Implication pitfalls for Targeted Mental Health in Schools: Evidence from a qualitative evaluation of the Cumbrian programme

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CITATION
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Abstract
This paper reports findings from a qualitative evaluation of the Targeted Mental Health in Schools (TaMHS) programme in Cumbria. Focusing on the two most widely documented problems in TaMHS implication at the national level – the style/content of basic training provided to school staff, and a restrictively short lead-in period – the analysis explores their impact as perceived by participants in the programme, and makes recommendations for future practice grounded in these.

Keywords
intervention; learning; mental health; teaching; schools; youth

Introduction
The national TaMHS programme was initiated in 2008 by the Department of Children, Families and Schools as a major component in a drive "to transform the way that mental health support is delivered to children aged 5 to 13, to improve their mental wellbeing"
and tackle problems more quickly". (DCFS, 2008, p.ii). The programme, aimed specifically at enabling schools to deliver a holistic, whole-school approach to the promotion of children's mental wellbeing, was implemented in three phases. In Phase 1 (2008–2009), 25 'pathfinder' children's trusts were funded for three years to develop and deliver a flexible, responsive, and effective early intervention model of mental health services for children and young people. The early evaluation outputs of these interventions would, moreover, inform a phased national implementation from year two of the programme (2009–2010) onwards. In Phase 2 of TaMHS (initiated April 2009), 55 Local Authorities joined the programme, receiving funding for two years. In Phase 3 (initiated April 2010), 72 further Local Authorities, including Cumbria itself, joined the programme, receiving funding for one year.

TaMHS in Cumbria

In Cumbria, the 12-month TaMHS project concluded at the end of March 2011. Formal work in schools began in September 2010, supported by a steering group including senior managers from Children's Services and the NHS. Eighteen schools, in three clusters across the county itself, were supported. These clusters each included a secondary school and partner primary schools, plus one Pupil Referral Unit (PRU) in the Workington cluster. A number of specialists from tier three Child and Adolescent Mental Health Services (CAMHS) and Specialist Higher Level Teaching Assistants from Local Authority, Children's Services, Educational Psychology and Behaviour Support Team were seconded to support each cluster of schools (working part time). These workers were mandated with the provision of staff training, support for parents, group interventions, and direct work with young people. Through the TaMHS project all involved schools accessed cluster meetings, support from a Primary Mental Health Worker, Specialist Higher Level Teaching Assistants (HLTAs) supporting schools in providing small group Social and Emotional Aspects of Learning (SEAL) and Family SEAL, mental health training, and a mental health toolkit, including a mental health and emotional wellbeing policy and information on mental health and emotional wellbeing for students. Additionally, some schools accessed parenting workshops, counselling for staff, outdoor activities for young people, 'Stardom' projects or after-school craft activities, and/or a whole-school health day.

Two common 'glitches'

In terms of the national picture, and particularly with very distinct implications for the interaction between the involved professionals in health and education:

Two common 'glitches'

In the results, some apparent systemic problems in its implication, however, related directly to the two global themes recurrent in many other subsequently published evaluations (noted above).

Global theme 1: Basic training

This core theme manifested in three main subthemes, which were further identified by a number of participants (STL, N=3; SSM, N=2) as having had unproductive (albeit moderately so) impacts upon school staff enthusiasm for the TaMHS project at the outset.

Table 1: Issues in early training

<table>
<thead>
<tr>
<th>Early training was...</th>
<th>Participants</th>
<th>Sample Evidence</th>
</tr>
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<tbody>
<tr>
<td>...too simplistic.</td>
<td>STL, N=3; SSM, N=4.</td>
<td>We attended two sessions...to do with mental health and sort of recognising mental health within...children and, and young adults. Both of those I found were not as helpful [as later sessions]...they did say it was very basic but it really was very, very basic, and...think with early years in key stage one certainly...we're very heightened to lots of aspects of this social emotional development anyway, because of the early years development profile.</td>
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<tr>
<td>...focused on typical 'mental health' concerns, without providing specific and tailored links to educational practice.</td>
<td>STL, N=2; SSM, N=2.</td>
<td>I think a lot of it came from the health side right at the beginning about mental health in...children and adolescents, but I think if [things may have been clearer], if right at the beginning they'd said 'if you've got children in your school who this, and this, and this, that actually would be classed as a mental health problem'...</td>
</tr>
<tr>
<td>...not designed to take account of different demographic compositions within and between schools.</td>
<td>STL, N=1; SSM, N=3.</td>
<td>I felt actually that...some of it’s it’s not differentiated enough...because everyone has problem children from whether you live in a £600,000 house or a 'sink' estate...people from all walks of life have problems with children and I felt that the [training] was aimed at more the Sure Start end of the market.</td>
</tr>
</tbody>
</table>

Proper and its actual delivery in schools was insufficient for full preparation, and that, therefore, even minor delays could result in major difficulties. In Trafford, for example, Jeyesingham (2011, p.15) reports that there was "some uncertainty about remit and referral criteria at the start of the project which can be explained by [initial] delays" that further shortened the available preparation period while, in Derbyshire, lead-in time was constrained by difficulties in initially filling Primary Mental Health Worker posts (Barrow, 2011, pp.20–21) and, also, some school staff found the early training to be of 'starter' level (p.9). As evidenced in the Results section (below), these apparently systemic problems also manifested in the Cumbrian TaMHS. The nuances of the data further demonstrate, however, a range of more complex ways in which they impacted at the level of participant experience.

Research design

With pertinent ethical approval and informed consent, data were collected through a programme of semi-structured interviews, conducted and recorded via telephone over a period of two weeks immediately following the closure of the TaMHS initiative itself.

Participant selection

Participants (N=30) were purposively selected from the three categories of professional involved in TaMHS implication in order to provide the most multifaceted overview possible: (a) School TaMHS Leads (STLs, N=13), (b) staff members at participating schools (SSMs, N=11), and (c) Dedicated TaMHS workers (DTWs, N=6).

Research materials

Three different, but strongly interrelated, interview schedules were developed (available from Dr Paul K. Miller – see below for contact details), one for each category of respondent with a view to elucidating all priority issues in a manner sensitive to the roles of each respondent. In this way a three-dimensional, but fully interlocking, sense of the overall picture (and any discrepancies in it) could be formed. Interviews were organised around a series of central broad and open questions, with subsidiary topical 'prompts'; rather than a rigid set of predefined inquiries, permitting participants to voice a greater range and depth of opinions than is often permissible within more structured data collection frameworks (Fielding & Thomas, 2008; Silverman, 2010). Interviews were on average 20 minutes in length, and questions in all three schedules were tailored to explore the impact and success of the TaMHS programme in terms of the set of central aims stipulated in Cumbria County Council's original participation documentation (see Cumbria County Council, 2010, pp.6–8).

Data analysis

Data were explored for patterns and themes in line with the core principles of Grounded Theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998), in order to generate robust and defensible, practice-oriented findings from a systematic and rigorous qualitative analysis of the corpus (Silverman, 2006). This process was conducted using Scientific Software's ATLAS.ti qualitative analysis package, which is optimally suited to this mode of inquiry (Lewins & Silver, 2007).

Results

The Cumbrian TaMHS was, on the whole, very well received. All issues voiced by participants in terms of
2, i.e., that many of the problems in the early training largely outputs of those embedded in Global theme assertion that the issues around Global theme 1 were the various themes identified above, with a dominant themselves made very explicit connections between It is highly noteworthy that a majority of participants problems, and the connections between them. However, the mode of evidence collected in the evaluation – with a specific focus on how problems manifest at the level of participant experience – facilitates an understanding of ways in which the initiative might have been buffered against some of the objective and subjective impacts of systemic obstacles. These have clear implications for the successful execution of future health interventions of comparable character, in a range of types of institution. With respect to interventions involving the provision of training to professionals outside the domain of health itself:

1. The one-size-fits-all model of training was not universally well received. Although adaptations to audience made during the training proved very fruitful, the earliest sessions often left a lasting impression and informed the manner in which school staff viewed the whole initiative.

2. An evidence base was required pertaining to the specific demographics and perceived training requirements of staff at involved institutions in terms of both style and content of delivery.

3. Baseline demographic data are generally freely available; simple surveys to assess prior knowledge and preferred modes of delivery are: a) relatively cheap, quick and easy to conduct as soon as participating schools had been identified and prior to the formal rollout of training itself; b) likely to result in training programmes that engage staff from the outset; and c) likely to provide staff with a sense of being involved in the learning process itself, rather than simply being its ‘audience’. The development of such an evidence base would also have impacted on other central matters. For example:

1. The prior assessment of school staff expectations and of training to professionals outside the domain of health itself;

2. Input into the form of the initiative at their own requirements of staff at involved institutions in terms of actual improved initiative from the outset in terms of actual improved stimulus a more uniformly positive reception of an initiative itself, with corollary benefits in terms of their own attitudes towards it.

Conclusion
The evidence presented herein makes a clear case for future health interventions in schools or similar bodies in the region to embed not only post-hoc evaluation, but also a priori investigation (even if relatively cursory) of the sometimes eclectic characters, needs, and expectations of client bodies. Such research could stimulate a more uniformly positive reception of an initiative from the outset in terms of actual improved experience of delivery due to more effective tailoring to audiences; the direct involvement of clients in the specific structure of the initiative at any given site; and the perception of shared responsibility inherent therein. With respect to educational institutions in particular, and much as it is axiomatic that medical professionals are prone to exercise a heightened critical eye on their own healthcare, it might well be anticipated that teachers/lecturers would take particular account of what and how they are being taught by others. The reality and the perception of shared involvement are, thus, critical to fostering affirmative attitudes towards health-related training provision for this group.

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References


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It’s ok to ask!

Free health research roadshow

Cumbria Partnership NHS Foundation Trust will be coming to a number of towns in Cumbria in August 2013 to:

- answer questions about NHS research
- provide information about available research opportunities and how to get involved
- find out why it’s important that people take part in research

There is also a chance to win a hamper of local produce or grab some freebies. Come along and be empowered in terms of health research.

Remember ‘it’s ok to ask!’

Contact Barbara Bishop for more information on 01228 602170