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Teachers' attitudes towards child mental health services

AIMS AND METHOD

To improve liaison between local schools and child and adolescent mental health services (CAMHS) by exploring teachers' experiences and perceptions of CAMHS. Semi-structured interviews were carried out with 25 volunteer primary school teachers.

RESULTS

Teachers reported exhausting education-based resources before seeking external advice. Most had positive experiences of child mental health services and were keen to be more involved. They favoured a service that provided rapid advice and ongoing support. Many complained about problems in communication.

CLINICAL IMPLICATIONS

Child psychiatrists should collaborate more effectively with teachers to promote mental health and manage children with behavioural and psychological problems.

Parental histories may be distorted by ongoing family stress or psychopathology. Teachers change from year to year, so their opinions are less systematically biased and are moderately stable over time (Verhulst & van de Ende, 1991). They predict poor outcomes, particularly in girls (Verhulst *et al*, 1994), with externalising disorders (Verhulst & van de Ende, 1991, Verhulst *et al*, 1994) and social problems, as accurately as parents (Verhulst *et al*, 1994).

As a significant influence on children's socio-emotional development (Maughan, 1994), schools are a logical point of intervention for child mental health professionals (Hendron *et al*, 1994). Even with increased resources, child and adolescent mental health services (CAMHS) alone are unlikely to be able to meet the needs of children with behavioural and psychological problems, leaving schools an important role in mental health promotion (Mental Health Foundation, 1999).

Developed from a project examining the impact of culture on parental attitudes towards children's mental health (Nikapota *et al*, 1998), this study aimed to improve our understanding of teachers' experience of CAMHS in order to improve collaboration. A third of our referrals were from schools, making us aware that local teachers felt increasingly overwhelmed by behavioural problems.

The study

A semi-structured interview devised for the parent study (Nikapota *et al*, 1998) was adapted for teachers. As the parent study involved 9- to 11-year-olds, we interviewed teachers involved with this age group.

The interview covered the following areas:

(a) desirable and undesirable attributes and how they can be fostered or discouraged;
(b) how they would identify and deal with a child with behavioural disorders;
(c) sources of advice, their experience of such services, and the types of problems they would refer.

We used open questions with prompts to ensure that all three areas were discussed, but (b) and (c) were also explored with vignettes chosen to illustrate common behaviours (see appendix 1).

Of 28 primary schools in the local education authority (LEA), 13 agreed to participate. Owing to cancellations (2) and time constraints (5), only 25/32 volunteers from 11 schools were interviewed. Head-teachers who gave a reason for declining to participate thought their staff were too overworked.

The 'framework model' of quantitative data analysis (Ritchie & Spencer, 1994) uses intensive study of transcripts to define emerging themes and form a framework that is applied systematically to the raw data. This method was used to develop a coding manual for the parent survey (Nikapota *et al*, 1998) that we used to classify the teachers' responses. An independent rater reviewed five transcripts, with complete agreement on 60% of the responses.

Findings

Demographic data

The teachers were between 22 and 61 years old (mean age 39.4), and most were female (72%), Caucasian (68%) and married/cohabiting (72%). The period for which they had taught at their current school ranged from one term to 31 years (median 4 years) (see Table 1).

Attitudes towards children's emotions and behaviour

Social behaviour towards peers was the most cited area of functioning: 21/25 teachers mentioned aggression, 13/25 mixing with others and 11/25 caring/being helpful. This contrasts with the study on parents' attitudes (Nikapota *et al*, 1998). Parents focused on social behaviour towards adults (214/220 discussed trust, no teachers mentioned it) and academic failure (216/220 parents cf. 2/25 teachers).

Teachers saw themselves as role models and used a combination of rewards and punishment within clearly defined rules to manage children's behaviour. Supervision (11/25 cf. none of the parents in the previous study) was considered more important in promoting good behaviour, while attending out-of-school clubs had a greater role in preventing naughtiness (16/25). They considered their

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Table 1. Comparison of the ethnic background of teachers who participated in the survey compared to the school population in the same borough at that time

Ethnic Group	Teachers (%)	School population (%)[1]
Caucasian	68	47
African–Caribbean	12	33
Asian	4	8
Dual heritage	16	13

1. Figures from local education authority records, 1997.

own upbringing (23/25) and teaching experience (20/25) as important influences on their attitudes towards children, whereas few mentioned their training (12/25) or the social environment in which they worked (4/25) (see Table 2).

The most common barrier to managing children with behavioural disorders was problematic relationships with parents: 17/25 reported lack of support from parents and 11/25 poor parenting.

Attitudes towards child and adolescent mental health services

Of 20 teachers who had experience of CAMHS, four thought CAMHS had not helped. There were spontaneous complaints about slow response (9/25) and poor communication (13/25). One teacher described an occasion where both she and a mental health worker had suggested that a child record his feelings in a book, resulting in the child and family feeling unsure what should be written in each book.

Response to the vignettes

Most teachers thought children required help, but not necessarily from professionals. If external agencies were suggested, teachers varied their recommendations with the behaviour displayed, for instance, the child running away prompted referrals to social services (10), whereas bed-wetting was seen as the parents' (19) or the general practitioners' (15) responsibility. The most common response involved discussions with the child and their parents, but class discussions were used to deal with general issues such as bullying and fighting (see Table 3).

Discussion

This study aims to stimulate debate. We obtained the views of primary school teachers working in a particular inner-city area at a particular time. Our findings have uncovered issues that we were unaware of, such that further modification to the interview and coding manual would more accurately tap teachers' concerns. Less than half the primary schools in the LEA participated and the teachers were volunteers, so their attitudes may not be representative. However, their responses are surprisingly consistent and raise some important general issues.

A study asking parents, teachers and children to rank pro- and antisocial behaviours found no significant differences between teachers and parents (Warden *et al*, 1996). In our study, divergent attitudes may have stemmed from cultural differences. In our sample 68% were White, but in this LEA Caucasians represent 47% of the school population. Whatever their origin, this difference in attitude may complicate relationships between parents and teachers (and other professionals) who need to remain sensitive. Few teachers' attitudes were influenced by training or socio-demographic factors, although their comments suggested that teaching in these areas would be welcomed.

A similar survey of secondary schools found that 39% of teachers were aware of CAMHS (Kurtz *et al*, 1995). We found a much higher (80%) level of awareness, which may relate to recent organisational changes in LEA services that had left teachers feeling unsupported, or to

Table 2. Teachers' responses to the open questions

Question	Coding category	Number of teachers
Response to a child with behavioural disorders	Discuss with parents	22
	Discuss with colleagues	22
	Contact general practitioner	1
	Contact social services	1
	Contact child and adolescent mental health services	16
Sources of advice/help	Senior staff	12
	Educational psychologist	11
	Educational welfare	4
	Behavioural support units	8
	Child and adolescent mental health services	20
	Social services	13
Reasons to refer	Persistence	16
	Severity	16
	Unusual problem	15
	Lack knowledge	12
	Adverse impact on child	9
	Adverse impact on class	2
	Child is suffering	7

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Table 3. Teachers' responses to the vignettes

Vignette	Why is the child . . .		Needs help?	What should be done?		Who should act?	
Fighting	Child's low self-esteem	20	Yes 25 No 0 ? 0	D/W child	24	Parent	21
	Violence at home	13		D/W parents	24	Teacher	25
	Bullied at home	13		Class discussion	9	Education services	3
				D/W colleagues	4	GP/school medical service	0
				External advice	6	Social services	0
						CAMHS	1
Withdrawn	Bullied by peers	5	Yes 17 No 1 ? 5	D/W child	15	Parent	20
	Isolated at home	11		D/W parents	17	Teacher	24
	Loner	12		D/W colleagues	3	Education services	1
	Low self-esteem	13		Involve peers in integration	14	GP/school medical services	1
	Medical problem	5		Class discussion	7	Social services	0
				External advice	5	CAMHS	1
Bed-wetting	Child distressed by moves	22	Yes 21 No 1 ? 1	D/W parents	15	Parent	19
	Other anxiety	15		Advise parents to seek medical advice	17	Teacher	6
	Physical problem	17		D/W colleagues	3	Education services	0
				D/W child	3	GP/school medical service	15
						Social services	1
						CAMHS	1
Stealing	Buy friends	23	Yes 21 No 0 ? 2	D/W child	19	Parent	23
	Too little pocket money	10		D/W parents	18	Teacher	23
	Coerced to steal	10		D/W colleagues	1	Education services	0
	Deviant peers	4		Class discussion	6	GP/school medical service	11
	Poor parenting	6		External advice	6	Social services	1
	Hunger	4				CAMHS	2
Stomach aches	Bullied	23	Yes 25 No 0 ? 0	D/W child	17	Parent	23
	Struggling with work	18		D/W parents	20	Teacher	23
	Issues at home	16		D/W colleagues	3	Education services	1
	Physical problem	18		D/W peers	3	GP/school medical services	11
				External advice	3	Social services	1
						CAMHS	3
At risk behaviour	Unhappy at home	24	Yes 25 No 0 ? 0	D/W child	11	Parent	15
	Deviant peers	16		D/W parents	12	Teacher	15
	Delinquent	5		D/W colleagues	5	Education services	1
	Poor parenting	12		D/W peers	3	GP/school medical service	0
				External advice	8	Social services	10
						CAMHS	3

D/W=discuss with; ?=don't know; GP=general practitioner; CAMHS=Child and adolescent mental health services.

Education services includes educational psychology, education welfare and behavioural support units. The teachers were asked open questions and were allowed several responses so that the answers to each section may have a total greater than 25.

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the (unusual) lack of a waiting list for our service. The relation of service structure to awareness of, and referrals to, CAMHS could be investigated by studying other LEAs.

Teachers' attitudes towards CAMHS are salutary. Even those with positive experiences complained of slow responses and poor communication. Our findings suggest that despite high levels of awareness of CAMHS, teachers contained the majority of problems within the school, referring only children with persistent and severe difficulties. A survey of secondary and nursery schools also found that teachers utilise education-based services before referring to CAMHS (Kurtz *et al*, 1995). Frustration at services that are slow to respond and fail to communicate is understandable.

As children spend a large proportion of their time at school, teachers could be involved in mental health promotion and reinforcing treatment strategies, in addition to being informants. Many children with behavioural disorders never reach mental health specialists (Offord *et al*, 1987), and recent studies suggest that many are managed in non-psychiatric settings, especially education services (Burns *et al*, 1995; Leaf *et al*, 1996; Gwendolyn *et al*, 1997). Although many clinicians routinely contact schools, issues of confidentiality arise if teachers become more actively involved, and the profession needs to consider how to balance this conflict. Resources are being wasted, as is suggested by the example mentioned above of professionals using the same strategy but undermining its effectiveness by acting in parallel. At a more severe level, Oliver's (1988) paper on successive generations of child maltreatment identifies poor collaboration as a major stumbling block to child protection, with fragments of information held by different agencies contributing to the failure to prevent some children from abuse.

The White Paper, *Excellence in Schools*, emphasised the need for 'behavioural support' (for a summary see Department Education and Employment, 1997). The NHS Health Advisory Service report, *Together We Stand* (1995), recommends a tiered approach to CAMHS. The service should support primary care workers, social services, independent clinicians and schools in the management of the majority of children with behavioural disorders, and see only those with severe disorders. The World Health Organization (Hendren *et al*, 1989) proposed a similar model for schools; mental health promotion could be integrated into the school curriculum, secondary prevention would target pupils at high risk while children with psychiatric disorders would be referred to CAMHS.

Comment

These teachers seem to be asking for a service that provides rapid advice and communicates with them. They will be the only professional involved with many children with psychiatric disorders and were keen to be involved in the management of their pupils' disorders. We recommend that child mental health professionals debate how to promote collaboration between mental health and education services.

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Appendix

The vignettes from the structured interview

For each vignette teachers were asked:

(a) What might be causing the behaviour?
(b) Did the child need help and if so why?

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(c) How would you deal with the problem?
(d) Who would you involve?

Vignette 1
A nine-year-old girl fights a great deal in school. She is tough and does not allow anyone to bully her or to make any remark to her.

Vignette 2
A nine-year-old boy has always got a smile on his face. He doesn't play or mix with other children and he doesn't do his work as well as he could.

Vignette 3
A nine-year-old girl is still wetting the bed. Her father's job has led to the family moving house five times.

Vignette 4
The parents of a ten-year-old boy complain that he is regularly stealing money from them. It appears to be spent on sweets for him and other children.

Vignette 5
A nine-year-old boy who is good at home and at school has stomach aches every morning and starts missing a lot of school.

Vignette 6
A ten-year-old girl has run away from home on four occasions. Six months ago her parents discovered that she started smoking.

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