Having the support of a multidisciplinary team means I feel less isolated and take more calculated risks, rather than make uninformed, hasty referrals that don't benefit the client or the therapeutic relationship

I took on a school-based counselling service three years ago and wanted to share my journey in setting up clear care pathways to external resources. I want to think about ethical issues, systemic thinking, the effectiveness of school-based counselling, and the growth of using these external resources. My line manager, Francesca Kamei, supported the development of our service, and David Levy, a consultant family therapist in the local child and adolescent mental health services (CAMHS) at Oxleas NHS Foundation Trust, also supported me and advised me on the creation of the service. Throughout the article, I will be thinking about the context in which young people live and the difficulties that school-based counsellors face if the correct support is not accessible.

I am a person-centred therapist and supervisor with an additional diploma in Children and Adolescence, and have just completed a certificate in Family Focused Practice using Applied Systemic Theory. My training has centred on young people and the need to provide an outstanding service within the borough of Greenwich. All training can be an amazing experience, but I do question if it prepares us for working with children in a realistic setting. Such work is a specialist field and is often linked with the need to achieve the goals of an educational provision, in addition to improving emotional wellbeing.

I remember sitting with one of my first clients early in my career. We sat in silence for the whole session. The only thing he told me was that it was better sitting in the session than in class. I remember thinking, this is not right, he's missing his education, and, anyway, what was it about sitting in a classroom that was so bad for him? No one questioned why he hated that. As time went on, he told me that he was angry because he did not understand and could not hold the information in his head when he read it. I asked him if I could look at his achievement record, and, sure enough, he was in the bottom set for everything. In the next session, I asked him if it would be OK for me to speak with the special educational needs and disabilities (SEND) team. Obviously, I could work with this boy all year, but every time he entered the classroom, the work I was trying to achieve with him – building his self-esteem – was being shattered. We were in a cycle. He disclosed to me that his mother was illiterate and therefore scared to engage with the school. This had led to a loyal son protecting his mother from feeling publicly shamed, but it was hindering his own progress.

I realised in that moment that, as a school-based counsellor, my work needed to encompass so much more. Referrals to the service were not just emotionally but also educationally based, and the school needed to be aware of how to separate the two. I needed wider school support and understanding, because this child's needs were lost in a system.

It was also difficult to show evidence-based practice or impact as a counsellor in an education setting – not only was I trying to improve a young person's emotional state, but also his attainment. So I questioned:

- How can I improve emotional wellbeing if other major factors are not being addressed?
- How can I improve the links between home and school?
- How can I improve communication between multi-agency systems to achieve a holistic approach?

I could see it was a three-dimensional problem.

In April 2013, I took the lead role of school counsellor in an inner-city, mixed comprehensive with 2,000 students. The school had been part of a Targeted Mental Health in Schools (TaMHS) programme, which involved bringing together existing pastoral, emotional

and wellbeing services in schools with the local CAMHS. The publication of the TaMHS findings coincided with a change within the school's leadership team, which in turn led to the service being restructured. The focus was to be about improving outcomes for young people in relation to the impact of mental health on the young person's participation in school life, in particular attendance, attainment and behaviour for learning. The school wanted the new service to be influenced by the principles of CYP IAPT, which include evidence-based practice, routine use of outcome measures and service user involvement.

While I knew (and still know) that it remains fundamentally important for young people to have access to a confidential service in schools, research demonstrates that, due to young people's developmental dependence, there are likely to be external factors that contribute to their difficulties that need to be worked on if change is to occur. I kept thinking about my experiences of children like the early client I mentioned, and my three-dimensional queries. I was now being faced with a number of stories like that child's.

Developing a team

In order to address my dilemmas, I began to develop a coordinated and integrated multi-agency team. Previous concerns had been expressed by the Head of Inclusion about frustrating, time-consuming communication with external agencies, with no outcomes or clear care pathways being furnished to the school. I therefore envisaged an increased in-house service. This was clearly going to be challenging, but I would relish it. I am grateful to have had a forward-thinking line manager and head teacher, who could recognise the impact that poor emotional wellbeing has on children's learning. They could also see how rich the service could be if I could establish the correct support.

The TaMHS finding helped us to think about how we educated our staff. So we ran a number of inset days for staff – some together with CAMHS – to help them understand that mental health is not something you send for counsellors to fix, but rather needs to be a whole-school approach, with understanding and awareness.

My first steps were to meet with the heads of year every half term to discuss any mental health issues that were themes within their year group. We employed CAMHS to come in once a week, and I began to build networks with external agencies. Too many young people were unable to access rapid support due to lengthy NHS waiting lists, so our new approach was excellent and I no longer felt alone. If a child had undiagnosed learning or health issues it required a team to think about who best could meet their needs – the school counselling service was not meant to be a 'dumping ground' that would never be able to meet the standards asked of it – an all-too-common scenario, in which a practitioner does not feel job satisfaction because young people's needs are continually unmet.

I was now aware that outcomes would be better because I was reducing certain factors. I began to build relationships with the SEND team to address additional learning needs prior to deciding the appropriate therapy. For example, if a child had anxiety about going to school because they couldn't read, I would monitor whether the anxiety improved once the educational needs were met. It might be that the anxiety decreased but that the low self-esteem still needed to be addressed. This would indicate that the child would be better suited to a person-centred therapist. Without this assessment, they might have been placed with a CBT therapist.

The regular meetings with the heads of year expanded their knowledge and understanding on how to complete and fill out the correct information in order for me to holistically identify who within the service would be best for the young person to see. This was an important task and a unique part of school-based counselling; the head of year knows the child and the family, and whether there have been concerns about safeguarding, education or family needs. This, along with the completed, newly introduced (to us) Strengths and Difficulties Questionnaire (SDQ) and a face-to-face meeting with the young person, started to provide me with a 3D assessment. I was asked to liaise more and more with the external CAMHS worker to explain the issues young people were presenting at school. This also improved communication of outcomes from external provision.

Because I was building trust with wider staff, students and their families, my line manager saw that staff views of counselling in school and fears of 'us and them' (a usual barrier to progress) were being overcome. Regular discussions were held when a situation was noticed but not understood.

Adding in family work

I joined an in-house family therapy CAMHS session for a child I was referring to the service. Obviously, I had to be very clear that I would be there as support but that I could not say anything, as our one-to-one sessions were confidential. The two pieces of therapy complemented each other. The individual therapy had prepared the young person to talk about their feelings, rather than facts, and the parent (who had been supported by Pete Brown, our CAMHS link worker) had been helped to think about the relationship with their child and feel reassured that they were not being judged. This enabled the parent to hear and understand, listen and be empathic to their child. It was a beautiful experience. Together, Pete and I started to link our work further, and the school could see the value it was adding. We decided to trial commissioning CAMHS to

come one day each week for family therapy. We were now holding more serious cases within school. For example, the treatment of choice for self-harm is family therapy, and we were able to include this way of working in house. The reduction in our self-harming figures was staggering. Our attendance figures were much better on site than at CAMHS. Parents have reported to us that it feels easier for young people and the family to come into school – there is less stigma, and others are not aware of why they are here. (My room is situated next to a lift on the second floor, on top of reception. It felt important not to have parents walking across the playground to my office.)

At this point, staff from both The Maudsley and Greenwich Borough had visited and begun to research our ever-growing service.

After the first year, David Levy (the consultant family therapist) came to join us, and encouraged us to link theory to the way we were working. David and I would start to model relationships within the room when we met with parents.

In my one-to-one practice that was also going to include family therapy, we had advanced into writing scripts, so that if the young person 'got stuck' it would have already been agreed what I could and couldn't say. These scripts were the basis of trust between the young person and me. It takes enormous trust for a young person to ask for their therapist to meet with their parents and to be sure that all their private thoughts and feelings won't be shared.

Relationships with external agencies had increased, and our referrals were meeting CAMHS threshold because the criteria were clear and had been discussed with CAMHS before we submitted a referral request. We now needed to build relations with the speech and language therapist and the attention deficit and hyperactivity disorder (ADHD) clinic. They, too, were accepting our referrals, but assessment forms were being sent backwards and forwards, which was time consuming. After we met at the school and in their offices and after again building a solid relationship, it was agreed that we would keep the forms on site so that we could send off completed packs on application. This also reduced time and unsuitable referrals. We also held coffee mornings for parents and staff with the ADHD clinical staff.

We were starting to remove a stigma and embed mental health within the school. When young people's needs could not be held by our service and needed a higher intervention by tier 3 CAMHS, I was involved with handovers with the young person and their families, which eased transition.

Ongoing expansion and training

One of our counsellors was seconded to another school, and I was asked to offer consultation to recreate our service there. This is now the second school that follows the model. For me, this is exciting because the model works. Having the support of a multidisciplinary team means I feel less isolated and take more calculated risks, rather than make uninformed, hasty referrals that don't benefit the client or the therapeutic relationship.

We now have GPs referring young people to us, and our links with others, such as community paediatricians and autism spectrum disorder (ASD) outreach, are strong. Our counsellors are trained by external agencies because it's important that we recognise each agency's expertise and expand our shared pool of knowledge around our specialist client group.

All this development has, of course, increased my workload, but the benefits and provable outcomes are rewarding.

I began with considering three questions, all concerned with whether counselling practice in school improves when systems around the young person are jointly involved. Our service outcomes do show a major increase, but for me it's about more than just outcomes. It's about hearing positive feedback from the young people about their experiences.

Linda Hafez is a qualified counsellor with extended qualifications in children and adolescence, CBT, special educational needs and supervision. She is now embarking on her second year of a diploma in Family Focused Practice using Applied Systemic Theory, and has also worked as a tutor teaching adult trainee counsellors. Education from a 3D perspective has been embedded in her therapeutic practice.