Hospital and home teachers' views about teaching students who have medically defined mental health needs.

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Introduction
Rising numbers of students with medically defined mental health needs are being referred to some hospital and home teaching services (HHTS). In July 2006 hospital and home teachers were surveyed about how this affects their work, in order to share ideas and help to promote good practice.

  A definition of mental health needs was not included in order to avoid limiting responses. In this challenging area, with no easy answers and this report, a small contribution to complex discussions, is intended to raise as well as to answer questions. 'Students' will refer to students with medically defined mental health needs.

The questionnaire survey
During a study day of the National Association of Hospital and Home Teachers, the members spent about twenty minutes completing a questionnaire. There were 67responses out of a possible 80. We offered closed questions, lists to tick as many answers as applied, and a few open questions with the request 'please quickly note down the first 3 or 4 points you think of'. Six people chose to remain anonymous, and 35 said they would like to be involved in future research.

Summary of main findings

1. The respondents
Of the 67 respondents, 31 worked in inner cities, 36 in suburbs/towns, 16 in semi-rural areas, and 5 in 'other areas'. They included 32 hospital teachers, 14 home teachers, 15 teachers-in-charge, 13 heads of HHTS, and 13 people identified other posts. One had been appointed to teach the growing numbers of local mental health referrals. Some people had two or more positions.

  Twenty respondents had worked in HHTS for 5 years or less, 39 for over 5 years, 35 for over 10 years, and 13 for over 20 years, the longest period being 31 years.

2. Numbers of students
While 37 (64%) respondents thought there had been a big increase in referrals of these students to HHTS, 16 (28%) reported a small increase, and some said that students were referred to Child and Adolescent Mental Health (CAMHS) teams. Nine people reported that they do not teach the students concerned, and so only 58 respondents completed the rest of the questions.

3. Key Stages and periods taught

Respondents taught across key stages 1 to 4 and also at Foundation and Post-16 levels. The periods ranged from less than a week to 4 years; 16 (28%) respondents said they had taught students for more than 2 years, suggesting that, in some cases, the HHTS may be replacing and/or supported long-term mainstream provision.

4. Settings for HHTS

Teaching settings ranged from planned to more ad hoc provision: mental health units, hospital classrooms, hospital cubicles, hospital bedsides, mainstream and special schools, school nurture/inclusion units, libraries, youth centres, virtual classrooms, Connexions offices and Surestart centres. Over half, 52%, of respondents taught students at home.

Written comments repeatedly noted the aim to meet individual needs, but also concern about inappropriate settings, 'lack of provision…for this group', and inadequate premises (15%) that do not feel safe or are too small.

5. Types of teaching contact

Contact included individual and group tuition and electronic learning. No one indicated that most teaching contact was through electronic learning, and only 3% felt it should be. One respondent noted that 'individual tuition and e-learning compound isolation'. The electronic learning included e-mails, free and subscription websites and CD-ROMs, listed in the appendix.

6. Support offered and its effectiveness

Chart 1. Main kinds of support offered and use/effectiveness
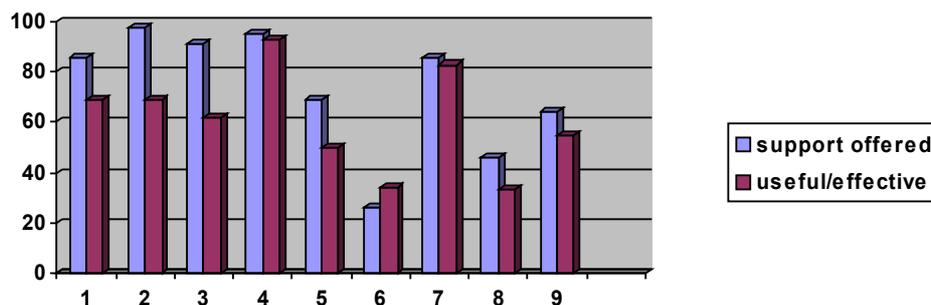
Percentage
replies

Chart 1 shows the main kinds of support that respondents offered and how useful/effective they considered it to be.

The support covered the following areas or needs:
1 Individual remedial help
2 Help with National Curriculum
3 Work set by home school
4 Reintegration into school
5 Seeking alternative educational provision
6 Support in schools to reduce referral to HHTS
7 Emotional support

8 Behavioural support
9 Support for Parents/Carers/Family

Whilst 46% of respondents felt that their work generally was 'very effective', 34% replied 'moderately effective' and 12% 'it varies'.

7. Contact with students' home school

The contact varied. *'Can be excellent in primary schools –far less easy with secondary schools.' 'Depends on schools and individuals.' 'It is still too much dependent on individuals rather than a firm structure.'* Most people wanted more contact with home schools, and for schools '*to become more proactive in planning for their students'*. In Chart 1, item 6 'support in schools to prevent referral to HHTS' is the only item showing effectiveness to exceed the support offered, suggesting that HHTS staff would like to give more support here.

8. Main systems and supports

Here are the percentage replies that listed main systems and supports to help teachers working with these students.

- Multidisciplinary teamwork (64%), including with: nursing and medical staff, education, youth and social services, pain control team, Connexions, nursery nurses, classroom assistants, education welfare officers, medical co-ordinator and mentors.
- CAMHS teams (24%) and, for example, *'having our own Community Psychiatric Nurse one day per week'.*
- HHTS managers (10%).
- Parents (9%).
- Small group work (9%).
- Individual work (7%).
- Good resources and relationships (7%).
- Local education authorities (5%).

9. Main barriers

Sometimes main supports, such as cooperative home schools and parents, could also be main barriers to effective teaching, if they were unsupportive.

- Limited funding and resources (27%): *'Insufficient funding for home education - less continuing professional development; home tutors not being paid for training.'*
- Lack of time (26%) including: the short stay in HHTS of some students; only 10 hours per week being allowed per student in some HHTS centres, although others allow only 5 hours, which *'restricts continuity, progress and security';* poor transport and isolated pupils increasing teachers' travelling time that is taken out of their teaching time.
- Schools that will not reintegrate these students, or support them, or share information with HHTS (22%).
- Parents who dominate or isolate students, or have their own mental health problems (19%).
- Inadequate teaching spaces (15%).
- Poor HHTS management and support (14%).

Other identified barriers were:

- the need for more multi-agency work;
- LEAs who lack knowledge, will not help '*the phobics'*, have nowhere to move students on to so that HHTS '*becomes a dumping ground';*
- '*The Education Welfare Service is creating mental health problems with my phobics and their families by creating too much pressure';*
- Students' experiences of anxiety and exclusion;
- Lack of training;
- Poor HHTs management;
- Lack of teachers;
- Age of referral when it seemed 'too late' to help students;
- '*Many familial problems which have caused the child's mental health problems in the first place.'*

10. Changes following increased referrals

Forty people said that increasing referrals had affected them, 7 said there were no changes, 4 did not know, and 7 did not reply. Responses to an open question about changes to work are grouped here into personal reactions and changes to the curriculum, time, resources and inclusion.

Personal changes. Some people reported increased awareness. *'I am more aware of teenagers' problems, especially in secondary schools.'* Some had felt adverse effects on their own mental health, with increased stress and frustration in trying to provide typical education services. *'We are judged in terms of achievement against national standards [with] little regard given to impact poor mental health has on learning.' 'With the shortness of stay in hospital [there was] a feeling of some frustration and inadequacy.' 'Guidelines less clear. Difficulty in grouping students.' 'Not having definite advice/goals to aim for.'*
   There was the need to support staff and *'for staff to know limits of intervention and [how to] work to Child and Family Unit guidelines and not impose their own thinking on situation'* (from an HHTS coordinator).

Curriculum Some teachers spent more time on counselling and life-skills, and less on academic teaching. There was more use of systems to measure emotional and social progress as well as academic. The curriculum was broader, extending to exams, contact with Connexions and multidisciplinary links with colleges.

Time There were more demands on limited time, with more intensive one-to-one support work being needed. *'More time is needed to build self-esteem and confidence in order to increase achievement.'* Besides frustration at the shortness of hospital stay for some, there was concern that longer stay pupils needed more time and support, and were harder to progress on to later educational stages. More time was spent on meetings, including child protection and multi-disciplinary ones.

Resources. Some people felt they had fewer resources now, but they needed more space, administrative support, larger budgets and also more specialist knowledge about mental health needs and special educational needs: *'Not trained enough to support wide variety of needs.'* (HHTS head of home education team). Some staff were not paid if they were not teaching.

11. Inclusion and reintegration

There were more problems with trying to reintegrate these students back into school than with other HHTS students. *'Our former [kinds of] pupils are now in mainstream schools and the mental health group now has serious illnesses.'* *'There are fewer special schools, leading to pressure for admission of different groups of pupils [into HHTS], also teach pregnant school girls and much harder-to-reach girls.'* There was also concern about *'lack of differentiation for less able pupils from their home school; schools' failure to meet adequately their needs creates anxiety and behaviour problems'* and also *'pupils on high levels of medication who cannot learn.'*

An unusual reply was '*generally very successful'*. More often, variety and problems were emphasised: '*Very individual, sometimes it is good, sometimes it does not work'.* One respondent believed that the school rather than the mental health need is most likely to determine the success of reintegration.

Some respondents noted the need for:

- *'small nurturing groups'*
- *'emotionally literate schools'*
- *'funding, time, dedicated outreach work'*
- *'everyone connected with the young person work(ing) together.'*

Some replies were pessimistic: '*I wonder if society just needs to accept large schools are not suitable for everyone.'*

Three models of HHTS were implied in the replies: HHTS as partners with mainstream schools, as longer term bridges into Further Education or as stand alone provision outside mainstream education. Only the first model was much to do with reintegration in home schools and in the third model, several people felt Key Stage 4 was too late to attempt reintegration into school.

12. Home teaching

Views about the effectiveness of home teaching also varied. It was generally thought to be too isolating, although *'sometimes effective initially'* to build up relationships and students' self-esteem. Moving young people into a unit and/or a school were main aims and seen as signs of progress *'towards socialisation with others [which] is usually better.'* Teachers could be vulnerable in the home, and some saw the *'home influence too focussed on … conditions/problems'.* However, there was sometimes '*no provision in the community for this group.'*

13. Examples of good practice

Finally, an open question asked for 'any examples of good practice with these students, which would you like to share?' We have grouped these into sections about main school and reintegration, teamwork and emotional

support. One person mentioned the importance of '*clear protocols and referral routes, clear timetables.*'

Main schools and reintegration
Many respondents aimed to maintain close ties with the home school and support reintegration back into school, for example, taking one pupil '*out for some respite sessions to work on his anxiety levels. Reintegration done gradually – successful so far!*' and with transferring students '*from home to out-of-school unit and thereafter back to school.*'

   Other students were a resource. '*A student who returned to a very large high school after 2 years away, usually part time. Another student will return soon. Key factor is they both have friends there.*'

   Time spent on liaison, careful planning and continuing support and multidisciplinary work were often seen as vital. '*Always hold meetings in school…involve all professionals working with pupil…keep involved by sending review notes, etc. Personal contact (with permission) with CAMHS workers and teaching staff can ensure continuity of support.*' Other people noted: '*A school who assigned a teaching assistant to an individual pupil, allowed flexible/part timetable and 'time out' when necessary rather than [always having to be in] class.*' '*Good contact in school vital, head or year or designated teacher.*' '*Knowledge of potential [support] pathways [for] students unable to return to 'normal' mainstream. Joint collaborative multi-disciplinary working.*' Also useful were half termly reviews with all concerned including the student, HHTS staff working in schools and '*Planned supported reintegration package agreed as appropriate at these review meetings supported by home teacher and gradually taken over by school.*' '*Anxious pupil with panic attacks, teaching…in small room at school. Pupil arrived and left school building when it was very quiet. Gradually attended more and began to attend lessons when they chose and would feel comfortable. Also had a good relationship with subject teacher. Had support in classroom if it was desired. Regular review meetings with [everyone] over 18-24 months.*'
 '*Time for students to talk about school related issues with the person they feel most comfortable with.*' '*Need to 'spoon feed' student in small steps so that they can feel confident to take the step into school and be responsible for their own education.*'

   For some older students, other moves were supported.
'*KS4 pupils integrating into alterative learning setting [with] teaching of… solution focus thinking, self esteem etc.*' '*Employing a 'reintegration and support officer' who can provide the pastoral support at home, which doesn't necessarily need a teacher.*'

Team work
As already shown, people valued and wrote many comments on multidisciplinary teamwork, sometimes including the family, CAMHS and '*a key worker from the school as a programme designed to go at the child's pace'.* Other team members mentioned were: HHTS staff, main school and LEA staff, GPs and hospital staff, ISS and Connexions. '*A mental health worker attached to the PRU [was] invaluable for staff and students alike.*' '*Full time learning mentor appointed 3 years ago has transformed effective liaison*

with schools and parents/carers and raised profile of importance of raising self-esteem as an essential life skill.'

Emotional support
Respondents constantly referred to having to be flexible and combine teaching with giving emotional support. Some felt that support sometimes replaced conventional teaching, but at times it could raise academic achievements. *'With the correct medication and a less pressured environment, it seems to enable these students to work at their best.' 'Success is heavily dependent on excellent relationships and gaining the confidence of the student.' 'Flexibility of allowing the student to choose where tuition takes place - home, library or schoolroom - (although a specific area for a group would be even more preferable).' 'Support of psychotic pupil – said to have been of as much benefit as medication.'*

Timing was seen as important. *'To begin individually. To introduce to small group when pupil is ready. Success noted and rewarded. Positive structures to raise self-esteem.'*

Peer groups could be vital, when students shared valued mutual support. *'Practical group involvement diplomatically handled.'*
'Encouraging pupils early on to get out of their bed space and join others in group or in 'different environment' – garden, school room, use of laptop is good in road to encouraging them to join in school and get motivated.'
'Students who have joined PRU – rediscovered self-esteem and contributed to work with other students going on to FE, HE or work – lots, not 100% necessarily but most.' 'Getting very small skills based groups going (e.g. cookery), unit awards – motivating self-esteem.' 'Princes Trust ASDAN x1 programme – once they are beginning to build some confidence with others.'

Teaching and achieving at schoolwork were part of the general emotional support. *'Group projects – art, murals, displays, further community and achievement. Outings – locally and into London, build relationships and trust. Liaison with other units, PRU, to permit students to sit literacy and numeracy National Attainment Tests when GCSEs impossible due to lack of attendance.' 'Award ceremony at end of year to recognise achievement.' 'Daily strengthening of resilience by positive reinforcement…Realistic expectations of post-16 and … exams.' 'Anxiety management course set up with CAMHS.' 'Personal advisers for regular sustained support, their quality obviously varies. One child supported to join 22 week course at job training centre, a week at outward bound and a week at summer school horticultural college and then admission to full time NVQ in small animal husbandry training.'*

There were innovative combinations of education and support. *'CAMHS group therapy session [brought] into HHTS centre to extend the day. Pupils who would not previously access these groups will, if brought to them.'*

Conclusions
It is not possible to generalise from the findings of this small study, although they suggest that:

HHTS are being stretched to provide broader and longer-term services for students with medically defined mental health needs.

HHTS are having to expand their multi-disciplinary contacts and team work, their training, resources and curriculum to meet students' mental health needs.

Teachers who can find these new challenges rewarding still tend to consider that more resources, time and training are required.

HHTS work can involve interesting innovative combining of educational with psychological and psychiatric services. The young people with medically defined mental health needs are likely to be the visible 'tip of the iceberg' comprising many more young people with borderline mental health problems who remain in mainstream schools. Approaches developed in HHTS might usefully be adapted in schools to support many more young people there, to reduce their emotional and behavioural difficulties and prevent these from becoming serious, to prevent exclusions and referrals to HHTS and to PRU, and potentially to improve mental wellbeing in schools for all staff and students. Schools might then shift from emphasising *personal* concepts of treating individual need, towards *social* concepts of promoting whole-school mental wellbeing.

The responses indicate the need for more research on the following topics:

specific records of the rising numbers of referrals to HHTS of students with medically defined mental health needs;

the range of diagnosed needs involved;

evaluations of the various health and education services to meet these needs;

ways in which HHTS are changing, deliberately or not, in response to the new demands;

the effects on services for these students of new HHTS management and funding systems;

the referral routes to CAHMS, or HHTS, or PRUs, or to other agencies (or none) of these students if they are not at school;

why some HHTS do not work with these students;

differences between students' experiences of HHTS and of reintegration into mainstream education at different key stages;[1]

teachers' and students' own views about the services.

Acknowledgements

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Appendix: E-learning

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[1] See also Farrell P, Harris K 2003 Access to Education for Children with Medical Needs – A Map of Best Practice. University of Manchester: Educational Support and Inclusion Research and Teaching Group/ Department for Education and Skills.