



NFER review



The role of primary mental health workers in education

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Contents

Page	Title
03	The role of primary mental health workers in education
03	Background
04–05	Summary
06	The Primary Mental Health Worker
06–07	How PMHWs work
08	How PMHWs are organised
09	The value of the PMHW role
10	Issues associated with the PMHW role
11	Working as the link between education and CAMHS
12	Recommendations for effective working
13	Recommendations for policy and practice
14–19	Illustrations
20–21	References



The role of primary mental health workers in education

This review evaluates the role of Primary Mental Health Workers (PMHWs) to date, focusing in particular on their role within education, and presents illustrations of PMHWs' practices. It can inform the development and expansion of PMHW links with education. It will be of interest to policy makers and practitioners in education and mental health, including PMHWs, CAMHS specialists and education staff.

Background

Promoting good emotional health is an increasingly important function in schools. Promoting the psychological wellbeing of children and young people is recognised as a shared responsibility.^{1,2} Consequently, better basic knowledge of mental health is needed across the children's workforce.² School staff require sufficient support, time and resources to develop their knowledge and expertise. An early report suggested that primary mental health workers (PMHWs) from CAMHS (Children and Adolescent Mental Health Services) could be employed to help tier 1 workers such as teachers (see figure 1) to support the mental health of children, develop relationships within local areas, and be the link between schools and CAMHS.³ These PMHWs are, therefore, key to promoting good emotional health, preventing mental health issues and identifying mental health problems early.

Summary

Figure 1: The Health Advisory Service (HAS) Model
This model focuses on functions rather than specific practitioners, and services are assigned to tiers.

Tier 1

Services provided by practitioners working within universal services (for example, teachers, youth workers, health visitors and GPs). These practitioners are not mental health specialists but have regular contact with children and young people. They offer advice and treatment for less severe problems, promote good mental health, facilitate early identification of problems and refer on to more specialist services.

Tier 2

Services provided by specialist CAMHS clinicians working on their own in community and primary care settings. They may be community mental health nurses, clinical psychologists or child psychiatrists. They offer consultation to other professionals and families, support to identify severe or complex needs and training for tier 1 professionals.

Tier 3

Services provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community setting. They offer a specialised service for those with more severe, complex and persistent disorders.

Tier 4

Services provided by highly specialised professionals for children and young people with the most serious problems. The children and young people may be seen as outpatients, in day units or in inpatient units.



PMHWs can be organised in four ways:

- as an outreach service from CAMHS
- in primary care or tier 1 services (for example, schools)
- in independent PMHW teams
- in integrated multi-agency teams.

The locus of control varies in each of these models, and each has different implications for the way in which PMHWs operate.

The PMHW role may consist of consultation-liaison with tier 1 workers or direct work with children and their families, or a combination of both. The role is new and it has yet to be fully clarified. There are also problems with recruitment and retention. There are often different views about the role from the perspective of CAMHS, tier 1 services and PMHWs themselves.

The role of the PMHWs in schools and education, more broadly, can pose particular challenges. Teachers can lack knowledge and understanding of mental health problems and be reluctant to take on responsibility for children's mental health. The cultures and practices of health and education services are very different and can create difficulties.

Regardless of the way PMHWs are organised, they can play a valuable and significant role in developing the skills and confidence of tier 1 professionals (including school staff) in identifying and working with children with mental health problems.

PMHWs can reach a large number of children with low-level mental health problems who might not otherwise receive the services they need. They ensure children receive help in school-based, non-stigmatising and familiar environments. They can act as an effective screening process for CAMHS, leading to a reduction in referrals. They provide a crucial role in directing children and young people to the most appropriate services, preventing delays and avoiding inappropriate alternatives.

‘ PMHWs in the primary care-based model can experience resistance to their role.’

The Primary Mental Health Worker

The PMHW role was developed to bridge the gap between tier 1 services and specialist CAMHS, to help tier 1 staff recognise and manage mental health problems and to reduce pressure on CAMHS.⁴ PMHW responsibilities are to:

- help the increasing number of children and young people with mental health needs in schools
- provide a responsive and accessible mental health service for children and young people
- identify children and young people at risk of mental health problems at an early stage in order to prevent the onset of more serious problems
- provide support and training for professionals in schools.^{5,6,7}

A range of responsibilities have been identified,^{8,9} and the seven key activities are set out in the National Committee of PMHWs’ guidelines.¹⁰

However, these guidelines contrast with the original report introducing the PMHW role. It outlined five PMHW key activities:

- consolidating the skills of primary care workers
- helping primary care workers to build their skills and confidence
- supporting the education of primary care workers in child and adolescent mental health matters
- aiding recognition of children and young people’s mental health disorders and referral to more specialist tiers when appropriate
- assessing and treating children and young people with mental health problems who are appropriate for management in tier 1.³

What PMHWs do: The seven key activities of the PMHW Role

- **Liaison:** network, instigate effective multi-agency working and collaboration and increase access to and signpost other services that work with children’s mental health needs.
- **Consultation:** identify a child’s mental health needs and consider appropriate ways of meeting their needs in partnership with other professionals. [Illustration 2](#), [Illustration 6](#)
- **Training:** provide training programmes for professionals working with children to increase and build on their understanding of mental health issues. [Illustration 1](#), [Illustration 10](#)
- **Supervision:** improve the ability of tier 1 professionals to manage child mental health needs by increasing their skills and knowledge, and facilitating reflection on their work. [Illustration 3](#), [Illustration 7](#)
- **Intervention:** work with tier 1 staff and directly intervene when a child has not responded to the measures undertaken by the tier 1 staff, if the intervention is likely to be short term and the level of need does not warrant intervention by specialist CAMHS. [Illustration 9](#)
- **Strategic planning:** pro-actively inform and influence children and young people’s mental health strategies, develop protocols, engage in joint planning and facilitate collaborative working relationships. [Illustration 4](#)
- **Research and development:** identify service needs and any gaps across different agencies, obtain service users’ views and involve them in the design, delivery and evaluation of CAMHS provision.



How PMHWs work

PMHWs' work varies in the degree of direct patient care provided and the amount of support given to tier 1 professionals.¹⁶ Three main ways of working are evident.

- **Consultation-liaison:** PMHWs working mainly with tier 1 staff in a consultation, supervisory and training role.
- **Direct work:** PMHWs mainly working directly with children, young people and families.
- **Combined roles:** PMHWs combining consultation-liaison and working directly with children, young people and families.

The following conclusions can be drawn from the evidence.

- PMHWs are able to offer either some components of the PMHW role (for example, just consultation or direct work) to a large population of professionals, or all aspects of the role to a smaller locality or defined population.¹¹ Whilst many schools have access to consultation and advice through CAMHS, direct work with children, young people and their families is less widespread.²
- In the consultation-liaison role the focus is on building existing capacity and resources within tier 1 to meet children's mental health needs.¹³ Tier 3 CAMHS workers can be eager for PMHWs to provide consultation-liaison to tier 1 professionals. This is an opportunity for preventative work and the number of less complex cases referred to tier 3 is reduced.

However, in contrast, tier 1 professionals value PMHWs having a direct patient care role, thereby removing some of the burden from tier 1 staff.¹⁶

- Focusing on consultation-liaison rather than direct work can encourage a change in culture and a move away from clinical work.¹⁷ It can also reach a wider population of children and young people.⁷ [Illustration 8](#), [Illustration 6](#)
- There can be tension when PMHWs combine consultation and direct work. A key issue is the appropriate balance between time given to direct work and that given to supporting primary care staff.¹⁶

‘ Young people can feel more comfortable and less stigmatised receiving support in their own environment.’

How PMHWs are organised

Organisation of PMHWs varies according to where they are located, by whom they are managed, how they operate and their relationship with other services. Four models of PMHW practice emerge from the literature.

- **CAMHS-outreach model:** PMHWs operate as an outreach service from CAMHS and are managed by the CAMHS team.
- **Primary care-based model:** PMHWs are based within primary care or tier 1 services (for example, in general practices, schools or social services) with some contact with CAMHS.
- **Independent teams:** a PMHW team is located within the CAMHS structure, but with their own team manager and referral system (and, therefore, more control over how they operate).
- **Integrated teams:** PMHWs are part of an integrated multi-agency team with an integrated services manager (who may, therefore, not be part of the NHS) and their own referral system.

A number of conclusions can be drawn from the evidence.

- The most prevalent model is the CAMHS-outreach model, which can include single PMHWs or a group of PMHWs typically employed by health trusts.^{11,12} The primary care-based model, where PMHWs are based within local infrastructures,¹³ and are most likely to be in jointly-funded posts,¹¹ is the least prevalent model. The integrated team model, for example, a child behaviour intervention initiative,¹⁴ is newly emerging.

- Independent teams of PMHWs focus on providing early intervention and undertake less direct clinical work compared to PMHWs in the other two models.¹¹ The teams typically cover small areas and can operate as independent services with their own referral systems.⁴
- PMHWs in independent teams tend to have greater role satisfaction and fulfilment than PMHWs in other models,^{7,15,16} as well as better access to peer support.¹⁶ This model can break down professional barriers and foster a culture of innovation.^{7,17} However, the close relationship with both CAMHS and tier 1 services can create tension.¹⁶
- PMHWs can be professionally isolated, regardless of their model of deployment. Primary care-based PMHWs report challenges to their professional identity, pressure from CAMHS to focus on tier 3 case work and resistance from tier 3 to providing support.^{13,16,17} Tier 3 professionals can also have concerns about the increased referrals and workload that PMHWs in this model might produce.^{11,16}
- PMHWs in the primary care-based model can experience resistance to their role.¹⁶ Working in an unfamiliar context, and with those who have different attitudes to mental health, can impact negatively on job satisfaction.¹⁶ Being managed outside of CAMHS can lead to professional isolation, restricted access to and a lack of knowledge about CAMHS and unclear referral pathways.¹⁷ It can also be difficult to find appropriate accommodation and establish an effective working environment due to, for example, lack of access to administrative support and IT facilities. Insecure funding for primary care-based PMHWs can also put the stability of their posts at risk.¹⁷



The value of the PMHW role

The benefits of the PMHW role are evident in all the models, for children, young people, families, education staff and CAMHS professionals.

- Most significantly, teachers and other tier 1 staff are able to develop their skills and confidence in recognising and dealing with mental health issues.^{5,18} [Illustration 7](#) PMHWs in schools, for example, increase school staff awareness, knowledge and understanding of mental health, and contribute to a better understanding of the behaviour of children.¹⁸ Teachers also develop their skills in early identification and in dealing with children's difficulties within the classroom.¹⁹ [Illustration 2](#)
- PMHWs increase accessibility to and uptake of mental health support.^{11,16,20} They reach a wide range of children and young people,^{5,7,11} including those with low-level mental health problems who have traditionally had poor access to services.² Young people can feel more comfortable and less stigmatised receiving support in their own environment rather than in CAMHS-based alternatives.² [Illustration 2](#)
- Early intervention and preventative work by PMHWs, and increased support for tier 1 staff so they can manage less severe cases, can reduce referrals to specialist CAMHS.^{12,16,21} These can also lead to more timely and appropriate referrals.^{12,19,22,23} [Illustration 6](#) PMHWs in schools, for example, speed up access to CAMHS expertise,²⁴ and allow school support staff to check informally whether a mental health referral should be made.¹⁸ However, PMHWs also identify unmet need.¹² There can be tension between increasing access to specialist CAMHS and ensuring demand is appropriate.¹⁶
- PMHWs can help children and young people through the mental health support system (tiers 1 to 4), ensuring they receive timely and appropriate treatment.⁹

‘ The PMHW role is new and evolving, and there are issues with role definition, recruitment and sustainability.’

Issues associated with the PMHW role

The PMHW role is new and evolving, and there are issues with role definition, recruitment and sustainability.

Role definition

- There are local variations and different interpretations of the PMHW role across the UK.^{4,25,26,27} Ways of working can vary according to individual PMHWs and across different settings. [Illustration 5] PMHWs also undertake a broad spectrum of activities [See the seven key activities on page 6.](#) The scope of activities can place unrealistic expectations and demands on PMHWs.^{26,28,29} They can be overwhelmed by work unless there is clear planning regarding their role and function, and clear governance arrangements.¹²
- There is a lack of understanding, and some disagreement and ambiguity over the PMHW role.^{30,31} This can lead to conflict among mental health professionals and can make referral routes and service boundaries more complex.^{20,30}

Recruitment and sustainability

- The scope of the role and the different settings within which PMHWs work can make it difficult to find employees with the right experience and expertise. Little is known about the characteristics that make PMHWs effective.²⁶
- Filling posts and retaining PMHWs is challenging and yet early estimates indicate the need for more posts.^{1,32,33} A high percentage of PMHWs leave due to dissatisfaction with career pathways,³⁴ and this, together with financial barriers, restricts the creation of new posts.^{32,33}
- PMHWs come from a variety of professional backgrounds: the majority are from a nursing background, but some are from social work, psychology, family therapy and teaching.^{25,26} Existing training and experience varies.^{25,30,34} It is recognised that PMHWs need support to effectively train, advise and offer consultation, as well as provide direct services.¹² However, access to training and development for PMHWs can be poor.¹¹



Working as the link between education and CAMHS

Working as the link between education and CAMHS raises further challenges for PMHWs. This is due to a number of factors, as shown below.

Teachers' lack of understanding of mental health issues

Many teachers describe their understanding as inadequate and consider pupils' mental health to be the responsibility of specialists.²⁷ Within schools, there is a shortfall in staff with the skills to deal with mental health issues,¹² and staff can lack confidence in supporting young people (particularly those with complex mental health needs). This can lead to strained relations with mental health staff and a resistance to consultation.^{16,27,35}

Teachers' lack of awareness or reluctance regarding their responsibilities for mental health

Teachers may be unaware of their role and responsibilities in relation to pupil's mental health.^{12,35} Some schools see their role in fairly narrow terms and there is a tension between driving up educational standards and the broader focus required to improve emotional health and psychological wellbeing.¹²

Teachers' concerns over their workload

Heavy workloads can lead to resistance to the PMHW role and a reluctance by education staff to take on what is perceived to be additional work.^{16,27,35}

Lack of support systems for teachers

There are few places where teachers can share concerns about pupils, leading some to suggest that referral systems into CAMHS are inadequate. Lack of time for staff to commit to training exacerbates this.^{27,33,36}

Lack of effective partnership working between education and health

A history of ineffective partnerships and poor relations between CAMHS and education creates an additional barrier for PMHWs.^{7,35} There are very different working cultures in health and education, and discussion is needed on how to facilitate effective ways for these two services to work together.³⁷

‘ Changes to policy and practice may be required to ensure the success of PMHWs.’

Recommendations for effective working

- The role should be clarified to avoid overlap with other roles, poor coordination with other agencies or dissatisfaction amongst PMHWs.^{14,34} Clear understanding needs to be fostered across agencies, and PMHWs need specific protocols and guidance for their work.^{15,16}
 - Clear management and accountability structures need to be put in place. In some cases, dedicated PMHW managers successfully lead teams instead of CAMHS,²⁸ and coordinators for PMHWs can be instrumental in managing caseloads.⁷
 - Early consultation and planning with tier 1 and CAMHS staff is important for developing role clarity and maintaining positive relationships.¹⁶ Collaboration and understanding is fostered by involving all relevant professionals at an early stage when developing PMHW practice.¹³
 - Training courses for PMHWs³⁸ have been useful.^{15,34} Having sufficient time and opportunity to maintain skills and knowledge is important. Training for tier 1 staff in how to work with PMHWs improves integration.⁷
 - Establishing formal career structures and effective career pathways will help to sustain the PMHW role, as would a formal system of professional development.^{15,28,34} This should be flexible enough to cope with the diverse range of needs among PMHWs. A series of modular-based academic courses would be useful.³⁹ These measures could reduce some PMHWs’ current perception that their training and development needs are not being met.
 - Capabilities and competencies for the PMHW role have been published.^{2,40} A wide range of personal attributes, knowledge, skills and expertise are required. These include the ability to develop supportive relationships and to empower primary care staff, the confidence and ability to communicate effectively and to work as part of a team^{20,26} and the need for clinical skills.^{16,20,26}
 - Evaluating the impact of PMHWs can help to inform training and professional development. Developing effective evaluation methods,¹⁵ ensuring ongoing feedback and growth of the role⁴ and evaluating models of service provision⁷ are all valuable.
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Recommendations for policy and practice

Changes to policy and practice may be required to ensure the success of PMHWs working as the link between education and CAMHS.

- Issues around recruitment and retention and role clarity must be addressed for the PMHW role to fulfil its potential. The PMHW role is still in its infancy. It is establishing itself as an important role in strengthening links between CAMHS and tier 1 practitioners, dealing with mental health difficulties and directing users to where they can most effectively and appropriately be supported with minimum delay.
- The PMHW role needs to be manageable and understood by all key stakeholders within the local context. Differentiating the role at a local level, with more senior PMHWs taking on strategic and developmental tasks and PMH practitioners focusing on ground-level work, could facilitate this. The wide remit of the role allows PMHWs to be innovative and adapt to local needs, but it can also lead to different interpretations and to unrealistic expectations.
- PMHWs should be based locally and excessive direct work should not prevent consultation and liaison. Clear role definition would help to differentiate the role from other professionals within the system, such as community psychiatric nurses.
- PMHWs should be based in schools, school-based children's centres or multi-agency/co-located settings. This will facilitate long-term cultural shifts and place a greater emphasis on schools' role in promoting psychological wellbeing, whilst also helping to secure sustainability.
- PMHWs need specific training and a high level of support and supervision to act effectively as the link between education and CAMHS. These services' differing cultures and ways of working make this role particularly demanding.
- Regular training for education staff, which is facilitated or supported by PMHWs and includes recognition and early identification of mental health problems, would be beneficial.
- Further investigation is needed into the effectiveness of different models of practice and, in particular, the way in which PMHWs work with education. This could focus on how PMHWs could work effectively across a range of educational settings and, in particular, within inter-agency teams.

Illustrations

Illustration 01

Shoreham: Mental health training for school staff

In Shoreham's schools, the Primary Mental Health Service provides mental health awareness training for reception staff, teaching assistants and special educational needs coordinators (SENCOs). Two-hourly sessions are offered over a period of eight consecutive weeks.

The training covers:

- the role of the PMHW
- promoting resilience
- dealing with confrontation
- the emotional aspects of school phobia
- recognising signs of anxiety
- supporting children going through divorce, separation, bullying or bereavement.

There has been a significant increase in the knowledge and confidence of participants at the end of the course, particularly in recognising resilience factors or factors that promote good emotional wellbeing in children, and the emotional aspects of school refusal.

Adapted from Atkinson, M. and Brooks, K. (n.d). *Improving the Emotional Wellbeing of Children and Young People in Schools: Mental Health Awareness Training for Teaching Assistants in the Shoreham Schools*. Unpublished report.

Illustration 02

Doncaster: Consultation clinics in schools

The aim of the CAMHS Schools Initiative in Doncaster is to increase PMHW services so they can provide intensive consultation clinics in individual schools. PMHWs advising personal tutors on emotional wellbeing issues has been extremely beneficial.

Two schools with high numbers of referrals to CAMHS were selected as pilots. The pilots demonstrated that PMHWs can successfully reduce school staff's anxiety, enabling them to manage mental health problems within their own pastoral care systems. Referrals to CAMHS were reduced by over half, and more children and young people with emotional and mental health needs have had access to appropriate services.

Staff in Doncaster are receiving on-site training and developing their capacity to respond to mental health issues. Service users also receive support from known professionals in familiar non-stigmatising settings.

The pilot project has proved that joint working between education and mental health services can be effective at the point of early onset of problems. Other professionals working in the schools have also improved access to support, advice and guidance.

Adapted from Calverley, L. (2008). *Doncaster Primary Care Trust Local Delivery Plan 2008/09: Business Case Template for CAMHS Schools Initiative: Early Intervention (January 2008)*. Unpublished report.

Illustration 03

Haywards Heath: Supervision and training with learning mentors

In Hayward's Heath, eight schools were dealing with emotional and mental health concerns beyond what they could reasonably manage. Staff were frustrated about access to CAMHS and felt services were not responding to their needs.

A PMHW has been employed by Sussex Partnership NHS Trust through Every Child Matters funding. A significant amount of work was undertaken prior to the commencement of the post, providing a clear understanding between schools and health professionals about the role.

It was important that the schools were included in developing the role. A one-month period of induction allowed the PMHW to develop good working relationships with the schools, understand the schools' needs and make links with the Primary Mental Health Team and other services.

The PMHW works with learning mentors (LMs) once a month, providing supervision and assisting with developing and consolidating their skills. The PMHW also facilitates groups alongside LMs and provides training. The training includes child-centred discussions as well as training packages on specific areas. The PMHW also liaises with CAMHS about children being seen by their services.

Adapted from Sussex Partnership NHS Trust (2007). *Six Month Evaluation of FACS Post*. Available: www.lindfield.w-sussex.sch.uk/Review%20of%20FACS%20post%20June%2007.doc [3 December, 2008]. and

Watkins, J. (2007). *Sussex Partnership NHS Trust; Six Month Evaluation of the FACS Post and Twelve Month Evaluation of Haywards Heath FACS Post*. Unpublished report.

Illustration 04

Northamptonshire: Implementing Emotional Health and Wellbeing Teams in schools

Northamptonshire have introduced multi-agency Emotional Health and Wellbeing Teams in its schools. A mental health handbook for schools has been developed with information on mental health, suggested approaches and contact details for mental health services.

The PMHW is helping schools to set up the teams. For each school, they look at:

- the school's unique needs
- guiding the process and working together
- support for school staff
- training and reflective consultation needs
- designing documentation
- early identification of mental health issues
- promoting good emotional health
- identifying if specialist CAMHS professionals are needed
- a telephone consultation service
- joint working and assessment processes
- liaison between tiers 1 and 2 CAMHS provision
- promoting the model with other schools, agencies and within the local CAMHS partnership.

Adapted from Northamptonshire Children and Young People's Partnership (2007). *Mental Health is Everybody's Business: Children and Young People's Mental Health: a Handbook for Schools and Other Agencies in Northamptonshire*. Unpublished report. and

Pawlikowski (n.d). *CAMHS South Northamptonshire: Emotional Health and Wellbeing Teams within Schools*. Unpublished report.

Illustrations

Illustration 05

West Sussex: The PMHW role in pupil referral units (PRUs)

In West Sussex, three PMHWs (18.5 hours each) worked in three PRUs for an initial two-year period. Due to the model's success, this has been extended.

There has been a range of interventions in each of the PRUs including consultation, training, assessment, ongoing individual work, family work and group work. Caseload sizes and interventions vary between PMHWs. For example, whilst one withdrew pupils from lessons to undertake individual work, another was more closely involved in family work within the home.

The PMHWs felt that most teaching staff had a clear understanding of their role, but frequent timetable changes could made it difficult to sustain a planned approach to working with young people. Issues with accommodation in some PRUs also limited the effectiveness of the PMHW role. There was a view that it would have been useful to have involved the heads of centres and SENCOs when drawing up the service specification. There was an acknowledgement that the very different cultures in health and education need to be discussed and worked through for people to be able to work effectively with each other.

Despite these challenges, all of the PMHWs felt education staff valued their knowledge and input on mental health. Individual work with students was said to have had a big impact. Early challenges were addressed before the pilot was extended, and the collaboration is now running smoothly and successfully.

Illustration 06

Luton: Consultation and referral meetings

In Luton, workforce development is thought to be key to developing a system that can promote good emotional health, identify mental health difficulties and prevent further development of problems.

CAMHS activities at tiers 2–4 are dependent on universal workers at tier 1 bringing families to their attention. For this to work effectively, tier 1 staff need support in how to detect and intervene early with mental health problems.

Consultation and referral meetings offer training for mental health awareness and identification. They are described as 'the backbone' of CAMHS work with schools. At these meetings tier 1 professionals bring cases they are concerned about. They are encouraged to think about the cases reflectively with CAMHS staff and generate their own solutions.

Through these consultations a large number and wide range of families are reached. In six months, across 22 schools, CAMHS staff conducted 370 consultations on 236 children. The children, schools and families received significant levels of support and experienced speedier referrals. In some cases, early intervention prevented further difficulties. The majority of the cases, where school staff had concerns about children's mental health, did not become a formal referral to CAMHS.

Illustration 07

Luton: Supervision: staff work discussion groups

When school staff were asked about their experiences of the consultation meetings, the staff said they:

- decrease anxiety and stress in tier 1 professionals
- allow early multi-agency partnership and collaboration
- offer an easy referral route
- offer quick and convenient access to tier 1 professionals
- help tier 1 professionals feel supported to carry out their role
- are a form of training for mental health awareness and identification.

Adapted from Roosmalen, M. and Gardner, C. (n.d). *Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust: Key Findings Report. CAMH Community Services to Education, Luton (Behaviour Improvement Programme and On Track)*. Unpublished report.

In Luton, ‘staff work discussion groups’ are used to support teachers and develop their confidence in identifying and working with mental health difficulties. These groups were described as a model of best practice by the Department for Education and Skills and the Department for Health. They found those in the groups persevered with challenging pupils, felt less stressed and had a significantly lower rate of absence than the whole staff group.

In Bedfordshire and Luton, these groups, along with consultation, help to develop a deeper understanding about the meaning of behaviour and extend teachers’ capacity to manage complex and challenging behaviour. Staff are encouraged to reflect on their internal reactions, feelings and behaviour. This can have a significant and positive impact on their own learning and teaching, as well as their broader role within the school.

Adapted from Roosmalen, M. and Gardner, C. (n.d). *Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust: Key Findings Report. CAMH Community Services to Education, Luton (Behaviour Improvement Programme and On Track)*. Unpublished report.

Illustrations

Illustration 08

Luton: Consultation leading to reduction in referrals to CAMHS

Before partnerships were established between schools and the community CAMHS, one primary school in Luton was reluctant to use the consultation service provided by the community-based CAMHS, preferring to send referrals to a clinic-based CAMHS. This school had a high referral rate with many cases having longstanding and complex problems. Once referred, there were high levels of disengagement with CAMHS and unsatisfactory outcomes.

Several meetings between the school and CAMHS resulted in a more effective working partnership. It was agreed that the school would use the consultation process as well as making referrals to clinic-based CAMHS.

A further audit showed referrals to be significantly reduced and there were 18 consultation meetings discussing 14 children.

It was shown that an effective partnership with schools can:

- be an effective screen for referrals to specialist CAMHS
- help the school, children and families
- help prevent unnecessary waste of system resources
- prevent dissatisfaction among schools and families.

Adapted from Roosmalen, M. and Gardner, C. (n.d). *Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust: Key Findings Report. CAMH Community Services to Education, Luton (Behaviour Improvement Programme and On Track)*. Unpublished report.

Illustration 09

Caerphilly: The Student Assistance Programme (SAP)

Adopted in Caerphilly, the SAP is an early intervention and prevention model that enhances school pastoral systems. It is a long-term strategy being implemented across the local authority, one that will impact not just on the schools and their pupils but also on the local communities and other agencies.

Support groups provide learning activities for children and young people exhibiting high-risk behaviours. The adults working with them are also supported. It is a positive alternative to exclusion. School staff, including inclusion and behaviour support staff, youth workers and school health nurses, are trained as SAP group facilitators.

The initiative was introduced via the CAMHS primary mental health team for the borough. It continues to help schools and the local authority implement and develop the programme.

With the support of parents, teachers nominate children with a wide variety of emotional needs including school phobia, bereavement, children of parents with substance misuse and children from divorced families. The groups offer a safe environment for addressing issues. The groups are structured and help young people develop skills and understand ways in which to deal with their feelings and concerns.

Illustration 10

Sussex: Training from PMHWs across a family of schools

The SAPs are reported to be a powerful vehicle for personal growth and transformation. The key skill is that of supportive listening and allowing children to express their concerns without implication, which can have far-reaching and positive effects for all concerned. All the children gained in terms of personal self-esteem and stated that it felt good to talk about their feelings.

Teacher evaluations indicated some children were less aggressive and more open to discussing confrontational issues, rather than losing their temper and lashing out at others, whilst very quiet children were more forthcoming and contributed to discussions.

Parent evaluations indicated the children were calmer at home and more prepared to accept rules—the introverted were more confident and able to articulate their opinions.

Staff are more approachable, have a greater understanding of the emotional and psychological needs of pupils and are more confident in supporting pupils with mental health issues.

Adapted from Caerphilly on Primary Mental Health Project (n.d). *Briefing Paper for Caerphilly County Borough Council Local Education Authority Outlining the Impact of Adopting the Student Assistance Programme and Teacher Research Report*. Unpublished report.

In Sussex, a two-year project has been focusing on providing a PMHW service for schools. It aims to raise awareness of mental health issues, strengthen school capability for identification and intervention, increase staff confidence and language around mental health and offer one-to-one support that can help them engage with tier 1 interventions.

Children in the schools were largely presenting with issues arising from parent's separations and divorces and for behavioural problems in the classroom. Consultation and training was provided.

Following a training needs analysis, all staff had access to one day's training every half term. The training was provided in addition to consultation time with the PMHW. Each session focused on a different subject, covering a range of topics, including attachment, separation and divorce, school refusal, introduction to CAMHS and mental health awareness.

Training was also provided for parents. This covered 'living with teenagers' and child development. Both forms of training were considered very useful.

Adapted from Pinnell, Y. (2008). *Durrington Family Group of Schools: Primary Mental Health Worker Project. Twelve Month Evaluation Report: 11th August 2008*. Unpublished report.

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