Elements to promote a successful relationship between stakeholders interested in mental health promotion in schools

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ABSTRACT

Objective
An evaluation of a mental health promotion program called iCARE which depended on collaboration between multiple partners.

Design
A qualitative exploratory evaluation that involved purposeful sampling of a range of stakeholders in the School settings.

Setting
Two Secondary Schools in Tasmania.

Intervention
iCARE stands for Creating Awareness, Resilience and Enhanced Mental Health and is a structured six-week program in which trained facilitators engage Year 8 students in learning about mental health and developing resilience. The collaboration involved university researchers, child and youth mental health clinicians, and education staff. It required investment in time and resources as well as intellectual effort and good will from each of the key players.

Results
Successful elements of collaboration were distilled from the interview data, indicating that for a mental health promotion program to succeed in schools, highly tuned negotiation and communication skills are required.

Conclusion
Nurses are increasingly working within the community to promote the health and wellbeing of many groups. To work effectively with young people in schools, and to share the impact of that work with the professional community, requires collaboration between health, education and university stakeholders. This evaluation found that success in this interdisciplinary connection requires respect, communication, negotiation and appreciation for disciplinary differences.

INTRODUCTION

Mental health is the leading health issue facing young people world-wide and it is a whole of community concern, an issue that crosses and even transcends disciplines and professions (Robinson et al 2016). The last two decades has seen a call to increase collaboration with a broad network of stakeholders involved in youth mental health including parents, schools and health services (Hoagwood et al 2010). Schools can only do so much to support health and wellbeing on their own, as their core business is education, and recent reports identify significant school-based workforce shortages as impacting on the ability to intervene early in youth mental health (Carbone et al 2011).

A mental health promotion program designed for delivery by health professionals within the Australian school context has been developed to respond to these concerns. 'iCARE' is a universal mental health promotion program that takes a solutions focus (McAllister 2013) and aims to build resilience strategies (Morrison and Allen 2007) in all young people. Its generation, development and feasibility is described at length elsewhere (McAllister et al 2008). Whilst there are other Australian mental health programs that take a whole of classroom approach (such as Mind Matters), some of the unique features of iCARE are that it:

- involves trained facilitators who run the groups in the class, rather than the classroom teachers;
- is a structured brief program consisting of six modules that trigger group discussion to enable young people to explore and develop the strengths and achievements of other young people, and themselves, so the repertoire of strategies will give them strength in challenging times that may be ahead in this turbulent life stage can be expanded; and
- it draws on material that are likely to be appealing but also challenging for young people – such as real-life stories, film clips, contemporary music, poetry, and discussion-based games.

Each of these resources is used in such a way that they reveal strengths and resources of someone else, but which can be discussed, developed, revised and perhaps taken up and used by participants in their future lives. In this way, iCARE is future-focused, strengths building and proactively develops mental health capabilities useful in life.

A central assumption of iCARE, which comes from the solutions focus, is that strengths and vulnerabilities are both likely to occur in all young people as they face the changes of adolescence (McAllister 2013). These strengths and vulnerabilities can be engagingly discussed by using narratives found in books and films, rather than in peoples' personal lives. This strategy is designed to create a safe environment - the group an opportunity to be analytical about what could work or not work in young peoples' lives, without slipping into personal difficulties, and issues that could be upsetting (Tsevat et al 2015). The idea, based in the solutions orientation, is that positive aspects are foregrounded, and deficiencies or challenges are discussed but not indulged (Sharry 2007).

Another key distinguishing component in the approach is that while the mental health clinicians trained in the solutions focus implement the program for an hour each week over six weeks with 13-14 year old students, they do so in a way that co-opts the support and involvement of teaching staff. In this way, solution focused communication approaches can be modelled by the facilitator, developed by teachers and shared. To relate effectively facilitators and teachers need to appreciate their distinct skills and that both sets of expertise will be needed to help this program work effectively within a large classroom. Further, having trained mental health professionals facilitate the program ensures the availability of support and referral should it be required if sensitive topics are raised by students, and assures the school that safety will be maintained and risks minimised.

Participating teachers bring a formal authority to the classroom, knowledge of behaviour management, and a personal knowledge of the strengths and limitations of individual students. iCARE facilitators and teachers work together to manage the tension between the strength based model of iCARE and the at times formal authoritative style of engagement embedded in school culture (Pounder 1998).

Hoagwood et al (2010, p16) have stated there is "still relatively little guidance available to researchers interested in increasing the level of collaboration within their research studies." Consequently, we aimed to examine the components of early collaboration that have proven to be facilitators and barriers to the development of iCARE and efforts to evaluate its efficacy in order to contribute to research methods that strengthen and promote interdisciplinary collaboration.

LITERATURE REVIEW

Collaboration is a term that is often used interchangeably with team work (Garrett 2005). It is a practice that can tend to be over-simplified and taken-for-granted. Whilst collaboration could simply be viewed as a mutually beneficial relationship (Mattessich et al 2001) others see collaboration as more dynamic, a journey without a clear destination where methods and styles evolve, based on cumulative and unfolding discoveries (Hoagwood et al 2010; Haythornthwaite 2006; Denis and Lomas 2003). Establishment of shared goals is seen to be important, and Kagan (1991) and others (Denis and Lomas 2003; Wood and Gray 1991) emphasise the centrality of sharing of power, resources and authority.

The benefits of collaborations are well documented. These include the facilitation of knowledge transfer, enhanced creativity, and access to broader networks (Carey et al 2009; Wiggins 2008; Loan-Clarke and Preston 2000). However, collaboration within and between institutions is difficult and challenging (Carey et al 2009; Wiggins 2008). Fullan (1993) also speaks of collaboration as hard work and operating in the world of ideas where existing practices are examined critically and where better alternatives are sought. Robinson (2005) addresses in detail a number of challenges related to what he refers to as the Five P's – people; professional cultures; policies; politics and practicalities. Carey et al (2009) speaks of collaboration being hindered by institutional politics, echoing Robinson (2005) and further identifies historical relations, perception of competition and other tensions including finance, resources and maintaining momentum as potential hindrances.

The Need for Collaborative Research in Youth Mental Health

Alberto and Herth (2009) describe a collaborative imperative within health care and that the art of collaborating is generally seen as a central component of successful professional activity. In relation to collaboration with schools, as far back as the mid 1990's it was recognised that strong partnerships were critical to ensuring that effective prevention and early intervention strategies were well received and to ensuring their ongoing sustainability (Galbraith et al 1996). This recognition is strongly reflected in major collaborative school-based research reports including KidsMatter (Slee et al 2009), CASEL (Payton et al 2008), PATHS (Kusche and Greenberg 1994; Greenberg and Kusche;1998, 1997, 1993) and SEAL (Humphrey et al 2010) that have as their focus the social and emotional well-being of students.

However, Mastro and Jalloh (2005) refer to a perception of resistance between schools and the communities within which they exist, going so far as to say that *"schools alone cannot meet all needs – social emotional, physical and academic, yet they stand as gatekeepers for access to youth..."* (p1). Despite this perception, there is also growing evidence that successful collaboration between school and community groups has resulted in improved academic and social/emotional outcomes for youth (Slee et al 2009; Mastro and Jalloh 2005).

Why programs for adolescents benefit from a collaborative approach

The mental health and wellbeing of young people is at the forefront of mental health policy in Australia and evidence is growing for the value of collaborative and integrated service systems to address the needs of young people, especially those aged 12 to 25 years (Rickwood et al 2011). Adolescence is a challenging life transition characterised by physical, psychological and social change that can impact on health and well-being. Mental health is fundamental to good health and to life enjoyment and a resource for life (Sturgeon 2007).

During this time, young people need to be introduced to the concept of positive mental health – so they appreciate that paying attention to existing and potential strengths can be an asset to them in taking on challenges optimistically and enthusiastically (Barry 2013). This is a much larger vision than simply illness prevention, though this is important.

In adopting a population-based mental health promotion approach, every young person and not just at-risk youth, become the focus for enhancing strengths and social competencies. Programs which target young people and provide a solid foundation of resilience offer the best hope of improving their mental health (Weare and Nind 2011). In line with this, there is now a worldwide movement to take a solution-focused, rather than problem-focused, approach to enacting changes in individuals and groups; an approach that has produced exceptional results in many disciplines (McAllister et al 2008; Mahlberg and Sjoblom 2005).

In an initial feasibility study, interviews with twelve school nurses determined both the need for the iCARE program and support among mental health staff for its implementation (McAllister et al 2010). Pilot data also suggest positive outcomes for youth who complete the program, including improved knowledge regarding self-harm, improved problem solving skills and a general enjoyment of the solution-focused approach inherent in the program (McAllister et al 2010). However, barriers to implementation, including securing support of school leaders, were also of concern to those likely to adopt the program (McAllister et al 2010). De Leo and Heller (2004) reported a reluctance to allow *any* material related to suicidal behaviours to be given to students. Yet as Barry (2013) states, the most appropriate location for these mental health promotion programs to take place is in the contexts and settings where young people live their lives. To overcome this key barrier requires trust from school staff that health professionals will be careful, safe and productive. This is only achieved with ongoing collaboration that fosters familiarity, trust and mutual respect (Weare and Nind 2011).

Collaboration in action: the iCARE program

In Tasmania, Australia, early collaborative processes involved re-partnership in 2011, with a large all girls public school. The iCARE program was delivered across six weeks to a Year 9 class (23 students) with the purpose of examining the program's relevance and validity in a whole of classroom setting. The school had previously been involved in 2010, in a small (eight students) group pilot research project involving iCARE and thus the beginnings of a foundation for a trusting relationship existed. Qualitative evaluative data was obtained from the students both pre- and post the 2011 program and the school Principal and iCARE teacher were interviewed at program completion. In 2014, a further pilot across two Year 9 classes (22-25 students) was implemented at the same all girls school and across two Year 9 classes at a private coeducational high school, a total of 90 students. Qualitative evaluative data was again obtained from the students both pre- and post the pilot program and the four iCARE teachers were interviewed at program completion.

Remaining open and inviting of all perspectives, whilst ensuring that clear leadership exists to maintain integrity of purpose, has enabled the current effort to realise what Pounder (1998) suggests is a strong foundation for effective collaboration. Shared reflections from stakeholders illuminates aspects about this collaborative experience.

THE STUDY

A qualitative exploratory study was designed to answer the following research question: *How did key school stakeholders perceive the process of being involved in the iCARE Research Project?* Ethical clearance for all project pilots was obtained by the Tasmanian Human Research Ethics Committee and Education Department as well as the relevant University ethics committees.

METHOD

In 2011 and 2014 two researchers interviewed the school principal and a teacher involved in delivering iCARE to elicit views on how the program was perceived by school leaders. They used an inductive approach to questions, but beginning broadly and then following up with focused questions (Braun and Clarke 2006). The principal and teacher were asked to comment on why the school supported the introduction of iCARE, to provide suggestions for improvement and what more could be done to facilitate student well-being. The teacher was also asked to provide observations on iCARE, including observed changes and engagement among students and relevance of the program.

Researchers took field notes through the course of the interviews, which lasted approximately one hour for each interviewee. This attempt to co-construct knowledge fits with the participatory paradigm (Hoagwood et al 2010).

Data analysis

Data from the 2011 and 2014 interviews were subjected to realist thematic analysis following the guidelines of Braun and Clarke (2006). That is, the analysis focused on experiences, meanings and the reality of participants. Initial themes were developed from the interview notes, and notes re-read to verify, merge or re-code the identified themes. The six phases of analysis described by Braun and Clarke (2006) were used to identify themes from the interview data – familiarising yourself with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing findings.

FINDINGS

Three broad themes were identified from the interviews: 1) meeting school priorities, 2) balancing need and resources, and 3) the importance of involving school staff. The following is an account of each theme combined with a brief engagement with the literature, post analysis.

Meeting school priorities

Both the school principals and the teachers commented that iCARE fit well within the school curriculum, and the strategic priorities of both the school and the broader education sector. They viewed social and emotional learning as being part of the development of young people, and argued it should be inherent in the school curriculum. These responses are encouraging given that when school administrators view schools as part of, and not separate from a larger community, the successful partnerships are likely to follow (Mastro and Jalloh 2005).

> *Projects like iCARE line up with our business of educating girls. Becoming involved in iCARE fits with my social consciousness, with the social consciousness of the school and the school curriculum does not really deal with emotional/social issues in an in-depth manner. (Mary, Principal, 2011)*

> *Programs such as iCARE would be essential in providing schools with the necessary skills to become more strengths based especially in a whole-of-school approach. (Peter, Teacher, 2011)*

In these ways, stakeholders indicated confidence in the iCARE program. Collaboration as a construct is

multifaceted and a very context-bound concept (Hoagwood et al 2010). It was vital in the early stages of the partnership with the School to align the iCARE Program with the school curriculum. In early meetings with the Principal and Health and Wellbeing coordinator the strength-based and solution focused approaches as a key feature of iCARE were emphasised. The early meetings with the program facilitators, one of whom was also lead iCARE researcher in Tasmania, were also characterised by a desire to move the conversations from being problem driven to being vision driven (National Network for Collaboration in Alberto and Herth 2009).

Early collaborative efforts with school staff were occurring within a context of existing embedded practices and it is important to acknowledge right from the start the negotiation of and co-evolution of practices. Haythornthwaite (2006) identifies one of the challenges to interdisciplinary collaborative work, in this instance, between mental health professionals and high school teachers, as “bridging practices”. It was beneficial to be clear about how iCARE would align itself with the existing school culture which has been described as the atmosphere or climate of the school but is also about a set of norms and values which provide a focus for everyone about what is important (Jerald 2006). The schools already valued the importance of empowering the young girls in the school and developing resilience and coping.

iCARE, like other programs could have influence or be obstructed by the hidden curriculum. The hidden curriculum, that which teaches but remains implicit within the school culture, is shaped by social forces to satisfy hidden agendas including serving the needs of society (Wren 1999). Youth mental health and a concern of schools about youth self- injury and suicide is, one could assert a major driving force for including or excluding learning experiences that address such issues (Green 2007). In promoting the iCARE Program it was necessary to acknowledge this context and be prepared to discuss how this aspect of the program would be supported.

Balancing need and resources

The principals and teachers of both schools were clear that there was a need for a program such as iCARE and expressed the view that geerally there is a lack of resources to effectively incorporate social and emotional learning programs into schools.

> *There is a huge need for inquiry-based approaches and iCARE and programs like it would help to meet that need. (Mary, Principal, 2011)*
>
> *Our expertise is around the pedagogy of teaching… so the content [emotional/psychological strategies], go to the experts. (James, Acting Principal, 2014)*
>
> *There is a need for a mental health infrastructure in schools. Where programs such as iCARE raise awareness around stress, coping etc there is a parallel need for support. Schools are under-resourced as far as emotional/psychological supports. (Mary, Principal, 2011)*

In line with this, the involvement of trained mental health professionals to deliver the program was viewed not only as a way to minimise burden on schools, but as indicative of a true collaboration between schools and mental health professionals.

> *The professional learning program needs to develop between the school and mental health professionals and other key stakeholders…[there is a] crucial necessity of collaborative partnerships between mental health professionals and teachers. (Mary, Principal, 2011)*
>
> *I’d probably re think about maybe getting more involved in some of the presenting itself…how that could then be where it’s a combined, collaborative thing. And I’m not just the supervising teacher… but because it is so – like, it’s quite confronting, some of the [iCARE] issues, it definitely I think needs to be a collaboration. (James, Acting Principal, 2014)*

Prior to iCARE commencing in the classroom, the facilitators initiated conversations about perceived and real needs and resources with the Principal and Health and Wellbeing coordinators. This required sensitive negotiation and goal clarification. The development of shared goals that are acceptable to both researchers and key stakeholders is necessary for productive collaborative effort and further, requires a melding of perspectives and priorities (Hoagwood et al 2010). The iCARE facilitators as researchers needed to work together with the school staff to implement a program that would deliver desired school curriculum outcomes, work with existing school resources and keep students safe and contained in the process.

Several features of schools identified by Pounder (1998) needed to be considered in organising for collaborative negotiation and the fit of iCARE. For example, schools are often characterised by stimulus-overload. In the day-to-day life of schools, teachers and principals are subject to numerous short multiple interactions with many individuals. Time is scarce. iCARE facilitators needed to demonstrate an appreciation of and respect for the tight schedules for both teachers and students. Teachers from both schools spoke on the difficulty with fitting the program into the curriculum and the possibility of having a shorter or more integrated program.

> *...for our school to invest in a six, eight-week program is a huge investment out of their time. (James, Acting principal, 2014)*

> *So while we couldn't run a six week block again because of other elements that are involved in the curriculum, we could look at ...some elements of the iCARE program that we could perhaps integrate into our teaching .... (Henry, Teacher, 2014)*

Interprofessional negotiations were characterised by mutual respect and with the intent to share knowledge, power and decision-making. Power can be shared in unique ways (Hoagwood et al 2010). The resources and needs that were the focus of discussions and described by some as challenges to successful collaboration (Mastro and Jalloh 2005) were space, time, scheduling, staffing roles, school rituals and more tangible resources such as art and craft materials required by the iCARE Program. Issues such as partnership capability, limits, expectations in relation to needs and resources often require ongoing discussion and exploration to develop and maintain collaborative partnerships (Burley 2003).

Involving school staff

The involvement of school staff in the delivery of iCARE was seen as a strength of the program. Not only did this provide an opportunity for up-skilling school staff, but involving staff familiar with school routines, and with individual students, allowed for a more structured environment in which to deliver iCARE. The authority provided by the teacher ensured the facilitators were respected and able to deliver the program with minimal disruption.

Through the interviews it became evident that the success of school-based programs depends on good communication with school leaders. The first contact with the school was with the school Principal. Chapman et al (2005, p9-10) notes that *'...the attitudes and skills of head teachers are clearly crucial, particularly in terms of both promoting and resourcing collaboration [which] ...has to be led, facilitated and supported over time ."* The leadership provided by the Principal and the teacher coordinator of health and well-being was crucial to the initial collaborative success of the iCARE project in Tasmania.

> *[It is] essential to have the Principal and Vice Principal involved. They must be cognizant of the knowledge and skills that teachers are exposed to and this must be seen to be valued by the school culture as a whole. (Mary, Principal, 2011)*

A teacher noted that his involvement with iCARE really helped him to better understand the whole notion of being strength-based.

At the beginning of the program I had a lot to sort out in my head regarding this. But iCARE opened up the scope of what I thought- skeleton keys; coping strategies. You can actually give kids the tools, not just stock answers! (Peter, Teacher, 2011)

Teachers and facilitators believed there was benefit in clarifying the roles of each other at the earliest opportunity because it can prevent problems occurring later.

The following quote is illustrative of a teacher reflecting on his role in the classroom-based iCARE program.

A couple of times I got frustrated with the students cause I didn't think they were ...doing as they should all the time, so sometimes I was unsure if I should go in and say something and really do my teacher bit, which is what I'd normally do if I was by myself, but then I didn't want to tread on your toes also. (James, Teacher, 2014)

The process of working with a school teacher in the classroom was not without its challenges. The distinctiveness that each discipline brings to the collaboration is reported as the single most commonly identified barrier to effective multidisciplinary work (Robinson 2005). The different professional cultures of for example, teaching and health care work, can bring unique approaches to language and time-management, overall orientation and expectations and standards (Robinson 2005). Table 1 provides a summary of the key enabling factors for good collaboration that are addressed in the three overarching themes previously described.

Table 1: Key facilitating factors of good school-based collaboration and program success

1.	An understanding by program facilitators of the unique needs and processes of the school, especially an appreciation of school scheduling
2.	Early confident, informed communication with leaders, especially the School Principal(s)
3.	Support for a program that was perceived to have a good curriculum fit, especially with the health and well-being aspect of the curriculum
4.	Program facilitators acknowledging and respecting the expertise of the teachers
5.	Teachers valuing the iCARE facilitator's skills in tackling and reframing confronting topics such as self-harm
6.	Power sharing and team work between teachers and iCARE facilitators who draw on their different yet complimentary roles and skills in delivering the program to achieve youth mental health promotion
7.	Early clarification of teacher and facilitator roles to prevent problems arising from any aspect of program delivery

Other authors have commented similarly on the key importance of these themes (Humphrey et al 2010; Slee et al 2009; Durlak and Dupre 2008; Greenberg et al 2005). In particular, program sustainability is dependant on the school's commitment to the program, and the key teachers' energy to drive the program forward.

Early Engagement with School: Trust and Respect

In addition to these identified themes from school staff interviews and subsequent analysis, the iCARE facilitators became increasingly conscious of the centrality of trust and respect in the early engagement with the school and indeed in maintaining and sustaining that trust and respect over the years. Our team has maintained contact with people within the schools and this has maintained trust and also openness to future research.

These recommendations for establishing trust and respect in the early stages of collaborative engagement with Principal and lead teachers have been discerned from this evaluation and are strongly supported by the literature (Hoagwood et al 2010; Carey et al 2009; Wiggins 2008; Robinson 2005; Denis and Lomas 2003).

CONCLUSION

Research and systematic improvements in a multidisciplinary issue such as mental health promotion requires collaboration. For it to be effective, collaboration requires ongoing commitment to the process. This paper has

explained the successful processes we identified in a collaborative research project involving teachers, child and youth mental health practitioners and academic researchers. Elaborating on the active elements may be useful in working out how to sustain engagement and enhance the sustainability of the working relationship between these three groups. Because these three groups have varied skill sets, training, and perspectives on youth learning and wellbeing, ongoing collaboration may also herald the development of new models to approach challenges and implement programs for youth mental health.

Sustainable collaboration depends on the establishment of ongoing, meaningful partnerships. How these partnerships are commenced is crucial. Further, collaborative research once begun, needs to be nurtured, sustained, and evaluated over time. Not only are collaborative research efforts labour intensive for all stakeholders but they require a level of communication and sharing of power and the development of relevant and effective youth based services.

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