Developing a school team to improve links between education and mental health services

A child and family consultation service set up a school mental health team in a joint approach with schools to help children with mental health difficulties

**INTRODUCTION**
Between 2005 and 2007, the national CAMHS grant funded 19 projects across England, which were known collectively as the NSF Development Initiatives. The agencies involved in these projects were not only health, education and children’s social care but also youth justice and several community and voluntary organisations.

The Social Care Institute for Excellence (2009), Massie (2008) and the Social Exclusion Taskforce (2008; 2007) stressed the importance of joined up working across not only children’s services but also with adult services to improve outcomes for the whole family.

**MENTAL HEALTH SERVICES**
In 2004, Hackney in east London created the inter-agency child and adolescent mental health services (CAMHS) strategy and planning group.

This group’s purpose is to identify and prioritise gaps in services in the borough and plan and develop them to address unmet needs. Health, education and children’s social care are all represented.

The group agreed with representatives from the Learning Trust (the not for profit company that runs education services in Hackney), that there was a gap in services for young people attending special schools and pupil referral units who had mental health problems and were not accessing appropriate support.

It was felt that mental health services would become more accessible if they were based at schools rather than in a clinic.

The group therefore agreed to use part of the mental health grant to set up a small CAMHS team with a different service delivery model from the existing teams.

Cole et al (2002) argued that CAMHS should provide active and regular support to special schools and pupil referral units.

Mental health workers have traditionally worked in CAMH teams and provided a service to schools on a consultation or case liaison basis.

The model for the school mental health team is for mental health workers to provide an outreach service in special schools and pupil referral units as members of the school staff team.

The team joins the teaching staff and becomes an integrated part of the school. Results show positive outcomes for most children and young people who have used the service.

**PRACTICE POINTS**

- The advantages and benefits of joint agency working are:
  - Expertise and learning are shared among different agencies.
  - A common professional language is developed.
  - CAMHS is demystified and awareness increased.
  - Greater knowledge and awareness of school systems is filtered back to CAMHS staff.
  - Stigma connected to mental illness is reduced.
  - Children with an identified mental health difficulty are helped to access education more easily, which increases their self-esteem.
  - Previously unacknowledged mental health difficulties can be identified, alleviating confusion for young people, their families and teachers.
  - In some cases, once a need has been identified, stress within the family is reduced, which can improve communication and relationships both at home and with the school.
  - Families engaging with the service have responded positively and this has led to improved relations with teaching staff and better understanding of a child’s individual needs.

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The school mental health team is a relatively new service in Hackney, east London, set up in line with recent government recommendations.

Its work is an outreach service of the tier 3 child and family consultation service. The team offers a child and adolescent mental health service to three pupil referral units, which schoolchildren attend when they have been excluded from or cannot attend mainstream school, and one special school.

It uses a different model from the traditional one of mental health professionals going into schools on a sessional basis for specific work. The team joins the teaching staff and becomes an integrated part of the school. Results show positive outcomes for most children and young people who have used the service.
THE SCHOOL MENTAL HEALTH TEAM

The team, now in its fourth year, consists of three mental health nurses: one clinical nurse specialist and two specialist community mental health nurses.

When the project started we were based in two pupil referral units and two special schools. One of the special schools closed and reopened as a pupil referral unit.

While school nurses have always been familiar in the education setting, it was thought that mental health nurses may have a similar ‘fit’. Also, one of the skills that mental health nurses have is that of a ‘broker’ (Hung Ng, 2007) between different agencies and different professionals.

The team works in the schools for most of the week, with one day as a designated CAMHS day. This is for supervision, team meetings and consultation when needed with other members of the specialist CAMHS team. Pettitt (2003) argued, to be effective, ‘health workers need to be accepted in the school and yet retain the support and clinical supervision of the CAMHS team’.

The community mental health nurses have supervision with the CNS, who in turn receives supervision from the senior nurse in the child and family consultation service.

There are regular team meetings and a monthly meeting with a child and adolescent consultant psychiatrist and the Hackney CAMHS senior nurse. There are also, within the mental health trust, two community CAMHS nurse meetings relevant to the SMHT: a monthly one for CAMHS nurses who work in Hackney; and one for all CAMHT nurses in the trust, which meets every eight weeks. The SMHT nurses are also seen by a consultant psychiatrist and the Hackney CAMHS senior nurse. They meet every week, with one day as a designated CAMHS day. This is for supervision, team meetings and consultation when needed with other members of the specialist CAMHS team. Pettitt (2003) argued, to be effective, ‘health workers need to be accepted in the school and yet retain the support and clinical supervision of the CAMHS team’.

The team has carried out group work, which has included a disability awareness group, communication/social skills groups and a girls’ group.

Referrals

A formal referral is made after discussion and agreement with the school head teacher, deputy or the special educational needs coordinator. A simple one sided referral form has been designed.

Teachers are encouraged to discuss concerns about a particular child or young person with the mental health nurse.

Consent

Once a child or young person has been appropriately referred to the SMHT, the mental health nurse contacts the family to gain consent to carry out an assessment. If the family is unwilling to attend, consent may be sought for the child to be seen individually. However a fuller, more detailed assessment can only be done with the family’s involvement.

Assessment and treatment

Following a mental health assessment, individual treatments have included CBT, behaviour management and supportive psychotherapy/counselling. The nurses also offer work with families and parents.

The team has carried out group work, which has included a disability awareness group, communication/social skills groups and a girls’ group.

Some of the groups have been run jointly with speech and language therapists, learning mentors and special educational needs coordinators.

Cole et al (2002) found that boys outnumbered girls in special schools by 12 to one and by approximately three to one in pupil referral units. The rationale for the girls’ group was to provide emotional support.

The nurses have facilitated joint work with CAMHS workers in the community clinics. This has included work with psychologists to assess young people with autistic spectrum disorders and with psychiatrists to provide medical treatment for neuropsychiatric disorders such as attention deficit hyperactivity disorder (ADHD).

The SMHT has built up a network of contacts within children’s social care, the Learning Trust and the PCT.

BACKGROUND

● The green paper Every Child Matters (HM Government, 2003) said the five outcomes that matter most to children and young people were: being healthy; staying safe; enjoying and achieving; making a positive contribution; and economic well-being.

● The Children Act 1989 was amended in 2004 – this was the same year the National Service Framework for Children, Young People and Maternity Services was published, which provides best practice guidelines (DH, 2004a). These documents stress the need to improve joint working between agencies and make services more accessible to children, young people and their families.

● Standard 9 of the NSF, on mental health and psychological well-being, outlined a vision of multi-agency services working in partnership to promote the mental health of all children and young people, and to provide early intervention and meet the needs of those with established or complex problems (DH, 2004b).

CASE STUDY: HELPING A CHILD WITH OBSESSIVE COMPULSIVE DISORDER

Neil* is a 13-year-old white British boy. He was previously seen by a psychiatrist at the child and family consultation service and had a diagnosis of obsessive compulsive disorder and was also on the autistic spectrum. His mother had similar difficulties. The family had not attended the clinic for some time.

Neil’s behaviour at school was becoming increasingly difficult. He was disruptive in class, often shouting and swearing at the teacher, which was affecting not only his learning but also his relationships with peers. The school was becoming extremely concerned and made a referral to the SMHT.

As Neil was already known to the psychiatrist, a joint meeting was arranged. The family attended, where it was agreed that the nurse would meet Neil individually at school for a CBT-based treatment and the family would continue attending the clinic for family therapy.

It transpired that some of Neil’s difficulties in class stemmed from an obsession with needing to see his coat. His anxiety would grow when he could not see it and he would get into trouble for leaving his seat.

Knowing this enabled teachers to have a better understanding of his behaviour and to therefore manage him differently, for example, by placing him in the classroom where he could see his coat more easily to ease his anxiety.

The nurse did some training with school staff around OCD and facilitated a case discussion where they put in place more strategies in order to help Neil manage better.

Neil’s mother began communicating with the school more as she felt less criticised since some of his more negative behaviour had reduced.

*The patient’s name has been changed.

Economic

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Information leaflet
An SMHT leaflet has been developed outlining the aims and objectives of the service, treatments available and the risks and benefits of using the service. The leaflet is given to parents/carers of children and young people who attend or will be attending one of the four schools.

Training and consultation
A large part of mental health nurses’ role in the SMHT is to offer training and consultation to school staff.

Some is formal, for example: training and presentations in team meetings; providing a mental health perspective during case discussion and pupil updates; and joint work with educational psychologists in staff support groups. Some is more informal and could include talking in the staff room about a particular pupil causing concern or mental health issues in general.

Recently the SMHT and other members of the child and family consultation service provided a training day to staff at all the schools on child and adolescent mental health. Overall, it was viewed positively. However, some lessons were learnt and future training will vary in content, structure and group size.

There is also an opportunity for CAMHS and school staff to run joint training, particularly on behaviour management and its theory and evidence base.

OUTCOME MEASURES
The SMHT has been included in the national pilot for the Children’s Outcome and Research Consortium (see www.corc.uk.net). This uses several tools for measuring the outcomes of children and their families who use the service.

These are the Strengths and Difficulties Questionnaires (SDQ), one for young people (depending on their age) and one for parents/carers to complete at the time of referral and then as a follow-up six months later.

Results from these measures show positive outcomes for the majority of children and young people who have used the service.

The SMHT also asks teachers to fill in an SDQ at the time of referral and then as a follow-up six months later.

P L A N S
This model of interagency working between health and education has proved to be extremely effective and has led to projects involving mental health nurses working in Hackney mainstream schools being funded.

In schools, mental health professionals are ideally placed to coordinate and liaison with services around the child. A challenge will be to widen the network of these agencies to include those working with parents.

CONCLUSION
The SMHT was set up in line with government recommendations to make mental health services more accessible and to meet the needs of children and families who were not engaging with services.

One key observation is that over half the SMHT caseload is made up of young people and families who had previously been referred to the child and family consultation service but not engaged with it.

The team’s continued success has depended on the steering group’s regular meetings and strong links with the CAMHS team. The support of both an experienced child and adolescent consultant psychiatrist and general manager, together with a solid nursing structure, has been invaluable in terms of developing and seeing through this innovative practice.

REFERENCES


Petitt, B. (2003) Effective Joint Working between Child and Adolescent Mental Health Services (CAMHS) and Schools. London: The Mental Health Foundation. tinyurl.com/effective-joint


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