, this will be an email group with potentially termly meetings to keep Schools apprised of developments and resources relating to mental health. • Devised a list of possible uses for the CAMHS links time, including things like consulting over individual children and young people and supporting the School with developing a whole school approach to emotional wellbeing.
P	• A multi-disciplinary steering group has been formed consisting of teachers, CAMHS, Educational Psychology and local VCS organisations. • A training matrix has been developed of all the training on offer to teaching staff and CYP which will be reviewed by schools and developed into a clear slim line training offer. • School Nurses are redesigning their drop-in offer to broaden the support they are able to offer school children. • As a result of the schools link pilot, fortnightly meetings are taking place between CAMHS and all schools in the pilot. • To test out joining up the local voluntary and community sector with the local schools, two local voluntary and community sector partners have been commissioned to deliver a mentoring project and mental health awareness specifically related to its impact on physical health
Q	• Updated referral guide available to schools and CAMHS system. • School coproduction in the development of Spot the Signs (suicide campaign) for young people. • Schools implementation group to be established as part of governance and accountability for CAMHS Local Transformation Plan. • Workforce development – Mental Health First Aid training will be available for schools. • Regular newsletter for schools and health colleagues. • Schools involved in the CAMHS Schools Link Pilot are being invited to work with local GPs. • Input and design into future priorities for training as identified by schools e.g. self-harm.
R	• Extension of the pilot next academic year by getting the schools involved to pair up with another school. • 2 weekly visits to each school by CAMHS management and Public Health • Local steering group established meeting bi-monthly

Summary

Effective joint working is crucial in a climate of decreasing resources and increasing need. As Minister, Sam Gyimah highlighted, "…[T]he relationship between schools and CAMHS can be difficult, often with one not understanding the other, or even knowing each other" ("Sam Gyimah: mental health pilots - where next?," 2016). Establishing and improving this relationship was the main focus of this pilot and was a large undertaking that will take time and effort to resolve. The data from both educational professionals and mental health professionals however, indicates that some crucial progress has been made in the improvement of joint working between these settings. One of the major achievements of the pilot was getting the stakeholders in the same room and starting to talk to each other to develop a shared understanding and a shared language.

As well as improving the relationship between CYP services and schools, the pilot's vision was to be able to test the concept of a 'single point of contact' and develop and maintain effective local referral route ways. An example of how the pilot has been successful in this area, is the improvement on the CASCADE framework category 'Agreed point of contact and role in schools and CYP mental health services where, by Phase II, all pilot areas progressed from the 'major challenge' category to nearly half of all areas feeling they had achieved 'widespread good practice' as a result of actions from the pilot. The improved confidence regarding each area's single point of contact in the alternative setting will hopefully allow for improvements in communication between settings and improve pathways between these settings, which will consequently provide better support for CYP; the aim of both settings.

Although improvements are evident, the fact that by the end of Phase II some areas still indicated they were in the 'major challenge' category, on six of the seven domains, indicates there is further work to be done, particularly in some CCG areas. An area's progression on the framework was dependent on a number of factors, including the engagement of the CCG lead, the enthusiasm and turnout of the attendees, the information on the workshops given to the attendees beforehand, the previous history of the relationship between CYP services and schools, the communication skills of the group, the starting point on the framework, and the size of the area. As a result of these factors, there was disparity in the progress of areas; however when considering the framework as a whole, all 26 areas improved following the workshops.

There was also inconsistency within areas, the most evident being educational professionals' views differing from those of CYP mental health professionals. CYP mental health professionals frequently viewed their area further along the CASCADE© framework than the educational professionals. This may be because procedures are more consistently defined across CYP mental health services and can vary more by schools. In addition, CYP mental health services often had the language in place to discuss aspects of joint working. For example, "evidence-based" is a term commonly used in CYP mental health services, whereas it is a term

that is less common in school settings (Reinke, et al., 2011). This highlights the need for a shared language between health and education professions. Although the workshops made progress in starting to develop this shared language, there is still room for improvement. As the framework is meant to provide an overview of joint working across the area as a whole, an area could only be as strong on the framework as the weakest area. Therefore, it is unlikely that the limited number of CYP mental health professionals present at the workshops, relative to educational professionals in some areas influenced the findings. Although individual schools or services may have very strong structures in place and have more effective joint working, consistency across the entire area is important, and was often not achieved. In some of the larger areas, where they rated themselves on the framework was dependent on their location in relation to schools/services. This raised a need to ensure that areas are more stable in their progress and services across their landscape, so that vulnerable adolescents can receive sufficient help for their problems.

Aside from the CASCADE© framework, looking at the key achievements from each area and feedback from the workshops, it appears that the majority of the attendees felt the workshops had facilitated a relationship between professionals and improved their communication skills. Although the scope of the project was broad, the fact professionals have started communicating and making those channels clearer through managing referrals pathways or attending steering groups, created either in or as a result of the workshops, is evidence of progress in the right direction, as it previously has been a major challenge. This improved communication provides a good foundation for future work.

The final summative account of the evaluation by Ecorys, expected November 2016, will be able to create a bigger picture of the pilot's results and identify any long term effects of the workshops, however from the data received from the workshops, there is evidence that the Mental Health Service and School Link Pilot had good outcomes for all areas and improvements to joint working between schools and CYP mental health services was made.

References

Benchmarking and analytics for CAMHS. (2016). Birmingham.

Dishion, T. J. (2011). Promoting academic competence and behavioral health in public schools: A strategy of systemic concatenation of empirically based intervention principles. *School Psychology Review, 40*, 590-597.

Fink, E., Patalay, P., Sharpe, H., Holley, S., Deighton, J., & Wolpert, M. (2015). Mental Health Difficulties in Early Adolescence: A Comparison of Two Cross-Sectional Studies in England From 2009 to 2014. *Journal of Adolescent Health, 56*(5), 502-507. doi: 10.1016/j.jadohealth.2015.01.023

Ford, T., Hamilton, H., Meltzer, H., & Goodman, R. (2007). Child mental health is everybody's business: the prevalence of contact with public sector services by type of disorder among British school children in a three-year period. *Child and Adolescent Mental Health, 12*(1), 13-20.

Ford, T., & Nikapota, A. (2000). Teachers' attitudes towards child mental health services. *Psychiatric Bulletin, 24*, 457-461.

Frith, E. (2016). Commission on children and young people's mental health: state of the nation (pp. 32): CentreForum.

Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing. (2015) (Vol. Improving mental health services for young people): Department of Health.

Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. (2005). *Mental Health of Children and Young People in Great Britain, 2004*. Basingstoke: Crown.

Masten, A., Roisman, G., Long, J., Burt, K., Obradovic, J., Riley, J., . . . Tellegen, A. (2005). Developmental cascades: linking academic achievement and externalizing and internalizing symptoms over 20 years. . *Developmental Psychology, 41*, 733-746.

Pettitt, B. (2003). Effective Joint Working between Child and Adolescent Mental Health Services (CAMHS) and Schools Retrieved 25 July, 2016

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly, 26*(1), 1-13.

Sam Gyimah: mental health pilots - where next? (2016) Retrieved 25 July, 2016, from https://www.gov.uk/government/speeches/mental-health-pilots-where-next

Weare, K. (2000). *Promoting mental, emotional and social health: a whole school approach*. London: Routledge.