

# The Team of Life: A narrative approach to building resilience in UK school children

Vicky Eames, Catherine Shippen & Helen Sharp

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*Concern about children and young people's mental health is high on the UK national agenda. Access to specialist Child and Adolescent Mental Health Services (CAMHS) is perceived as problematic due to high thresholds, clinic-based service delivery and associated stigma. Schools and youth work contexts present alternative and more accessible settings for early intervention and preventative work aimed at promoting positive mental health. The Team of Life is a narrative group methodology with sporting metaphors, which encourages young people to recognise the strength and resilience in their life teams. The approach has been used within diverse contexts internationally, for example with former child soldiers in Uganda, young men from refugee backgrounds and young people in Australian schools. Innovative partnership work between health and education has led to the implementation of the Team of Life in a UK school and the development of a manualised Team of Life Programme. We now report findings from pilot work evaluating feasibility and outcomes for the programme within a UK secondary school setting. Quantitative findings include significant positive change in Goal Based Outcomes as well as significant reductions in emotional and behaviour difficulties measured by the Child Behaviour Checklist. Qualitative thematic analysis of participant feedback indicates benefits relating to the experience of 'shared understanding', 'confidence', 'peer support' and the 'positive impact of sport'. Further research is planned to evaluate the effectiveness on a larger scale. This pilot study was undertaken as part of CAMHS Extended Schools work. Potential for collaboration between clinical and education psychology colleagues in relation to the promotion of positive mental health in schools is discussed.*

**Keywords:** narrative; resilience; mental health; schools; partnership.

## Background

INNOVATIONS in school-based provision over recent years, such as Extended Schools and Targeted Mental Health in Schools (TaMHS) services, aimed to tackle problems more quickly, primarily focusing on students whom have been identified as vulnerable. Findings from such programmes have highlighted the key role schools play in mental health provision and the importance of inter-agency working between schools and specialist CAMHS (National Evaluation of TAMHS, Department for Education, 2011). However, despite evidence that partnership working, early intervention and preventative work in schools can reduce referrals to specialist services and lead to more timely and appropriate referrals (NFER, 2010), many local authorities and clinical commissioning groups have scaled back such services due to the financial crisis (House of Commons Health Committee, 2014). Access

to specialist mental health services in the UK is also widely viewed as problematic due to high thresholds, clinic-based service delivery and the effects of the stigma on help-seeking for mental health problems (Wahl, 1999; Wolpert, et. al., 2015). In response to concerns, the UK government is now calling for a fundamental shift in the way care is provided to focus on prevention, early intervention and recovery. Promotion of resilience and emotional wellbeing is also viewed as a key aim for services (*Future in Mind*, Department of Health, 2015).

## Concept of wellbeing

When young people contributing to the National CAMHS Review (Department for Children, Schools and Families, 2008a) were asked what is important for children and young people's wellbeing, three factors were consistently mentioned:

- Having good support networks – across family, friends and school.
- Being able to do things they enjoy – ranging from sports and community based activities, to having time with family and friends, and time to relax.
- Building self-esteem – in particular by having their achievements recognised and by having goals to work towards.

These messages are in keeping with the literature in the wellbeing field which emphasise the importance of:

- **Connecting** (e.g. building social relationships, spending time with friends and family).
- **Being active** (e.g. engaging in regular physical activity).
- **Taking notice** (e.g. being mentally ‘present’, focusing on awareness and appreciation).
- **Keeping learning** (e.g. maintaining curiosity about the world, trying new things).
- **Giving** (e.g. making a positive contribution to the lives of others).  
(Foresight Mental Capital and Wellbeing Project, 2008)

### Concept of resilience

Resilience, or the capacity to ‘bounce back’ in the face of adversity, is another concept that is considered to have important implications in the promotion of wellbeing. Research in the resilience field suggests that individuals showing resilience are able to interact with their environments in ways that promote wellbeing or protect them against risk. Studies across different cultures and contexts have also highlighted the role and impact of culture, history, community values, and geographical settings on individual and community responses to adversity (Castro & Murray, 2010). Young people who have high expectations, a meaning for life, goals, personal agency, and interpersonal problem-solving skills are more likely to be resilient (Benard, 1991). A strong positive relationship with at least one adult is also important, though this does not have to be a parent.

School and community based supportive relationships can, therefore, play a vital role (Werner, 1995). Communities which foster resilience provide opportunities for children and youth to participate in the life of the community as valued members (Benard, 1991; see Luthar, 2006). Friends, support networks, valued social roles and positive views on neighbourhood reduce the risk and severity of emotional and behavioural problems among young people (National Mental Health & Wellbeing Impact Assessment Collaborative, 2011).

### Narrative therapy approaches

Resilience is also thought to be strongly linked to the meaning we give to adverse life events (Cicchetti et al., 1993; Werner, 1995). Narrative therapy is an approach to counselling and community work that aims to address the meaning people give to their experiences by emphasising the stories of people’s lives, viewing people as the experts in their own lives, and viewing problems as separate from people (White, 1988; White & Epston, 1990). Narrative therapy is based upon the assumption that humans are ‘interpreting beings’, making sense of their experience by linking the events of their daily lives together across time, the ‘narrative’ being understood as like a thread weaving the events together to form a story (see [www.dulwichcentre.com.au](http://www.dulwichcentre.com.au)). Narrative therapists assume that people have many stories about their lives and relationships, developing simultaneously. Aiming to assist people to reduce the influence of problem stories in their lives, narrative therapists pay attention to the history of skills, beliefs, values and commitments, bringing to the fore the resources and knowledge within individuals, families and communities. Narrative methods have been shown to be effective for a range of mental health problems in children, including depression, trauma, attachment issues, and family violence (Vetere & Dowling, 2005). Research evidence also suggests that narrative approaches to intervention, where the child

or young person is not viewed in terms of their 'problems', are particularly effective in reducing stigma (Ertl et al., 2011).

### **The Team of Life**

The Team of Life is an example of 'collective narrative practice', which is when narrative methodologies are used beyond the counselling room (Denborough, 2008, 2012). Collective narrative practices build upon people's connections with everyday lived experience so that nature, sports, stories, songs and histories are the starting point for conversations with the aim of helping young people to tell stories of strength and resilience. For instance, the Tree of Life narrative approach (Ncube, 2006) uses metaphors from the natural world while the Team of Life narrative approach uses sporting metaphors.

The narrative process in the Team of Life first invites young people to think about who is in their 'team of life', by creating 'team-sheets' representing significant people in their lives, for example, GOAL KEEPER: Who is your goal keeper? Who helps to 'keep' what is precious to you safe? Who helps to guard your goals? DEFENDER: Who else assists you in protecting your dreams, in protecting what is precious to you? STRIKER: Who assists you and encourages you in trying to score goals?

Young people are encouraged to go on to think about the personal and shared goals that they have achieved in their 'teams'. Ways of celebrating goals are then explored through 'goal maps' that are re-enacted through the metaphor of football; the 'passes' to team members that were made and subsequent 'goals' or achievements.

Next, discussions focus upon 'tackling' within sport and then move on to 'tackling problems' in the young people's own lives. Within the theme of avoiding obstacles and assisting others, collective thinking about injustice and hardship takes place. A narrative process of 'externalising' the problems in young people's lives enables recognition that people cannot be blamed when they are

disadvantaged. Also there is exploration of how people 'overcome obstacles' in sport before moving on to thinking about skills used to overcome obstacles in life. Finally, the Team of Life creates a space whereby young people may offer contributions to others who may have endured similarly difficult experiences. This approach facilitates a sense of agency in the young people, who can be active contributors to the lives of others as well as to their own lives (Denborough, 2008).

### **Use of the Team of Life as part of an Extended School Service**

We now report pilot data from the use of the Team of Life as part of an Extended School Service in the UK. Seeking a culturally relevant and sustainable programme for delivery in local schools, a CAMHS Clinical Psychologist adapted and manualised the original Team of Life (Denborough, 2008; Eames & Denborough, 2015) methodology in collaboration and consultation with educational colleagues including, a learning mentor (Claire Owens, partnership working between June 2011 and February 2015) and a Healthy Schools Advisor (Phil Rhodes, partnership working between June 2011 and April 2012). In parallel to the current project, educational psychology services were implementing TAMHS work within some schools locally. Consultation with the educational psychologist leading on the TAMHS project helped to support the thinking behind the current project, including making links in relation to the 'flourishing' work being undertaken by educational psychology colleagues (Simon Ward, personal communication, September 2011, September 2012 and October 2014). The project also benefited from wider discussion and collaboration between CAMHS clinical psychologists and educational psychologists, working together with public health and education colleagues on the Wirral Promoting Positive Mental Health in Schools Steering Group (2013–2015).

The Team of Life programme was piloted with targeted groups of students experiencing difficulties following the transition to secondary school with peer mentors and sports coaches involved in the delivery. This particular group of students was selected since previous research indicates that: (i) the support available from the family, community, school and peers each have a part to play in successful transition (Jindal-Snape & Miller, 2008); (ii) within schools, transition can be facilitated using peer mentoring as a means of raising aspirations and outcomes for young people in the UK (Department for Education and Skills, 2005a, 2005b); and (iii) enhancing student's personal coping resources (e.g. self-efficacy) and social support (e.g. seeking help from others) can reduce the negative impact of difficulties faced in transition (Fenzel & Blyth, 1986; Frydenberg & Lewis, 1993).

### **Research questions**

It was beyond the scope of these initial pilot studies to evaluate whether participants were more 'resilient' following the intervention as this would require investigation of the longer-term impact upon outcomes related to resilience such as personal agency, interpersonal problem-solving skills, social support and help-seeking behaviour.

The specific research questions investigated in these exploratory studies of the Team of Life Programme were:

1. Do perceptions of goal attainment significantly change following the 'Team of Life'?
2. Are reports of emotional and behavioural difficulties reduced following participation in 'Team of Life'?
3. How do participants experience 'Team of Life' and what perceptions of change are reported qualitatively?

## **Method**

### **Design**

A pre-post design was adopted to generate initial preliminary evidence of intervention effectiveness based on data from two pilot groups (Group One and Group Two).

### **Participants**

Twenty-six secondary school students took part in the programme. The school was a boys' comprehensive school with a higher than average number of pupils on free school meals and special educational needs and much lower than average levels of ethnic diversity. The majority of those referred were Year 7 and 8 pupils who were identified by school pastoral staff as experiencing social, emotional, or behavioural problems (77 per cent). The remainder were Year 9 and 10 students participating in a peer mentoring capacity (23 per cent). The attendance rate for the programme workshops was very high (96 per cent). Eighteen participants were included in the quantitative analysis in relation to perceptions of goal attainment (*Mean age*=12.5, *SD*=0.5). Fourteen participants were included in the analysis in relation to reports of emotional and behavioural difficulties (*Mean age*=13.2 years, *SD*=1.13). Eight participants were included in the qualitative analysis (*Mean age*=12.6, *SD*=0.3).

### **Procedure**

A proposal outlining the purpose of the pilot evaluation was submitted to the NHS trust for Research Governance review and approval. They advised that explicit NHS Ethics approval was not necessary since participants were not recruited as NHS patients. All parents gave informed consent for their child to take part and each child provided informed assent. All data was anonymised so individual children could not be recognised.

The data collection and analysis was completed independent from intervention delivery. Pre-data was collected in the week prior to the Team of Life intervention. Post-data and qualitative feedback was collected

in the two-week period after the intervention. Data from Group One was collected by a trainee clinical psychologist and submitted in part fulfilment of her doctorate in clinical psychology. Data from Group Two was collected by an assistant psychologist employed by the NHS Trust.

### **Measures**

Perceptions of goal attainment was measured using Goal Based Outcomes (GBOs) (CAMHS Outcomes Research Consortium, 2006). Participants identified up to three goals that they wished to work towards, and rated how close they were to achieving their goals on a scale of 0 to 10 (10=achieved). Ratings were made before and after taking part in the intervention as reported above.

Reports of emotional and behavioural symptoms were measured using the Youth Self-Report Form of the Child Behaviour Checklist (Achenbach & Rescorla, 2001).

A semi-structured interview was developed to collect qualitative feedback from participants following the intervention. The questions in the interview were based on those used in a previous study in South Africa that evaluated a similar intervention (Peacock-Villada, 2006).

### **Intervention**

The intervention involved sporting and team-building activities alongside reflective exercises taken from the Team of Life. Group One was facilitated by a clinical psychologist, learning mentor and healthy schools advisor, with the support of sports coaches from a local football club and sixth form peer mentors. It consisted of a two-day workshop delivered over consecutive days off site at a local sports centre. Group Two was facilitated by a clinical psychologist with support from a learning mentor, local sports coach and Year 9 and 10 peer-mentors. The second group differed in some elements of delivery as it was spread out over a two-week period as four half-day workshops and took

place on the school site, mainly within a classroom setting with some time spent taking part in outdoor sporting activities. This was due to practical limitations related to time-tabling and the lack of an available budget for an external venue. There seemed to be advantages and disadvantages of each mode of delivery which were not part of the research questions for these pilot studies but are commented upon in the discussion section.

The aims of the workshops were to:

- Enable young people to experience an enjoyable sense of teamwork.
- Enable young people to identify key support people/team-mates in their lives and build a sense of connected identity.
- Celebrate young people's existing coping skills and resilience.
- Enable young people to further develop coping skills and resilience.
- Celebrate the goals and achievements young people and their families have already accomplished.
- Enable young people to plan steps towards achieving future goals in life.
- Improve psychological wellbeing at a time of transition.

## **Results and analysis**

### **Perceptions of Goal Attainment**

Results from analysis of change in GBO's are combined across the two groups. Pre- and post-responses were available for eight participants from Group One (A1-A8) and 10 participants from Group Two (B1-B10). Table 1 describes examples of the goals identified by participants and shows the pre and post ratings given. Participants focused on academic, friendship, confidence and behaviour goals. Progress was reported on the majority of goals, particularly those related to confidence. A paired *t*-test indicated that mean ratings for goal attainment were significantly higher post-intervention ( $M=7.44$ ,  $SD=2.1$ ) compared with pre-intervention ( $M=3.44$ ,  $SD=0.98$ ),  $t(17)=7.36$ ,  $p=.0001$ ).

**Table 1: Goal-based outcomes.**

Participant	Goal	Pre-intervention	Post-intervention
A1	'Very shy I want to be able to interact'	4	6.5
A2	'I want to improve my concentration in class'	2	2
A3	'I want to be able to try new things'	4	9
A4	'I want to get better at football'	3	8
A5	'I want to move up a pathway in school'	3	8
A6	'I want to improve my school work'	4	4
A7	'I want to improve my confidence'	3	8
A8	'I want to overcome my nervousness'	3	9
B1	'Reduce behaviour incidences down from 70 to 30 incidences'	3	6.5
B2	'Improve tests by at least one level'	3	6
B3	'Improve by one level in science'	5	10
B4	'See friends more outside of school'	2	10
B5	'Get less detentions, I would like to focus more in class because I am easily distracted'	4	7
B6	'Make new friends'	5	9
B7	'Participate more in team sports to improve confidence'	3	9
B8	'Be able to focus a bit better in maths to be able to go up a level'	4	8
B9	'Spend more time out with friends, go out once a weekend'	2	9
B10	'Move up a grade in drama'	5	5
	<b>Mean score</b>	<b>3.44</b>	<b>7.44</b>
	<b>Standard Deviation</b>	<b>0.98</b>	<b>2.14</b>

**Reports of emotional and behavioural symptoms**

Participant’s self-reported symptom scores on the Internalising, Externalising and Total Problem sub-scales of the CBCL were compared using a paired *t*-test. Effect sizes were calculated to provide a measure of change. Pre- and post-responses were available for 14 participants from Group Two. All participant scores on the CBCL fell within the normal range both pre- and post-intervention, in line with expectations.

Table 2 summarises the change over time. Post-intervention ( $M=44.07, SD=11.93$ ) scores for the Internalising Problems sub-scale were significantly lower than pre-intervention scores ( $M=53.43, SD=9.12$ ),  $t(13)=5.34, p=.0002$ . The values for Cohens *d* indicated that the magnitude of the effect size was large,  $d=1.98$ . Post-intervention scores ( $M=40.57, SD=11.24$ ) for the Externalising Problems sub-scale were significantly lower than the pre-intervention scores

( $M=46.14$ ,  $SD=12.54$ ),  $t(13)=3.02$ ,  $p=.0098$ . The values for Cohens  $d$  indicated that the magnitude of the effect size was large,  $d=1.04$ . The Total Problem scores were also significantly lower post-intervention ( $M=41.29$ ,  $SD=12.43$ ) compared with pre-intervention ( $M=50.93$ ,  $SD=12.08$ ),  $t(13)=5.67$ ,  $p=.0001$ . Again, the values for Cohens  $d$  indicated that the magnitude of the effect size was large,  $d=1.75$ .

CBCL Scales; Internalising problems=emotionally reactive, anxious/depressed, somatic complaints and withdrawn scales; Externalising problems=delinquent behaviour and aggressive behaviour.  $t$ -scores for Internalising, Externalising and Total Problem scores in the Clinical range are  $\geq 64$ , those deemed to be Borderline fall within the range 60 to 63, scores in the Normal range are  $<60$ . \*\* $p<.01$

### Thematic analysis

A thematic approach was used to analyse the qualitative data collected from interviews with eight participants from Group One. The aim was to identify key themes (Braun & Clarke, 2006). The data was analysed using an inductive approach at the semantic level; that is, the themes identified were strongly linked to the data (Patton, 1990), the researcher was not looking for anything beyond what the participants had said (Braun & Clarke, 2006). A reflective group

was set up with an independent trainee clinical psychologist to check the validity of themes derived. The analysis was exhaustive, in that 88 per cent of the data analysed was allocated to at least one category.

The over-arching theme related to ‘shared experiences’. Within this, three core themes were identified; ‘confidence’, ‘peer support’ and ‘the positive impact of sport’. Participants spoke about meeting new people, trying new things, learning about their peers and ultimately enjoying themselves.

### Confidence

Participants described an increase in confidence in their social skills. Engaging in group games and activities appeared to increase their belief in their own ability to socialise, and take part. They spoke about meeting people whom they would not normally have spoken to and forming friendships with these people.

*‘I’ve learnt I can do things, I am able to talk to other students, I can join in with others. This makes me really happy.’*

*‘I can make friends with different people.’*

Participants described what appeared to be a change in attitude about their own ability, referring to themselves as ‘able to do things’, which reportedly had a positive impact on their mood.

*‘I can try new things, which feels great.’*

**Table 2: Child Behaviour Checklist Results.**

Subscale score	Mean (SD)		95% Confidence interval		$t$	$df$	Cohen's $d$
	Pre	Post	Lower	Higher			
Internalising Problems	53.43 (9.12)	44.07 (11.93)	5.50	13.22	5.34**	13	1.98
Externalising Problems	46.14 (12.54)	40.57 (11.24)	1.59	9.55	3.02**	13	1.04
Total Problems	50.93 (12.08)	41.29 (12.43)	5.97	13.32	5.67**	13	1.75

Participants also described learning about their own abilities and described themselves using positive language, for example, being able to make friends.

*'I learnt how to communicate with others.'*

*'I learnt I can make friends with different people.'*

Participants spoke about a belief in their ability to overcome difficulties.

*'I can do things, I am able to talk to other students.'*

*'I've learnt that I can do it, I've already started believing, I can do all of it if I put my heart to it.'*

*'I can overcome my nervousness if I try hard enough.'*

### **Peer support**

The second core theme related to 'peer support'. Within this, there were three sub-themes: 'friendships', 'shared difficulties' and 'sixth formers'.

Participants spoke about the excitement and importance of making new friends.

*'I thought I wasn't anybody's friend but I actually made friends. I feel really happy.'*

*'I am proud of the friends I've met they're amazing and supportive.'*

They also described learning about others experiences and sharing their difficulties in a mutually beneficial way. Some of the participants were surprised that other young people had similar difficulties.

*'Others have things in common with me.'*

*'Other students have similar difficulties with anger, I hadn't realised.'*

The sixth former 'peer mentors' seemed to provide practical and emotional support to the younger students.

*'All the sixth formers were teaching me different football skills and helping me let out all of my feelings.'*

*'I had a brilliant time and I see the sixth formers out and about which makes me happy.'*

### **Positive impact of sport**

The third core theme related to 'the use of sport'. Within this, there were two sub-themes: 'enjoyment' and 'as a vehicle for new experiences'.

Participants spoke about playing team games as one of the best bits of the workshops.

*'The best bit was becoming a big team, working as a team.'*

*'The best bit was doing activities, I really enjoyed it.'*

The team games not only provided enjoyment but also appeared to act as a vehicle for meeting people and achieving goals.

*'The best bit was using football to achieve goals in my life.'*

*'It was the best two school days of my life so far.'*

### **Discussion**

The preliminary findings from the pilot studies were in keeping with the aims and objectives of the Team of Life intervention. These were to promote positive mental health by enabling young people to build a sense of connected identity or 'shared experience' as well as develop skills and confidence in working towards their goals.

Participant's perception of their goal attainment was higher after the intervention workshops. The goals that were most likely to improve were those related to confidence, which was also a key emergent theme within the qualitative findings. Previous research on group interventions targeting children during the transition period have reported similar results; for example, Shepherd & Roker (2005) reported an increase in participant's self-esteem and confidence, although the use of different outcome measures does make it difficult to compare results across studies. The results for academic goals were more mixed, which is in keeping with previous research on peer mentoring programmes that have reported limited direct impact on educational outcomes (Parsons & Knowles, 2009). Research does suggest that there is a relationship between confidence in achieving goals and academic attainment in the long term. Young people need the resilience to cope with setbacks as well as the self-efficacy to believe that they can achieve their goals through working hard with a reasonable chance of success



(Department for Children, Schools and Families, 2008b). It may be that the improvements in confidence reported by young people participating in programmes such as the Team of Life can mediate progress with academic and behaviour related goals, although this remains to be tested in a larger sample of students.

Participants also reported improvements in emotional and behaviour symptoms. Internalising symptoms improved the most, suggesting that the Team of Life may be particularly useful for children at risk of or currently experiencing anxiety related problems. Positive change was also observed in relation to externalising difficulties, which reflect common mental health difficulties including hyperactivity and conduct problems. The active nature of the intervention may particularly appeal to young people showing these types of symptoms including hard to reach groups who may be less likely to engage in traditional talking therapy. A particular strength of the intervention is that young people are not required to speak in the first person about their difficulties, instead, the Team of Life emphasises the skills, abilities, hopes and dreams of participants. This strength-based approach which externalises the problems participants are experiencing reduces the risk that participants may be stigmatised or 're-traumatised' and makes the intervention relatively safe for delivery by non-mental health specialists and within community contexts.

The thematic analysis identified an overarching theme of 'shared experiences' and three core themes; 'confidence', 'peer support' and 'the positive impact of sport'. The children's perception of their own abilities, for example, their social skills, appeared to increase. This may reflect an increase in self-efficacy which research suggests can be improved by group interventions which involve encouragement from significant others (Marks et al., 2005). The participants spoke very positively about the involvement of peer mentors, who seemed to provide emotional as well as practical support. In line

with previous research, the use of sport appeared to provide a common framework that facilitated engagement (Cullen & Munroe, 2010). It is possible that sport provided a familiar and non-threatening environment that allowed the children to begin to overcome some of their difficulties, such as shyness. Although the use of sport seemed to be a positive experience for these children, research does suggest that for some, it can have negative connotations, such as rivalry, aggression or exclusion (Ley & Barrio, 2010). The skill of the coaches may have been influential to the children's positive experience.

Research suggests that transition to secondary school and the parallel transition to adolescence can be a stressful time for some children (Galton & Morrison, 2000). Thinking about transition in terms of theories about resilience and self-esteem highlights the importance of secure attachments in secondary school, with both peers and adults (Jindal-Snape & Miller, 2008). Our sense of 'worth' is likely to be influenced by the quality of the relationships we have with others; if we are receiving affirming messages from our family, friends and significant others our sense of worth is likely to be secure (Jindal-Snape & Miller, 2008). Interestingly, the relational aspect of this workshop seemed an important factor for the participants. Many spoke about the importance of forming new friendships, in fact, one boy said, 'I thought I wasn't anybody's friend but I actually made friends. I feel really happy.'

#### *Feasibility, limitations and future research questions*

These pilot studies suggest that the Team of Life is feasible for delivery within the UK school setting. There seem to be advantages and disadvantages of delivery either intensively or spread out over more sessions. Students from Group One who took part in the qualitative interviews spoke favourably about spending time away from school in a local sports centre as a rewarding and memo-

rable experience. Having said that there were practical advantages to delivery within the school setting in terms of fitting in with the school time-table and reducing costs, which is important in terms of sustainability. Future research could evaluate the optimum frequency and length of sessions for maintaining relationships and consolidating experiential learning. The current study included students involved in a peer mentoring role, which again was positively experienced by the participants. Previous research on mentoring programmes suggests that they offer the greatest benefit to those identified as 'at risk' but not yet demonstrating significant difficulties (Hamilton & Hamilton, 1992). Additional research is needed to further investigate the role of peer mentors and the impact upon educational outcomes such as school readiness. Future studies should also include data collected from parents and teachers.

Although these preliminary results are encouraging, it is not possible to say whether the changes observed were truly the result of the intervention as there was no control group of students not in receipt of an intervention. Improvements might therefore only reflect spontaneous changes in wellbeing over time. Similarly, we cannot be sure from this study whether the changes observed relate to this specific intervention or would have been present following any similar group-based experience. These studies were small-scale pilot projects undertaken with the support of a trainee clinical psychologist and an assistant psychologist who were both working on a short-term, temporary basis. This limited the scope and scale of the research. Future larger-scale research, with adequate numbers to make robust and reliable conclusions and including a control group, would allow researchers to examine the effectiveness of the Team of Life in comparison to 'transition-as-usual' and also in comparison to other interventions.

Another limitation is that the participants were all male so it is not clear whether this intervention would be effective for

females. Research is required with a sample that includes females and that investigates which demographic variables are likely to predict who is most likely to benefit from an intervention such as the Team of Life. The current pilot groups were delivered alongside sport. While sport is not a core component of the intervention, the sporting activities were positively experienced by this particular cohort of male students.

The current project evolved from CAMHS extended schools work taking place alongside TAMHS work led locally by educational psychology. While consultation and wider collaboration had taken place in relation to the promotion of positive mental health in schools, the potential for closer collaboration and partnership working between the two services was arguably missed due to funding limitations. Discussions about the current and similar projects within local networks did highlight the overlap between CAMHS and educational psychology services in aiming to develop support for schools that is focused upon improving emotional wellbeing and promoting resilience. It is hoped that the current policy drivers aimed at transformation of CAMHS service delivery will open up possibilities for closer partnership working between clinical and educational psychology colleagues.

## Conclusions

The Team of Life programme is an example of innovative joint working between health and education to promote children's emotional wellbeing. Joint working is essential if services are to survive, especially in times of financial hardship. However, this work is not always straightforward; each organisation has a different culture, language, and goals. In this case a narrative approach utilising sporting metaphors helped bridge the gap. The relational aspect of the workshop also appeared to facilitate friendships, promote participant's confidence in achieving their goals and may have reduced some of the symptoms associated

with the development of mental health and behavioural difficulties. The apparent success of the peer-mentoring component highlights potential to develop a structure for long-term 'teams' within schools, where participants 'graduate' to become mentors of younger students coming through the school. The current project highlighted the potential for greater collaboration between clinical and educational psychologists working towards common aims of promoting positive mental health in schools.

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## Address for correspondence

**Dr Helen Sharp PhD DCLinPsy**  
Consultant Clinical Psychologist  
Cheshire & Wirral Partnership NHS  
Foundation Trust

Reader in Clinical Psychology,  
Department of Psychological Science,  
Institute of Psychology, Health and Society,  
Whelan Building,  
University of Liverpool,  
Brownlow Hill,  
Liverpool L69 3GB  
Email: [hsharp@liv.ac.uk](mailto:hsharp@liv.ac.uk)

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