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Implementing the Green Paper: The Challenges of multi-disciplinary team collaboration. A review of the evidence

The mental health of children and young people (CYP) is of growing national concern, with an estimated 1 in 8 having a diagnosable disorder (NHS Digital, 2018). Conjointly, waiting times for Child and Adolescent Mental Health Services (CAMHS) have more than doubled since 2011/12 (Frith, 2016), compounded by the reduction in the amount of services (Young Minds, 2015). This means that schools are often the first place CYP and their families look to seek support for mental health (Cortina, Saunders, Smith, & Wolpert, 2016), something the Department of Health (DoH) and Department for Education (DfE) have stated they intend to utilise in *'Transforming Children and Young People's Mental Health Provision: a Green Paper'* (subsequently referred to as the Green Paper) (2017).

However, teachers often feel they lack the knowledge and expertise to handle such issues (Lendrum, Humphrey, & Wigelsworth, 2013) and have expressed a desire for better communication with mental health services (Shelemy, Harvey, & Waite, 2019).

This paper will examine the background to CAMHS before assessing the current obstacles to working more collaboratively with schools, moving onto a recommendation as to how barriers can be overcome in order to ensure better access to support for secondary school pupils.

Background

Nationally, there is concern about the lack of accessible services for children and young people's mental health (CYPMH) with services available dependent on area (CQC, 2017a). Mental health provision for CYP is a complex multi-agency service, split into 4 tiers:

- Tier 1: Universal services e.g. schools and GPs
- Tier 2: Targeted services e.g. schools and youth counselling
- Tier 3: Community CAMHS
- Tier 4: Specialist inpatient and outpatient CAMHS

(Parkin, Long, Gheera & Bate, 2019).

Funding is split between local Clinical Commissioning Groups (CCG), voluntary sector and NHS England dependent on tier (Parkin *et al.*, 2019). As different sectors provide different services, it is important that collaboration amongst all stakeholders takes place to ensure an effective robust service (Joint Commissioning Panel for Mental Health, 2013); however, the current ability of services to respond to the growing demand of emerging mental health disorders is limited. The DoH have revealed that only 25 to 35% of CYP with a diagnosable mental health disorder were being treated (DoH, 2015) often due to high thresholds (Children's Commissioner, 2016).

With the system under increasing strain, focus has shifted onto the use of schools as a strategy for building resilience and early intervention. 'Future in Mind' (DoH, 2015) highlighted the effectiveness of schools in adopting a whole school approach to mental health and wellbeing, encouraging a mental health lead within each school. In 2017 the prime minister announced a review into how educational establishments could be better utilised to support emerging poor mental health (H.M. Government, 2017). The House of Commons (HoC) Education and Health Committees (2017) made a number of recommendations including the development of whole school culture promoting Social and Emotional Welfare (SEW), timetabled teaching of

the same, and staff training. The report also encouraged collaboration between health and education services (HoC Education and Health Committees, 2017).

The publication of the Green Paper later that year incorporated many of the features highlighted in the report, its stated aim, to address whole school culture with processes that would support and promote good mental health through school based Designated Senior Leads for Mental Health (DSLMH), supported by NHS-CAMHS based Mental Health Support Teams (MHST) (DoH/DfE, 2017). However, funding for Green Paper implementation remains unclear; whilst it is stated that funding will be received through CCGs, there are no plans to ringfence it (Partnership for Well-being and Mental Health in School's [PWBMHS], 2018). Moreover, the role of DSLMH is not a statutory requirement (PWBMHS,2018), something confirmed in personal communication with the DfE (2019), who stated, "*Since the senior lead role is not mandatory, there is no requirement to confirm that an individual has reached the required standards to effectively carry out the role,*" revealing a further issue regarding training for the position. Additional difficulties arise when considering that the roll out of the MHST is over a 10-year period as opposed to just 5 for the DSLMH (DoH/DfE 2017).

Current training that does exist is aimed at collaborative working between DSLMH and MHSTs with the Green Paper (DoH/DfE, 2017) recommending the CASCADE Framework (Wolpert & Cortina, 2018) as a tool to improve collaboration between services. It is this framework that will be examined in more detail later.

Assessment

Public Health England (PHE) profiles (2015) estimated the percentage of 5-16 year olds with a diagnosable mental health disorder at 9.2% nationally with the number varying according to region (see Table 1, for a breakdown of regional statistics http://www.thrivingfutures.co.uk/444551355). Whilst the reasons for these differences are not stated amongst the figures, examination of vulnerability factors (Table2 http://www.thrivingfutures.co.uk/444551355) within different areas, offers some potential clues whilst also highlighting the important role school plays in determining not just academic success, but also health outcomes. The impact of socioeconomic factors becomes apparent when comparing the North East, which has the highest estimated level of mental health disorders at 10%, with the South East which has the lowest at 8.5%. Comparison of circumstances (Table 2, http://www.thrivingfutures.co.uk/444551355) reveal stark differences, particularly that of pupils in receipt of free school meals (FSM), an indicator of social deprivation and accepted risk factor for developing poor mental health (DfE, 2018) with 18.9% of North East CYP receiving FSM compared to just 9.4% in the South East.

Equally, the rate of fixed period exclusion is nearly twice as high in the North East compared to the South East. Risk factors are cumulative, hence a young person from a disadvantaged socioeconomic background, eligible for FSM, who also has a special educational need (SEN) and problematic parenting, is also more likely to develop a conduct disorder (Murray, 2010). The Timpson Review into school exclusion echoed this revealing that 78% of permanent exclusions were of students who had either a SEN, needed support, or received FSM, and that 11% met the criteria for all three (Timpson, 2019). The review made a number of suggestions for improving the current rate of exclusions, calling for a need to understand and respond to the mental health issues that lead to problem behaviours (Timpson, 2019). This fits in with the Green Paper's (DoH/DfE, 2017) plan to address mental health in schools.

The Green Paper is now on phase 2 of its roll out with an initial 25 'trailblazing' areas piloting the introduction of 59 MHSTs in 2019. A further 57 trailblazing areas were added to the list in July 2019 in phase 2, expanding the original sites and creating new ones; these are expected to have started work towards introducing 123 MHST by the end of 2020 (NHS England, 2019). (See tables 3, 4 & 5 http://www.thrivingfutures.co.uk/444551355 for a breakdown of sites).

The majority of teaching staff believe that schools should address the mental health needs of CYP (Reinke, Stormont, Herman, Puri, & Goel, 2011) however there is a perceived lack of knowledge and skills to deliver such lessons or interventions (Lendrum, Humphrey & Wigelsworth, 2013). Teachers have also expressed concern that they will be expected to become the therapist (Shelemy, Harvey, & Waite, 2019) highlighting a need for better communication and

increased support from CAMHS (Shelemy, Harvey, & Waite, 2019). Challenges in communication between educational and CYPMH services are not new (Cortina *et al.,* 2016; Weare, 2000), and the '*Future in Mind*' report (DoH, 2015) highlighted the need for improved communication, recommending a designated points of contact in both schools and CAMHS.

This has been addressed in the Green Paper (DoH/DfE, 2017), with the recommendation of DSLMH within schools and MHSTs working collaboratively to help bring about whole school cultural change to support mental health. The Nursing and Midwifery Council (NMC) have also recognised the need for greater collaboration with other organisations such as Ofsted to ensure a robust service as the nature of the NHS adapts and evolves into new ways of working (Sutcliffe, 2019). Concordantly, the Care Quality Commission [CQC] (2018) emphasised the need for effective collaboration by reporting on a disjointed system that fails to work well together resulting in poor results for vulnerable CYP.

However, the challenge is not easy as logistical barriers must also be overcome as school and local authority boundaries do not necessarily match NHS and Clinical Commissioning Group (CCG) boundaries (CQC, 2017b). Whilst complex, evidence shows that integrated working can be effective (PHE, 2018) and explains why collaboration has also been the government's priority with regards to implementing the Green Paper. The afore mentioned CASCADE framework aims to improve joint working amongst all stakeholders in CYPMH including schools, CAMHS, CCGs and local authorities (DoH/DfE).

Recommendation

The CASCADE framework is a self-assessment tool to assist in multi-disciplinary team integrative working, developed by the Anna Freud National Centre for Children and Families (AFNCCF) (Wolpert & Cortina, 2018). Based around seven domains including clarity, structures, adaptability and evidence-based practice, CASCADE helps stakeholders within both mental health and education, to work to an agreed framework thus assisting in developing the collaborative approaches needed to enable effective mental health support within schools (Wolpert & Cortina, 2018).

Piloted between September 2015 and 2016, the '*Mental Health Services and Schools Link Pilot*' used the CASCADE scaffold, developed specifically for the trial, to help plan, implement and reflect on collaborative working between CCGs, schools, CAMHS, and local authorities (Day, Blades, Spence, & Ronicle, 2017). The pilot was based around three phases that ran concurrently during the academic year; one - planning, and two – embedding and sustaining practice, were facilitated by joint workshops; phase three focused on supporting ongoing development (Cortina *et al.,* 2016).

During the pilot, the CASCADE framework proved effective on a number of levels; improved knowledge of CYPMH, more efficient and frequent communication between stakeholders, and increased understanding of referral routes for CYP (Day *et al.,* 2017). Evaluation of the trial also suggested that whole school staff knowledge improved, resulting in more timely, appropriate referrals to CAMHS, although the report acknowledges this is harder to quantify (Day *et al.,* 2017). The '*Agreed point of Contact*' within CAMHS demonstrated the largest improvement with 0% of participants still regarding it as 'a major challenge' at the end of the year's pilot (Cortina *et al.,* 2016, p13). As a result, £9.3 million over 4 years, has been set aside by the DfE for training schools in using the CASCADE model through 2-day workshops offered to 20 schools at one time (Cunliffe, 2019); as the programme is externally funded, CCGs will not be charged for the training (AFNCCF & DfE, 2019). However, senior stakeholders within CYPMH services must ensure that all partners fulfil the demands placed on them for collaboration to work.

CCGs

As the training is about improved integration and communication, it is the responsibility of the CCG to govern implementation and ensure that sessions consist of

- the commissioning lead and local authority representative to facilitate and provide oversight,
- practitioners and managers from within NHS CAMHS,
- DSLMH from schools

(AFNCCF & DfE, 2019)

Research emphasises the importance of this role in creating structure and governance to enable

effective collaboration (Granrud, Anderzèn-Carlsson, Bisholt, & Steffenak, 2019).

Schools

Despite the role of DSLMH not being statutory in schools (DoH/DfE, 2017; PWBMHS, 2018), analysis of the Link trial demonstrates that it is important that schools have a senior lead as a single point of contact and that they fully commit to creating a whole school response to the mental health needs of CYP (Day *et al.,* 2017). Granrud *et al.* (2019) argue that it is the school and teachers that are the strongest determinants of successful collaboration and implementation of integrated working. Hence, school leaders must ensure a culture and environment in which the mental health needs of pupils and staff is valued regardless of academic and curriculum pressures.

CYPMH services

As health professionals are not a constant in the school, Granrud *et al.* (2019) qualitative study revealed some found it difficult to be accepted into the school culture and were often overlooked. The research emphasised the importance of them having a physical presence within schools in addition to acting in an advisory capacity. Whilst this study was small, involving just 18 public health nurses, it does highlight some of the potential issues implementing the CASCADE framework and ultimately the Green Paper; it is important therefore, that health professionals are active and assertive in their role through supporting with workable school-based resources and in defining clear referral processes for school leads to follow (Day *et al.,* 2017). It is also vital that CCGs ensure their prominence within the programme (Granrud *et al.,* 2019).

Statistically, the numbers of CYP presenting with mental health difficulties is increasing (NHS Digital, 2018), however services are struggling to cope with demand evident from increased waiting times and the failure of up to 75% of young people to meet the threshold for CAMHS (Children's Commissioner, 2016). Consequently, schools are increasingly the first place young people and their families look to for support. The government have announced its intention to utilise this through the use of collaborative working between educational and mental health services. The CASCADE framework piloted by the Schools Link Project offers a practical solution for stakeholders to begin this process, however this will only work if all partners have shared goals and vision, if there are clear lines of communication and roles, and if all stakeholders are active and committed to working in partnership to overcome the inevitable obstacles that will present.

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