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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 respect to Phase 3 TaMHS initiatives, two problems in implication are reported more commonly in published evaluations than any others. These are: (a) that basic training provided to school staff was seen as either too basic or too generic; and (b) that the allocated lead-in period between the beginning of any initiative 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, Jeyasingham (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 constricted 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 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

Early training was...	Participants.	Sample Evidence.
...too simplistic.	STL, N=3; SSM, N=4.	*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…I 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.*
...focused on typical 'mental health' concerns, without providing specific and tailored links to educational practice.	STL, N=2; SSM, N=2.	*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'…*
...not designed to take account of different demographic compositions within and between schools.	STL, N=1; SSM, N=3.	*I felt actually that…some of it 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.*

Global theme 2: Lead-in period

This theme also manifested in three key subthemes, with very distinct implications for the interaction between the involved professionals in health and education:

Table 2: Consequences of short lead-in period

Short lead-in period resulted in...	Participants.	Sample Evidence.
...difficulties in organising activities around schools' pre-existing activities at short notice.	DTW, N=2; STL, N=2; SSM, N=1.	*[It is important that] the planning's done a little bit before we start the project, [that] schools are given more notice, because what we found was schools were quite booked up, their timetables were booked up, a lot of the training slots were booked up....*
... confusion over the exact roles of the DTWs in schools.	DTW, N=1; STL, N=3; SSM, N=2.	*I think there was a little bit of confusion at the start about how the primary mental health workers would actually work in schools, and I think we were under the impression in schools that they would be working one-to-one with a lot of young people and there was quite a lot of confusion about that...*
... a lack of awareness among school staff in terms of what TaMHS was 'really about'.	STL, N=3; SSM, N=2.	*I am glad we've taken part now, but they need to give schools bigger lead-in time to get their heads round things like this...*

Thematic integration

It is highly noteworthy that a majority of participants themselves made very explicit connections between the various themes identified above, with a dominant assertion that the issues around Global theme 1 were largely outputs of those embedded in Global theme 2, i.e., that many of the problems in the early training were *because* of the short lead-in period itself. For example, one STL participant maintained that the DTWs did not seem to have been adequately prepared to deliver to an audience of professional educators not in terms of content, but in terms of style. An SSM, meanwhile, reported that time constraints had even resulted in training and practice being 'chronologically inverted': *"I actually worked on a small group SEAL programme first of all and we [then] went and we had one or two training sessions...So I just felt that was bit back to front."*

Figure 1 schematises the full range of ways in which the themes discussed above were linked by participants themselves [Note: one should be mindful that this schematisation is one of the relationships between issues that were raised, not quantification thereof].

Discussion

Participants in the evaluation identified two central 'problem' issues with respect to the implication of TaMHS in Cumbria, a set of perceived outcomes of these 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.

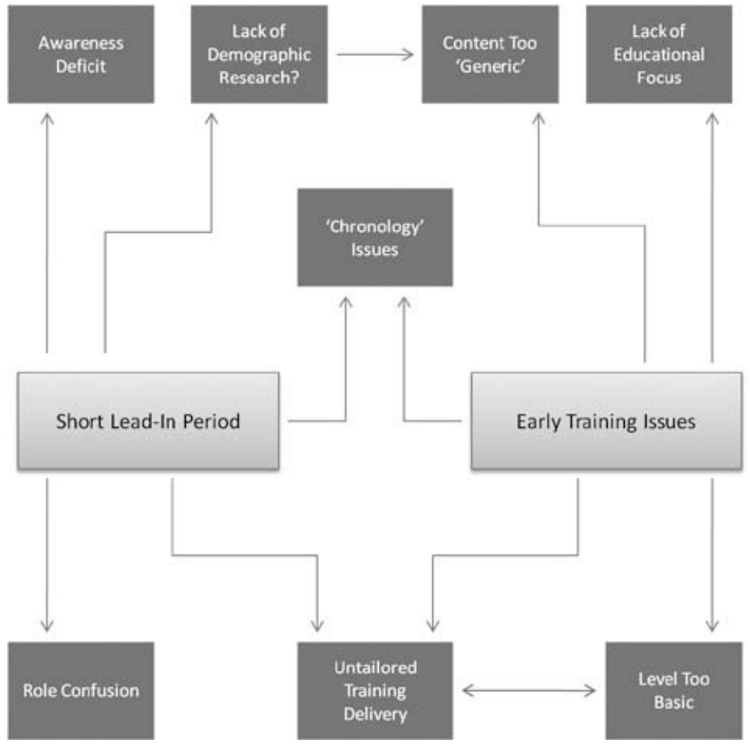
With respect to interventions involving the provision of training to professionals outside the domain of health itself:

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 in terms of the roles that visiting health professionals would play may well have assisted the TaMHS staff themselves in providing clarity from the outset.
2. Input into the form of the initiative at their own schools would have invariably impacted positively upon staff members' awareness of the initiative itself, with corollary benefits in terms of their own attitudes towards it.

Figure 12: Network analysis



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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