





# Heuristic assessment of psychological interventions in schools (HAPI Schools)

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## Abstract

Children spend more time in school than in any other formal setting and, with mental illness in children on the rise, there is more pressure on schools to intervene in student mental health than ever before. In the current study, two phases of semistructured interviews were conducted with school leaders and special educational needs coordinators (Phase 1,  $N = 23$ ; Phase 2,  $N = 11$ ), to investigate first-hand experiences in dealing with student mental illness. Thematic analysis, drawing on Grounded Theory, was used to identify themes. The results identified deprivation as one of the main causes of mental ill-health in students, with insufficient budgets, inappropriate mental health services, and overly long waiting times as barriers to intervention. Difficulties in identifying appropriate mental health interventions to use in school were also reported. The authors propose a simple four-point heuristic, for assessing the quality of school-based mental health interventions to be used by school staff, so that educators can more readily identify appropriate mental health support for their students.

## KEYWORDS

assessment tool, heuristic, mental health, student support

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## 1 | INTRODUCTION

Positive mental health (the dimension of psychological wellbeing including purpose in life, personal growth, and self-acceptance) has benefits for physical health, relationships, and finances (Keyes, 2007; Lyubomirsky et al., 2005). It is also associated with educational attainment, productivity, reduced mortality, increased social interaction and engagement, lower risk of mental illness and suicide, less risk-taking, and increased resilience (Campion et al., 2012). In the United Kingdom (UK), mental illness accounts for 22.8% of the total health burden, whereas cardiovascular disease accounts for only 16.2%, and cancer 15.9% (WHO, 2008). Half of all lifetime mental illnesses start by the age of 14 and 75% by the age of 25 (Kessler et al., 2007). More than 10% of UK children and young people are reported to have a mental health disorder at any one time, which includes 6% with conduct disorders, 4% with emotional disorders, 2% hyperkinetic disorders, and 1% with autism (Green et al., 2005). Mental illness costs the UK economy £70–100 billion each year or 4.5% of its gross domestic product (Goldie et al., 2016). Research has also shown an association between childhood mental illness and the ability of those affected to work and earn when they become adults (Goodman et al., 2011).

There are 353 local authorities (LAs) in England. These provide the local government for their metropolitan borough, county, or district (National Audit Office, 2017). It has been shown that the North West region of England contains five of the 10 most financially deprived LAs in England (Gill, 2015). The proportion of the population in the most deprived group is at a low of 7.3% in the South East and a high of 32.8% in the North West (Newton et al., 2015). A link has been demonstrated between deprivation and negative outcomes in physical and mental health and the statistics above suggest that the UK likely experiences significant mental health inequalities, despite major government policy initiatives (Grey et al., 2013). Reductions in National Health Service (NHS) expenditure for specialist mental health care since 2008, mean that some LA's expenditure has reduced by up to 32% (Docherty & Thornicroft, 2015). The same report cites this as a major contributing factor in a 48% decrease in the number of people with mental illnesses receiving any care. Child and Adolescent Mental Health Services (CAMHS) are no exception to this trend. A survey of the Faculty of Child and Adolescent Psychiatrists (Hindley, 2014) reported; 77% having difficulty accessing admissions to inpatient beds, 79.1% having to safeguard concerns or incidents while waiting for a bed, 76% having young people with unacceptably high-risk profiles managed in the community due to lack of beds, and 61.9% having experienced young people being held in inappropriate settings. All this is taking place while childhood and adolescent depression in Western countries is increasing. Around 2% of 11- to 15-year-old children and 11% of youth aged 16–24 are currently suffering a major depressive disorder in the UK (Green et al., 2005). Wealthier countries invest relatively little in protection for the safety of young people (Bonniwell & Ryan, 2012), yet the UK is still in the bottom third of 21 rich countries for child wellbeing. Indeed, the UK is last in self-reported health, interest in school, and subjective wellbeing (i.e., children's sense of their own wellbeing) (Adamson, 2007).

Children spend more time in school than in any other formal setting (Rutter et al., 1979) and school hours have remained unchanged for several decades (Symonds & Hagell, 2011). Therefore, schools have a major role in child relationships, cognitive development, social skills, academic attainment, and emotional and behavioral control (Fazel et al., 2014). It remains to be seen what effect Covid-19 will have on all this. Indeed, intervention into children's mental health increasingly takes place in school (Wyn et al., 2000). A previous meta-analysis found 81 studies where students had undergone some sort of depression and anxiety prevention program in school (Werner-Seidler et al., 2017). Of these, 27 were conducted in the United States of America and 20 were conducted in Australia, whereas only three were conducted in the UK. This illustrates the need for more empirically tested school-based interventions in the UK. Barriers to the use of such interventions include "poor engagement" of school staff, school counselors, and support staff. Others include individual factors such as stigma, parental issues, and existing risk factors, community factors, access to funding, excessive waiting times, and limited availability of training (Fazel et al., 2014).

The situation outlined above makes it clear that educators and school administrators require assistance in intervening in the mental health of the children and adolescents who attend their schools. The current study aimed to investigate the opinions of school leaders and special educational needs coordinators (SENCOs) of current mental health services for children and mental health interventions in schools. The current study aimed to answer

several questions. What are the main causes of mental ill-health in school-aged children in the North West of England? How do schools intervene? What help do they receive? What help do they need?

The attempt to answer these questions took place in two phases. Phase 1 was a scoping study which involved contacting schools via telephone. Schools were asked a few short questions regarding the types of interventions they have in place for their students, and the improvements they would like to make to this provision. Phase 2 involved longer, face-to-face interviews with a smaller number of school staff, in an attempt to investigate the specifics relating to the types of issues that students present with, the interventions in place to help students, the outside help received by the school, the training and support received by staff, and the ways that interventions into mental health are assessed at each school. Though a small number of studies of this type have taken place to assess teachers' perceptions of the role of school psychologists (Ahtola & Kiiski-Mäki, 2014; Gilman & Medway, 2007), there is a paucity of studies investigating their attitudes towards the specific mental health interventions being used in their schools.

## 1.1 | Phase 1

Phase 1 employed qualitative research methods, taking the form of semistructured interviews. The rationale for this approach was that educators are the professionals who spend the greatest amount of time with school-aged children, as schoolwork is the single activity that children in Europe spend the most time undertaking (Larson, 2001). It was, therefore, expected that educators would have insights and perspectives into child mental health that healthcare professionals and researchers may be unlikely to share. It is also possible that, due to a lack of specialist training, educators do not necessarily have the vocabulary relating to mental health. Therefore, interviewing educators offers the opportunity to tease out the desired information, which quantitative methods may not. This approach is also recommended by Fabiano et al. (2014), for studies intended to yield either exploratory or explanatory data.

### 1.1.1 | Materials and method

Schools in the North West of England were contacted by telephone to establish what mental health interventions these schools had in place for their pupils. Participants were headteachers, SENCOs, and heads of safeguarding. An attempt was made to obtain a representative sample of the schools in the region, by contacting schools based on their LA, Ofsted rating (the external inspection scheme used in schools), school type, and religious character. However, due to a low response rate, it became necessary to contact as many schools as possible, to establish a reasonable sample size. At the beginning of the telephone calls, consent was obtained verbally, and a script was read out to participants describing the measures used to ensure anonymity and with contact details, should they decide they wanted to withdraw from the research. Out of the total 3,499 schools in the 23 LAs in the North West of England, 151 schools were telephoned for comment. Of this number, 87 schools requested that questions be sent via email. Twenty-three schools responded to the questions, 15 of which were primary schools, and eight of which were secondary schools. Only two schools responded via email, one primary and one secondary. Twenty-three was considered to be a sufficient number of participants for the study, as saturation was reached, with later interviews failing to yield new coding categories and information (Guest et al., 2006).

Participant responses were analyzed using NVivo version 11 software (QSR International). The approach used was inductive thematic analysis, as recommended by Braun and Clarke (2006), for use when themes are derived from data, without attempting to fit them into an existing theoretical framework. Investigator triangulation was used, as recommended by Farmer et al. (2006), to ensure the completeness and convergence of, and dissonance between, the key themes. Two researchers independently coded the telephone interview transcripts and agreed upon themes.

## 1.1.2 | Results

Table 1 shows the themes identified in Phase 1, along with subthemes and the number of participants who discussed each subtheme. The table also includes an example quote for each theme or subtheme, with the participant number of the educator who made the statement.

### *Deprivation*

Phase 1 identified that deprivation is one of the key themes. However, these findings are identical to previous work, discussed above, stating that the proportion of the population in England who are in the most financially deprived group ranges from a low of 7.3% in the South East to a high of 32.8% in the North West (Newton et al., 2015). According to the current study findings, not only mental health but also students' readiness to learn has been greatly influenced by deprivation.

"Deprivation at home and not being ready to learn." Response from School 1

It was also emphasized that adverse family backgrounds play a key role in students' psychological stability and their academic achievement.

"Deprived area, lots of kids with parents who drink and take drugs." Response from School 4

"Adverse home life and frustration at the lack of understanding." Response from School 7

**TABLE 1** Emerging themes from telephone interviews with school staff

Themes and subthemes	Example quote
Deprivation	"Deprivation at home and not being ready to learn." School 1
Family	"Deprived area, lots of kids with parents who drink and take drugs." School 4
Circumstances	"Adverse home life and frustration at the lack of understanding." School 7
Variety of mental health problems	"Various problems including anxiety." School 3
Attachment	"Parental issues such as splitting up causing attachment issues." School 4
Relationships	"We work closely with the school nurse to build relationships with parents and outside agencies." School 5
Knowing the children	"We know the children very well through relationship building." School 3
Self-expression	"We have many young people who express their personal distress in often what would be generally considered unacceptable behaviors." School 10
Signposting to outside agencies	"All we can do is signpost and counsel." School 4
Service waiting times	"Waiting list is a massive problem." School 3
Variety of interventions	"A wide range. We have a play-based counselor visiting, talking therapy, sometimes just a change of environment." School 5
Lack of money	"Our policies are robust. Resources are the issue." School 21
Staff	"Mental health is an extra responsibility for schools. There are simply not enough people. People that deal with mental health have to have the time to do so." School 20
Training	"More funding is needed, particularly in order to train staff." School 13
Engagement	"It is difficult to get kids to engage if the problems are entrenched." School 4

Out of 23 participating schools, 16 schools mentioned that deprivation and family circumstances have a major impact on children's psychological wellbeing and readiness to learn. Deprivation was identified as the main driver of child mental illness in the region. School staff highlighted family problems such as domestic violence and divorce as problems for many children, particularly those in the most deprived groups.

#### *Variety of mental health problems*

Educators also cited several different mental health problems in the children they taught, particularly issues around attachment. Attachment issues were also stated to be more prevalent in more deprived areas.

#### *Relationships*

Strategies for identifying children who might be suffering from mental health problems largely centered around teachers' relationships with the children. Participants stated that teachers tend to know the children they teach very well, and are, therefore, able to notice changes in day-to-day behavior. These changes in behavior were highlighted as being important, particularly as many children are unwilling or unable to express what is really bothering them. Educators highlighted the difficulty children have expressing their feelings.

#### *Signposting to outside agencies*

A number of the educators interviewed spoke about their inability to do much to intervene in child and adolescent mental health, beyond signposting children and families to outside agencies. The main difficulty when doing so was waiting times for access to such agencies, with one educator describing these as "inordinately long". Waiting list and wait times from services such as CAMHS and other providers have been identified to be key barriers to support children with emotional, social, and psychological needs.

"Waiting list is a massive problem." Response from School 3

"Waiting list for seeking services." Response from School 15

#### *Variety of interventions*

Educators who stated that they were able to offer interventions to address the mental health of the children and adolescents that they taught, described a wide range of interventions, with no one intervention being used by a large number of schools. Indeed, the only form of intervention that was used by more than one school was "Lego therapy."

#### *Lack of money*

The main barriers to offering mental health intervention were lack of money, lack of staff, and lack of training for staff. Lack of money was cited as the main cause of the lack of both training and staff.

#### *Engagement*

Another barrier that was cited was a lack of engagement in interventions, both from children and from their parents. More generally, societal attitudes to mental health were cited as being problematic. Several educators stated that mental health is not treated in the same way as physical health and that this disparity leads to mental health problems not being tackled effectively.

### 1.1.3 | Discussion

Phase 1 showed that deprivation is one of the main causes of mental ill-health in children and adolescents in the North West of England. The relationship between deprivation and health outcomes discussed here is consistent

with the findings discussed above. Family issues, domestic violence, and divorce are not exclusive to deprived children, but are more likely for this group and exacerbate problems caused by deprivation. Previous research shows a relationship between deprivation, family dissolution, and academic performance (Downey, 1994; Pong & Ju, 2000). Results here highlight a skills gap in regard to dealing with mental health problems in children. This skills gap is exacerbated by low budgets and staff numbers, as well as training for staff relating to child and adolescent mental health. Previous research shows that embedding mental health interventions in schools involves a unique resource burden (Fazel et al., 2014). Results here show that underfunding results in children being failed at school and in specialist mental health services. They also show that specialist mental health services not meeting children's needs and agree with previous research regarding waiting times (Frith, 2016), showing that long wait times make services unfit for purpose.

## 1.2 | Phase 2

The results of Phase 1 agree with the literature around child and adolescent mental health. However, to establish what might be done about this situation, a more detailed investigation of the needs of, and issues encountered by, educators in the region attempting to intervene in child and adolescent mental health is needed. Therefore, it was felt important to conduct a more in-depth investigation using face-to-face interviews.

### 1.2.1 | Materials and method

Thirty-four of the schools that had been contacted during Phase 1 were contacted again to schedule a face-to-face interview with the headteacher, SENCO, or head of safeguarding. Of this number, 11 were interviewed. Four of these schools were secondary schools, and seven were primary schools. The smallest school was a rural primary school with a pupil population of only 65 children. The largest was a suburban secondary school with a pupil population of approximately 1,250 children. Interviews covered a variety of topics around mental health interventions in schools, with questions covering the issues that might cause mental ill-health in students, the ways in which mental illness might be identified, the types of mental health intervention used in school, and the methods by which these interventions are assessed. The sample size is considered to be of sufficient size as saturation was reached, with enough information having been gathered with which to replicate the study (O'Reilly & Parker, 2013). It also became apparent that later interviews were not yielding further information or coding categories (Guest et al., 2006). Interviews were conducted face-to-face in schools and their duration ranged between 15 and 45 min.

Participant responses were analyzed using NVivo version 11 software (QSR International). As it was hoped to develop a substantive theory regarding school-based mental health interventions in schools in the North West of England, responses were analyzed using Grounded Theory, as described by Fassinger (2005) and recommended for use by Glaser and Strauss (2012) in such situations. To establish and improve inter-coder reliability, two interview transcripts were coded independently by two researchers. This produced a coding framework and codebook for the remaining interview transcripts.

### 1.2.2 | Results

Table 2 shows the themes identified in Phase 2, along with subthemes and the number of participants, who discussed each subtheme. The table also includes an example quote for each subtheme, with the participant number of the educator who made the statement.

**TABLE 2** Emerging themes from face-to-face interviews with school staff

Themes and subthemes	Example quote
<b>Deprivation</b>	
Parental issues	"Often it's the parents' problems you are picking up as they're part of the school community." P1
Drugs	"Though there's not a lot of money in some of the households, there's a lot of use of cocaine and heroin in this area, a lot of drug and alcohol abuse." P7
Domestic violence	"We get some developmental problems or PTSD linked with domestic violence." P11
<b>Variety of mental health problems</b>	
Getting worse	"Our concerns about emotional and mental wellbeing seem to grow by the day." P9
Girls versus boys	"Girls' mental health takes a different form to boys' mental health." P6
<b>Socialization</b>	
Peer support	"We have a lot of peer-to-peer work where, particularly the younger children will be supported by older pupils who listen to them read and chat with them once or twice a week." P7
Peer pressure	"I would say peer pressure, there's this self-image issue and not exclusively among the girls." P7
Social skills and self-expression	"We've got children lashing out physically and verbally because they don't know how to express themselves any other way." P9
<b>No written policy</b>	
Informal processes	"Individual interventions tend to be less formal. There are staff who speak to children or children share experiences with." P2
Relationships and knowing children	"The teachers. They get to know, cos they see the children day in, day out." P6
Informal outcome measures	"There's been feedback given after the sessions that the coach has run with the classes with the year groups. I think that feedback's been given but other than that probably no." P4
Recent changes in approach	"Designated days throughout the year which are going to focus on mental health. We're also having whole staff training. We're having an inset day where for staff, completely around mental health of students with a small focus on mental health of staff but it is a big focus for the school this year." P7
Prevention versus intervention	"We try and do everything preventative rather than being reactive all the time." P8
Needs and opinions of child	"We also ask children to create their own person-centered paths so they kind of tell us on there if we're doing something that they don't want or if we're not doing something that they do want" P7
<b>Lack of resources</b>	
Services	"Significant improvement in the CAMHS resource. Significant reduction in referral time. What does that person, that family do in the 12, 16, 20 weeks, the referral time?" P7
Support for children	"It's still very difficult to access the support you need if you've got children with serious mental health issues." P5

(Continues)

TABLE 2 (Continued)

Themes and subthemes	Example quote
Money	"The funding gap is a huge thing. I think the government are not doing enough to support our young people." P2
Staff	"The counselor. He was very good; he'd meet people but again he was only one person and he could only see one person at once. We've got a big need here." P5
Teacher mental health	"If you've got stressful and anxious teaching staff who are feeling looked upon by observations from senior management, from local authorities, from inspections who, in less than 50 min will kind of write off their career as inadequate then how are you going to produce healthy children?" P3
Training	"Would be great to look into for whole staff training but of course there's the cost implications for things like that." P6
Teacher understanding of mental health	"Staff to start understanding mental health because when you go to teacher training college you don't get that much help and advice on mental health." P10

### *Deprivation*

Educators who participated in Phase 2 believed that deprivation is the main driver of mental ill-health in children and adolescents in the North West of England. These educators linked deprivation to several parental issues affecting children in the region. They linked deprivation to a higher likelihood of parental discord and divorce, and even domestic violence. Educators also linked each of these factors with a higher likelihood of mental ill-health in the children they teach. Some interviewees also drew links between deprivation and drug use among the parents of school children in the region, with one headteacher stating in reference to this that "Some of the coping mechanisms that our families deploy are not ones you want these children to think is the way out."

### *Variety of mental health problems*

The educators interviewed here did not tend to agree on the types of mental illnesses that were most prevalent in their schools. A wide variety of different mental health problems were cited. However, there was broad agreement between the educators that mental health problems have become more prevalent in the last 5–10 years among the children and adolescents that they teach. Several of the interviewees also highlighted the perceived differences in the etiology and expression of mental ill-health between girls and boys.

### *Socialization*

One of the factors discussed by all of the participants in the study that is believed to have a big impact on child and adolescent mental health is socialization. Educators were keen to point out the different interventions they offer to their pupils, in terms of improving social skills. This was seen as important for several reasons. Participants believed that poor social skills and mental ill-health go hand in hand, each exacerbating the other. They, therefore, believed that improving a child's social skills will help improve their mental health. They also believed that improved social skills enable children to express themselves when it comes to their mental health, therefore allowing the educators themselves to better intervene and help the child recover. Interviewees also highlighted the important role that peer relationships play in child and adolescent mental health. Several of the participants mentioned peer pressure and the negative effect this can have on a child's wellbeing. Some of the educators cited social media and the potential they believe these have to negatively affect self-image, particularly in adolescents. The final way in which socialization was seen to affect child and adolescent mental health was through peer support. The vast majority of



the schools in this study have some form of formal peer support system in place to help their pupils. These take the form of academic help as well as pastoral support.

#### *No written policy*

One theme that was ubiquitous in the current study was the lack of a written policy regarding mental health. None of the schools involved in the current study had such a policy, although several mentioned safeguarding, inclusion, and pastoral policies that make mention of mental health. A small number of educators mentioned that they were in the process of writing a mental health policy, suggesting that this was something that schools are beginning to look at. This change in approach was mirrored in other areas of discussion, with several participants pointing out that the overall school approach to pupil mental health had changed in recent months and years. This seemed to be linked to the perceived upturn in the number of children and adolescents with mental health problems, and an appreciation that something needed to be done to tackle this. Despite the changes in approach highlighted in some schools, it is still true that the majority of participants in the study stated that their schools employ informal processes to identify and intervene in mental health problems with their pupils. Overwhelmingly, educators highlighted the role that relationships play, particularly in identifying potential mental health problems. They pointed out that teachers see their pupils every day and are, therefore, able to spot any changes in behavior that might indicate that a child is suffering from a mental health problem, or experiencing life events that might result in such a problem. Many of the participants pointed out that the teachers at their schools are very adept at this, and felt that it was unlikely that such issues would be missed. However, some expressed concern that there was a possibility that this might happen, and that if it were to happen, the lack of formal processes might be blamed. Several interviewees also stated that pupils identified as having some kind of problem that may be affecting their mental health have a particular member of staff that they can discuss issues in a relatively informal way, while also pointing out that such discussions are documented so that there exists a record of the support a child is receiving.

Two related issues that were highlighted, that perhaps come as a result of schools lacking written mental health policies, were the wide variety of mental health interventions that are offered by schools in the region, and a lack of formal outcome measures for children that have received these interventions. There were a large number of interventions cited by participants in the study, with no one intervention being offered to children at a large number of the schools involved. There were also several different approaches used when assessing the impact of mental health interventions, including informal chats between the children receiving the interventions and the teachers involved in the delivery of the interventions. However, there does seem to be some consensus between participants in this study regarding what a school-based intervention should look like. Several educators stated that they believe that the interventions that have been put into place thus far focus too much on intervention into child and adolescent mental health after the fact, where they would prefer to focus on prevention to avoid children's mental health reaching crisis point in the first place. Several participants also highlighted the need to build the opinions of children into their mental health provision, with several stating that this already made up a significant part of the approach they currently use.

#### *Lack of resources*

The main obstacle to schools offering fit for purpose mental health interventions to their pupils was considered by participants in the study to be due to a lack of the necessary resources. Almost all of the interviewees highlighted the problems they encountered when attempting to refer children and adolescents to specialist mental health services. The vast majority of participants stated that a lack of investment and a lack of personnel in such services have led to their pupils not receiving the help they needed, due to what they considered to be extremely long waiting times and insufficient or inappropriate services. This lack of money and resources is not seen as being exclusive to specialist mental health services. Participants largely felt that the money provided to schools for them to intervene in pupil mental health was insufficient. Several of the interviewees highlighted a lack of funding and resources as the main cause for concern regarding their pupils' mental health. One of the issues that they

considered to come as a result of this lack of funding was that schools do not have enough staff to deal with child and adolescent mental health. Several educators discussed staff leaving their school in recent months and years and not being replaced, thus adding more pressure to a higher workload. The pressure and workload on teachers were also mentioned by several participants, regarding staff mental health. They highlighted the link between staff and pupil mental health, discussing the difficulties in ensuring pupils are mentally healthy if they are unable to ensure that staff is mentally healthy. The final issue that was raised by the interviewees relating to a lack of funding was its impact on schools' ability to properly train teachers in mental health. Some participants pointed out that they had been forced to send a single member of staff to a particular training event, and then have that staff member disseminate what they had learned to the rest of the staff. Others stated that they had simply not participated in certain training due to the costs involved being too high. As one might expect given this information, one theme that was identified was teacher understanding of mental health. Several educators stated that one of the improvements they would like to make to their school's mental health provision was to improve the staff's understanding of child mental health so that all of the staff are all working in the same way, giving their pupils consistency of both approach and expectation.

### 1.2.3 | Discussion

#### *Etiology of child and adolescent mental illness*

The opinions expressed in the current study regarding a link between deprivation and mental ill-health, concur with the extant literature, which has shown a link between deprivation and a wide range of poorer health outcomes, including mental health (Marmot & Bell, 2012). The assertion given by participants regarding the relationship between deprivation and parental issues including relationship breakdowns, drugs, and domestic violence, could potentially be quite a complex issue to "unpack." However, the effect these factors have on child and adolescent mental health is something that has been examined by Hickey and Carr (2002). They looked specifically at these issues and their effect on suicide risk in children and adolescents. Hickey and Carr found that family histories that included previous suicide attempts, depression, drug and alcohol abuse, and experience of assault, all increased childhood risk of suicide. They also found an increased risk of suicide in children whose families are socially isolated, live in stressful, overcrowded conditions, and if their families are not supportive of the child or deny the seriousness of their suicidal intentions. The discussions in the current study around the breakdown of parental relationships have been addressed by Flouri and Buchanan (2003). They found that father involvement in the upbringing of a child from a nonintact family at the age of 7 was a protective factor against psychological maladjustment in adolescence. They also found that father involvement in such families when the adolescent is aged 16 was a protective factor against psychological distress in adult women. These results are of particular interest as they relate to the opinions of the educators here, that the factors affecting girls' and boys' mental health are different, as will be discussed further in the next section. It has also been shown by Koenen et al. (2003), using a twin study, that domestic violence is associated with a lower intelligence quotient in children.

#### *Factors affecting child and adolescent mental health*

The opinion expressed by the educators here, that children and adolescents present with a wide range of mental health problems, is borne out by NHS findings. The assertion that these mental health problems are getting worse also appears to be borne out by previous research, not just in England but across many high-income countries (Achenbach et al., 2003; Bor et al., 2014). However, this trend may be, at least in part, due to improvements in diagnosis (Collishaw, 2015). There also exists some evidence in the literature that mental ill-health tends to take somewhat different forms between girls and boys, as discussed by educators here. A study by Bolognini et al. (1996) showed that girls tend to have lower self-esteem than boys. They showed that the significant differences were around appearance and athletic performance. They also showed that self-esteem has more of an influence on

levels of depression in girls than in boys. However, it is worth noting that a more recent study has shown that gender typicality is a predictor of mental health, particularly among boys, and that this relationship may be mediated by the social repercussions of not being gender typical (Jewell & Brown, 2014). Issues around socialization were another of the factors mentioned by participants in the current study. It has been shown by Chandra and Minkovitz (2006) that girls with mental health issues tend to turn to friends before attempting to access mental health services, whereas boys are more likely to turn to a family member and are less likely to seek out professional help. However, some similarities between the sexes do exist. It has been shown that for both boys and girls, frequent bullying and low social support both contribute significantly and independently to poorer mental health (Rigby, 2000). These findings provide some evidence for the effectiveness of peer support interventions. However, it is worth noting that one SENCO in the current study mentioned that the peer support scheme used in their school has only ever been utilized on one occasion since it was established! This provides support for the findings of Kidger et al. (2009). They highlight the fact that insufficient consideration of children's views can result in a mismatch between the problems targeted by intervention and what young people say about their own lives and needs. They claim that this can have the knock-on effect of pupils sometimes having negative views of the support that exists. They further point out that this can be exacerbated if children do not view an intervention as being confidential, available to all, or sympathetic to their needs. One of the main concerns highlighted by the children in their study was the stigma. They feared being seen or treated differently by their peers. Kidger et al. showed that this fear can potentially create a significant barrier to children using a particular source of support. They point out that findings such as these highlight the importance of ensuring that pupils have a good understanding of what a particular intervention or service provides. They also recommend finding out pupils' opinions of services, to identify areas where provision can be altered to better meet needs. The question then, is whether the best approach would be to attempt to improve pupil attitudes to such interventions or to replace them with interventions that are more likely to be utilized by children and adolescents? One intervention that has been shown to be both favorable to pupils and effective in improving mental health outcomes, which operates through improvements in social and emotional skills, is KidsMatter (Littlefield et al., 2017). This finding provides evidence supporting the opinion expressed by participants in the current study, that social skills and the ability for children and adolescents to express themselves effectively are important factors in their mental health that should not be overlooked by educators.

#### *Dissecting schools' approach to mental health*

The lack of a formal, written mental health policy in schools in the North West of England is a cause for concern that some of the educators interviewed here have identified and were in the process of addressing. The lack of specific guidance for teachers was something that several of the study participants mentioned as a concern, that they felt might have a negative impact. However, there may be some positives that could come from embedding mental health provision into the wider school curriculum and culture, rather than treating it as separate and distinct. It has been stated that schools tend to address mental wellbeing using separate initiatives, alongside mainstream teaching, whereas whole-school reviews of values, policies, and practices are needed (Spratt et al., 2006). The suggestion is that schools should employ the skills and knowledge of specialist mental health workers, to build a whole-school culture for the benefit of all of their pupils. Using a holistic approach to mental health, that is embedded in standard teaching practice, has been shown to improve outcomes for a wide range of age groups (White & Waters, 2015). This holistic approach, with less emphasis on specialization in mental health, also has the potential to assist educators in building relationships with the children they teach, so that they can identify and intervene in their wellbeing, as in this circumstance it is the same people who teach the children and intervene in their mental health. A study into the qualities that children and adolescents consider to be most important in mental health professionals (Farnfield & Kaszap, 1998) showed that the children's responses centered around four major themes. These were general helpful qualities, counseling skills, the adults' ethical stance, and helpful outcomes. This study showed that what matters most to children is that adults possess these qualities and

that the profession of the adult is far less important. As was mentioned by one of the participants in the current study when discussing types of counseling available to her pupils, "It doesn't matter which style you have, as long as you've got a listening ear." Despite the positives that may come from a holistic approach to mental health, the lack of a specific mental health policy has the potential to create several problems in the attempt to intervene in the mental health of school-aged children. Ferial et al. (2011) have argued that best practice involves a whole-school policy approach, involving as many actors as possible. They also recommend that actions are taken that take effect on several levels (e.g., school, classroom, and pupils). They also highlight a need for initial assessment and final evaluation of any policies and practices. To ensure adherence to such practices, explicit written policies regarding child and adolescent mental health in schools are required. Therefore, the finding in the current study, that schools largely use informal processes not only for the identification of potential pupil mental health problems but also for outcome measures, is of some concern. Another point of concern is the fact that there was no consensus between the participants in the current study, regarding which mental health interventions they offered to the pupils at their schools. As stated by one headteacher, when discussing the number of companies offering school-based mental health interventions, "I would go for it if somebody gave me a very strong personal recommendation of a company." It seems clear from the results here that there is not yet a "gold standard" school-based mental health intervention that schools feel comfortable offering to their pupils. The same could be said for outcome measures, given the fact that the participants in this study largely used their own, more informal measures. This agrees with the results found in other investigations into school-based mental health provision. It has been shown that headteachers find it difficult to know what quality of service is being offered unless it is recommended by a respected colleague (NAHT/Place2Be, 2017).

Despite some of the problems described above, results from the current study do suggest that some improvements are being made to school-based mental health provision in the region. Several of the educators interviewed stated that their school had changed its approach to pupil mental health in recent months, with others suggesting a desire to do so in the near future. One of the main changes highlighted in both instances was a change from intervention into specific mental illnesses, to the prevention of mental ill-health. This change in approach is one that should be welcomed, agreeing as it does with previous research, that suggests that school-based mental health identification and prevention programs can promote improvements in both academic and mental health functioning among children and adolescents (Levitt et al., 2007). Another positive to come from the current study is the fact that the educators interviewed here highlighted the importance of putting the needs and opinions of children at the center of their approach to mental health intervention. This has been recommended as an important factor that should be used to inform policy in all areas of child and adolescent mental health (Fattore et al., 2009).

#### *Barriers to intervention in child and adolescent mental health*

Participants in the current study highlighted several barriers and difficulties that they encountered when attempting to intervene in child and adolescent mental health. The main barrier they cited was a lack of resources. This lack of resources was discussed in several different contexts, suggesting that it is pervasive and affects children's lives in a range of different ways. One such way was a lack of services available for referral. Participants complained of excessively long waiting times for children referred to specialist mental health services. This is consistent with the existing literature (Anderson et al., 2017; York et al., 2004). As discussed above, disinvestment in child and adolescent mental health services has been taking place across the UK for several years, leading to lower staffing levels in these services and longer waiting times for service users. Another way in which a lack of resources was said by the participants in the current study to have negatively affected the outcomes of vulnerable children was that it caused a lack of appropriate support for these children, thus leading to poorer outcomes. However, this finding would seem to disagree with those of Garralda (2009), who stated that research on comparable samples of referred and non-referred children has tended to fail to show differences in outcome. This issue is further complicated by the fact that there exist large gaps in the available data, used to monitor vulnerable

children's health outcomes, which makes assessing whether current provisions meet their needs extremely difficult (Evans, 2012).

When discussing lack of resources, the theme that the educators here most often referred to was the lack of money for schools. Their concern was that there was an insufficient budget for teaching, let alone child and adolescent mental health. This is consistent with what might be expected as education budgets have been suffering from similar disinvestment as the specialist mental health services discussed above. Crawford and Keynes (2015) have stated that the Department for Education budget was cut by 7.4%, in real terms, between 2010 and 2016. This lack of money for schools was believed by the participants to manifest itself in several ways. Several interviewees stated that there were not enough staff in their schools to adequately deal with pupils' mental health. Low staff numbers may also contribute to concerns found here, regarding the impact of teacher mental health on their ability to provide for the mental health of pupils. A literature review (Nagel & Brown, 2003) has shown a variety of studies that have found that between one in five and one in three teachers report their job as being either "very" or "extremely stressful." A study into job satisfaction, stress, and coping strategies of teachers in Norway (Skaalvik & Skaalvik, 2015) has shown that, although these teachers reported high job satisfaction, they also suffered from severe stress and even exhaustion. This was found to be the case for teachers across different age ranges and levels of experience. Another finding from this study which is of interest here is that the coping strategies employed by the teachers in the study varied with different age groups. This would seem to be consistent with the findings in the current study that attitudes and approaches to mental health are changing in the education sector.

The final way in which a lack of money for child and adolescent mental health in schools was considered by participants in the current study to have an impact was in teacher training. Participants believed that insufficient budgets meant that teachers were not being trained sufficiently in mental health. Some stated that very little training in mental health took place at their school. It was also mentioned that mental health did not feature in initial teacher training. This is consistent with the literature, which shows that initial teacher training in mental health is varied at best, and often not covered at all (Byrne et al., 2015). In their literature review on the subject of teacher training in mental health in Canada, Whitley et al. (2013) have stated that to recognize mental health problems, teachers need appropriate knowledge, skills, and attitudes. They also stated that teachers should be aware of the steps necessary to both integrate the affected pupils in classroom activities and ensure that they receive the required care. A study into teachers' ability to identify symptoms of mental ill-health (Vieira et al., 2014) showed that they were able to identify the possibility of mental ill-health when pupils displayed both internalizing and externalizing of problems. However, that study showed that teachers struggled to identify pupils who only internalized their problems. It showed that at least half of the teachers involved could be trained to identify hypothetical problem cases and make an appropriate referral, and also that 60% of teachers who could not identify normal adolescent behavior before training learned this skill after training. The importance of training to improve educators' knowledge of, and attitudes to, mental health is something that has been highlighted by Kutcher et al. (2013). They acknowledge the importance of improving educator knowledge and attitudes to allow schools to provide effective mental health promotion and mental ill-health prevention.

## 2 | HAPI SCHOOLS

The lack of a "gold standard" school-based mental health intervention, combined with the reported struggles in identifying appropriate mental health support in the current study, shows that educators require an approach that is readily adopted to assess such interventions. Given the lack of focus on mental health in initial teacher training, such an approach should be easily understood by staff who do not have a detailed understanding of mental illnesses. Previous research has suggested that a heuristic approach to evaluation meets these criteria when applied to digital health interventions (Madan & Dubey, 2012). It is proposed here that adapting such a heuristic approach to the school setting will give educators a simple tool that can be used to assess the suitability of any mental health intervention that is

offered to their schools by outside agencies. This tool, HAPI Schools, follows a simple, four-point protocol, adapted from Baumel and Muench (2016). Each point is illustrated here with example questions that might be asked when assessing whether to employ a particular intervention for student mental health.

(a) *The intervention should be easy to use in the school setting.*

Is it easy to use the components of the intervention and the intervention as a whole? Can the intervention be used during the normal school day with minimal disruption?

(b) *The intervention design should respond to teacher, student, and carer needs.*

Can the intervention be personalized (Pluess et al., 2017)? Have individual differences been accounted for in the design of the intervention (e.g., time constraints, learning style)?

(c) *The intervention should make it easy to engage in activities by providing necessary tools.*

Do the tools promote the proposed activities? Are those tools easily accessed at home and in school?

(d) *The intervention should provide a feasible and measurable pathway to growth.*

Do the features provided seem to reasonably support the aims of the school, the students, and their carers? Does the intervention involve monitoring of outcomes, that can be easily assessed by school staff? Are the features integrated in a way that helps students to understand their current state and how to use each feature of the intervention?

The HAPI Schools tool takes into account the five principles of usability typically used in computer system design (Nielsen, 1993), adapting them to mental health interventions in a school setting. The five principles in this setting are:

(a) It should be easy for staff and students to learn how to use the intervention.

(b) The intervention should be time and resource-efficient.

(c) Features of the intervention should be memorable.

(d) Errors in use should be easily identified.

(e) The intervention should ultimately satisfy the needs of both students and teachers.

Of note is the fact that this heuristic approach can be used not only to assess interventions into student mental health but also that of staff.

### 3 | CONCLUSION

The HAPI Schools tool offers the opportunity to overcome some of the issues raised in the discussions with school staff regarding their struggles when assessing the usefulness of psychological interventions for their students. The HAPI Schools tool can be used by headteachers, SENCOs, and pastoral leads when attempting to decide which interventions might be best delivered to the students they work with. The HAPI Schools tool is easily used by a single individual or in group decision-making scenarios involving multiple stakeholders.

#### ACKNOWLEDGMENTS

The authors are grateful to MedEquip4Kids for their role in setting up and helping deliver the Hummingbird Project. We thank especially Ghazala Baig, Ghalib Hussain, and Catherine North, along with the charities that supported the project.

#### CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

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**How to cite this article:** Platt, I. A., Kannagara, C., Carson, J., & Tytherleigh, M. (2021). Heuristic assessment of psychological interventions in schools (HAPI Schools). *Psychol Schs*, 58, 1399–1415. <https://doi.org/10.1002/pits.22527>