Developing a Resilience in Schools Programme in Luton

Marc van Roosmalen describes the development of a model of working with schools, focused on building resilience, and working across schools and localities. The challenge was to work in partnership with CAMHS, schools and the local authority to provide early intervention support.

How does this fit into local i-THRIVE plans?

The resilience in school's model cuts across the Getting Advice and Signposting and Getting Help needs based groupings through offering consultation and therapeutic intervention if appropriate, with a focus on integrated working and a resilience model of mental health and well-being. In both the THRIVE framework (Wolpert et al., 2016) and the Five Year Forward View there is an emphasis on developing capacity and integrated working and the resilience in schools model works to these markers. Providing consultation and advice through schools often reduces the need for direct input. Thus, through early intervention there is increased capacity in CAMHS which means more children, young people and their families can access specialist help and support.

What was the approach you took to developing this model?

We took a programme logic approach and looked at the overall aims of the service, to improve mental health, access to hard to reach groups and competency in schools. We developed an outcomes framework and worked to enhance frontline staff's resilience and confidence in supporting CYP and their families. This work started in 2007 and we went on to service 50 schools in the locality. We then developed a theory of change and throughout the implementation of the new model researched the impact we were having. This was published an article in 2012 on 'A systems relations model for Tier 2 early intervention child mental health services with schools: An exploratory study'*.

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* van Roosmalen, M., Gardner-Elahi, C., & Day, C. (2013). A systems relations model for Tier 2 early intervention child mental health services with schools: An exploratory study. *Clinical child psychology and psychiatry*, *18*(1), 25-43.

Please can you describe the model and any development plans for the future?

The Targeted Mental Health in Schools Project, that was part of the CAMHS Early Intervention Service initiative, had a systematic impact on the education environment. In 2014 due to local authority budget cuts of around 33%, the schools service was decommissioned and changed to a traded service, meaning the service had to be sold to schools. It is currently commissioned individually by 27 primary and secondary schools and special education services in the locality. More recently, there have been discussions about the traded model as it presents a postcode lottery with inequitable access. Commissioners are currently considering reinstating a consistent model of service across all schools.

A key element of the model is that it is relational. School have taken to this because they can see the impact they are having, and are motivated to be involved in supporting the child or young person's mental health and well-being. In addition, CAMHS actively acknowledge the ongoing support schools provide to CYP daily.

There are three functional levels of work provided:

1) Targeted work with the most vulnerable CYP with presenting mental health difficulties and their families
2) Targeted support of the professional and school system, working together to develop solutions, identify resilience and using difference as a source of richness.
    - We found over the years that 60% of the cases were categorised as Tier 3 hard to reach individuals who do not get to CAMHS, but are most in need of the service. They are often suspicious of the service, having had failed attempts of CAMHS, and can be in conflict with schools and other agencies. We offer this group early intervention by using a resilience model that supports service engagement and collaborative work with other agencies.
3) Training and sustained support for school staff (pastoral and teaching) to do their jobs. Skills-based training in collaborative engagement and working with families, group supervision/reflective practice support for the most complex cases, consultation and other trainings.
    - We look at system working and predominantly engage parents before a referral is made. The CAMHS clinician, of which there is one linked to each school, meets with the parent and the school to reach a collaborative decision about whether to

refer to CAMHS. This process removes the blame from the parent or child and enables shared responsibility to be developed, a collective formulation of the issues. Young people are often not included in this conversation as it can be overwhelming, but we always ensure that their voice is heard in a meaningful way. Of the 30-33% referred, only a small proportion are referred on to specialist CAMHS. We also provide brief support in the community where the CYP and their family want to be seen – this can include family therapy, parent access to the service they require, and other therapeutic interventions. If this happens, most parents prefer being seen in the clinic rather than at home. We have also noticed that primary school CYP and families prefer to be seen at the school, whereas secondary school CYP and families prefer to be seen at the clinic as they feel it is more private.

We have a multidisciplinary team that consists 6 full-time equivalent members of staff who work across 50 schools. All clinicians have a clinical qualification relevant to CAMHS, however psychiatry is not represented. As we are co-located with Tier 3 CAMHS and work in an open plan office we can consult with psychiatrists with ease.

A detailed explanation of the model is given in - van Roosmalen, M. (2016). **A whole systems model of early intervention with schools and other frontline partner agencies.** In A. Vetere and E. Dowling (Eds). Narrative Therapies with Children and their Families: a Practitioner's Guide to Concepts and Approaches (Second Edition). Routledge: London.

What has been the biggest success of this model?

- There is a much more multicultural and diverse mix of people accessing CAMHS, with a broader cross-section of the community now accessing services. Communities previously not accessing our service, for instance, a local South Asian community, are now accessing CAMHS substantially. This increased access has continued showing the long-term impact of our work.
- We have a better partnership with schools through the commissioned early intervention pathway. However, there is inequitable access as this is only available in

about half of the schools in the locality. This is about to change however, with the commissioners funding a locality wide early intervention service.

- Training is offered to those who commission the service, and all participate across the three functional levels of working. School staff bring cases for reflective discussion and consultation in partnership with the CAMHS clinician.
- The approach provides strong buffers for specialist CAMHS, destigmatises mental health, provides improved and increased access and integrates care.

An example of consultation feedback from school staff:

"It gave me more confidence to think… I can do this rather than I can't…"

"…has allowed us to have a better relationship with the families (and) with the pupils"

An example of skills-based training feedback from school staff:

"It gave me an understanding of my role as the facilitator to empower parents to unpick their problems."

"Being encouraged to take a systemic approach helps to take the blame away from the child and to look at the root of their difficulties."

What has been the biggest challenge?

In the beginning, it was challenging bringing two different cultures together as both agencies had to change and think together. On top of this, each school has its own culture, so it is important that the CAMHS clinician assigned to a particular school is flexible and strong professionally.

How did you create a system change?

Continuous evaluation and stakeholder experience helped. We developed a systemic training and evaluated the schools' and parents' experience of consultation. This process helped increase meaningful involvement and getting feedback is really valuable. We also responded to their needs and the schools' anxieties by building individual relationships with each school. We provide a single contact who is linked to a school representative (a mental health link) and they are given time to develop their relationship. Fitting with the resilience-based approach we employ, which does help demystify the concept of mental health, training

provides the rationale for why 'CAMHS is also their business', and how schools can and do impact on children and young people's mental health. This would not be supported by an illness paradigm.

How did you create capacity? Were there any challenges?

We offer consultation and regular and continued training (skills and competency-based) and support for school staff, thinking about children and young people in supervision groups that happen at least once a term. School staff prefer calling these conversations 'case discussions' as the term consultation is often seen as a barrier to school discussions. By calling it a 'case discussion' CAMHS take some of the responsibility for the CYP. In these discussions the school representative brings 3-4 cases, and about a third are referred to CAMHS. Through this early intervention there is increased access to CAMHS for those with mental health issues. In addition, there is a feedback loop about the cases that are with CAMHS in their school and this is given following consent being obtained from the CYP and their family.

What impact has this had on CAMHS?

We have seen a variety of changes such as increased capacity, with CAMHS clinicians able to see more service users. Within a 6-month period, we consulted about approximately 300 children across the locality about their mental health. In addition, the CAMHS clinician who knows the school is able to liaise with the CAMHS service with the consent of the parent enabling closer working between agencies.

Example: In one school the relationship between the CAMHS clinician and the school had broken down, with the school filing a complaint and the CAMHS clinician unhappy about how the school supported CYP with mental health difficulties. Marc facilitated a meeting between the two representatives and worked through how they would work together more effectively. A year on the relationship is much better and the school has engaged in whole school mental health promotion.

When needed, Marc can have a meeting with the school, parents and clinician to discuss the collective predicament in an open and frank manner and come to a solution together.

The schools service an ethnic community which has led CAMHS to think about how they can support the community better and create an ethnically sensitive service.

Is the model sustainable?

Yes, however it is tenuous as the service must be bought in, which makes it more vulnerable to commissioning changes. A positive is that commissioners in Luton are developing an emotional wellbeing strategy, and have just approved funding for a CAMHS-Schools partnership initiative.

How do you support multi-agency working?

We include any agency involved with the CYP and their family when we have our case discussions. Many of the children and families have early help support so we have created a partnership with the Stronger with Families Partnership, with an adult mental health and CAMHS clinician embedded with them.

What has the feedback been from children, young people and their families?

Parents feel that this is a gentler introduction into CAMHS and is less threatening than being seen in a clinic setting. The parent meets together with a school worker with whom they have a good relationship and trust, which means they feel safer when meeting the CAMHS clinician. They then have a conversation together about the needs of the child and their family and who else should be involved.

What are your top tips for building resilience in schools?

1. Help the school with the cases they are struggling with through a formulation and systemic based approach to understand the problem. Often behind the worries of the school are feelings of being overwhelmed by the issues faced.
2. Change the conceptualisation schools have about mental health away from the idea that they develop individually. Include interventions that alter the conceptualisation from being a medical illness to a resilience and wellbeing one.
3. Work with communities, it is helpful for the CAMHS clinician to have knowledge of the area and the schools. Having a single point of access to a CAMHS clinician is helpful.
4. Working with schools requires a different skill for CAMHS clinicians. Practitioner training therefore needs to move away from an illness paradigm to a relations paradigm.

5. Schools need support in how to work with challenging CYP and their families. This can be achieved through skills based training for pastoral workers so that they move away from a more didactic way of working.

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