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Embedding mental health support in schools: learning from the Targeted Mental Health in Schools (TaMHS) national evaluation

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The Targeted Mental Health in Schools (TaMHS) programme was a nationwide initiative that funded mental health provision in schools for pupils at risk of or already experiencing mental health problems. The implementation, impact and experience of this programme was evaluated using quantitative and qualitative methodology involving three main studies: (1) a 1-year RCT involving 8658 8–10 year olds and 6583 11–13 year olds, (2) a 3-year longitudinal study involving 3346 8–10 year olds and 2647 11–13 year olds and (3) qualitative interviews with 26 TaMHS workers, 31 school staff, 15 parents and 60 pupils. The RCT demonstrated that TaMHS led to reductions in behaviour problems but not emotional problems for 8–10 year olds. No impact was found for 11–13 year olds. The effects on behaviour problems in primary school were enhanced by the provision of evidence based self-help materials, but not by other area level support. The longitudinal study found information giving and good inter-agency working correlated with more positive outcomes for behavioural problems in secondary schools. The qualitative findings indicated that TaMHS was well received by all groups, though challenges to its implementation were noted. Overall, findings indicate the utility of targeted mental health provision in schools, particularly in primary settings. The implications for implementation are discussed.

Keywords: CAMHS; children; mental health; intervention; multi-agency; booklets; schools

The role of schools in meeting the mental health needs of children and young people

The possibility of embedding mental-health support efforts in schools has generated a great deal of interest in recent years (e.g., Greenberg 2010). In this report we summarise the implementation and evaluation results of one such national effort, called ‘Targeted Mental Health in Schools’, hereafter referred to as TaMHS (Wolpert et al. 2011), while exploring the implications of this programme for the broader field. Like reports by others included in this issue (e.g., Humphrey, Lendrum, and Wigelsworth 2013), we begin by acknowledging evidence (1) that a significant minority of children and young people experience clinically recognisable mental health difficulties (Green et al. 2005), (2) that the proportion affected has risen over the last several decades (Maughan, Iervolino, and Collishaw 2005), (3) that schools are ideal settings for intervention (Greenberg 2010) and, finally, (4) that there may be organisational issues that need to be addressed if mental health is to be successfully

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implemented in school settings (Pettit 2003). After addressing the rationale for embedding mental health services in school, attention is turned to evidence of the effectiveness of school-based mental health provision. Thereafter we provide an overview of the TaMHS initiative, describe the national evaluation of this approach, draw on qualitative data to discuss issues of implementation and first-hand experience of TaMHS and demonstrate the impact of the approach on children's mental health outcomes.

Why embed mental health provision in schools

In addition to justifications for embedding mental health efforts in schools advanced by other authors in this issue, we offer some additional reasons. First, there is the compelling economic argument: the annual cost of mental health disorders among young people in the USA is estimated to be around \$247 billion (O'Connell, Boat, and Warner 2009). In the UK, the annual cost *per child* for mental health services to address complex difficulties is £50,000 (Clark et al. 2005). Moreover, accumulating evidence of associations between mental health and academic achievement in observational studies (e.g., developmental cascades [Masten et al. 2005; Moilanen, Shaw, and Maxwell 2010] and intervention research [Durlak et al. 2011; Sklad et al. 2012; Wilson and Lipsey 2007]) clearly highlight the possible long-term costs to individuals and society of the unmet mental health needs of children. Humphrey (2013) contends that long-term improvements in academic scores brought about by school-based mental health provision could result in a 5% increase in lifetime earnings (Humphrey 2013). School-based provision, then, provides an approach that may ultimately reduce the aforementioned costs (e.g., exclusion, which can cost upwards of £60,000 per child [Brookes, Goodall, and Heady 2007]), while fostering economic gains in two ways: (1) by equipping most children with the capabilities that will prevent the emergence of difficulties and (2) through provision of early intervention for the minority of children already at risk for or showing difficulties who need extra support.

In addition, schools are a potential hub for integrated working between different agencies. This should increase access and reduce stigma. Indeed, disadvantaged children and those who do not traditionally access specialist services find securing help in schools more acceptable (Armbruster, Gerstein, and Fallon 1997; Weist and Evans 2005). Locating services in schools may also reduce time away from academic activities that occurs when a child must attend speciality services outside school. In so doing, it could lessen any adverse impact of such help-seeking on their attendance or attainment.

Whatever the potential benefits, it must be acknowledged that embedding mental health services in schools poses challenges. Research highlights the need for greater staff training to increase school personnels' appreciation of student mental health needs (Moor et al. 2007). In this regard, one important issue is the absence of a common language across mental health and education services, which creates barriers that prevent effective, integrated service provision (Allison, Roeger, and Abbot 2008; Attridge-Stirling et al. 2001; Ford and Nikapota 2000). Despite national policy attention, joint working between schools and child and adolescent mental health services (CAMHS) remains hindered by differences in organisational and professional cultures, lack of communication, differences in core service priorities and training deficits and attitudes among both service groups (Ford and Nikapota 2000; Pettit 2003; Vostanis et al. 2011).

Evidence of the effectiveness of school-based mental health provision

The array of approaches used in schools under the auspices of 'mental health promotion' is vast and varied. As evidence of this, consider that schools in the USA report using a median

of 14 different programmes to achieve this goal (Zins et al. 2004). In the research reported herein, carried out across England, 13 distinct strategies were evident (Vostanis et al. 2012). These can be conceptually organised, according to Humphrey (2013) and others, in terms of reach (e.g., universal, targeted, indicated), components (e.g., focus on curriculum, school climate and ethos, parents/community or some combination of these) and prescriptiveness (e.g., the degree of manualisation or flexibility). To this we might also add variation in the theoretical underpinnings and modalities of the different approaches (e.g., behavioural, cognitive-behavioural, social skills training). These are not mutually exclusive, however. Indeed, most interventions typically embrace a blended approach. Furthermore, the evidence suggests that these blended approaches produce largely similar effects (Wilson and Lipsey 2007).

Even if not entirely compelling, evidence for the efficacy of school-based mental health services appears extremely promising. At the universal level, a series of systematic reviews and meta-analyses indicate that high quality programmes can impact significantly on a range of pertinent outcomes (e.g., Adi et al. 2007; Durlak et al. 2011; Sklad et al. 2012; Wilson and Lipsey 2007). Effect sizes, it needs to be acknowledged, prove rather modest (Weare and Nind 2011), with larger ones emerging from efficacy trials with limited external validity. Furthermore, measured effects vary greatly – and not surprisingly – as a function of quality of implementation (Durlak and DuPre 2008). Finally, and perhaps most importantly, we still know relatively little about whether, or the degree to which, different universal interventions benefit students with the highest level of need (Humphrey 2013). Thus, we still need to understand ‘for whom, and under what conditions, interventions work’ (Weisz et al. 2005, 640; see also Roth and Fonagy 2004).

Beyond effects of universal services, a large body of work addresses the impact of more targeted/indicated provision. Systematic reviews and meta-analyses indicate that such interventions can be effective in promoting positive outcomes for children and young people at-risk of (or already experiencing) mental health difficulties (e.g., Gansle 2005; Horowitz and Garber 2006; Shucksmith et al. 2007; Wilson and Lipsey 2007). Effect sizes here generally prove larger than for universal interventions, which is perhaps to be expected given the greater intensity of targeted approaches and the contrasting levels of need in universal and at-risk populations (which can often produce a ceiling effect in the former) (Humphrey 2013; Weare and Nind 2011). Despite such promising results, concerns similar to those expressed in relation to universal approaches need to be acknowledged. Specifically, the research focus on efficacy rather than effectiveness raises issues of external validity, replicability and sustainability when ‘proven’ interventions are brought to scale (Shucksmith et al. 2007). Also, maintaining fidelity to treatment models is easier said than done, though essential to achieving anticipated outcomes. Having said that, it should be acknowledged that the ‘manualised’ tradition inherent in targeted/indicated interventions often makes this easier than in the case of more diverse universal interventions.

In both universal and targeted/indicated school-based mental health provision, some attention has been paid as to who are the most effective ‘agents of transmission’, such as teachers or external specialist staff (Weare and Nind 2011). Although research is not definitive, several high-profile analyses indicate that interventions led and implemented by school staff are at least as effective as those involving external professionals (e.g., Durlak et al. 2011). Given the likely cost-savings associated with in-house delivery of interventions and the ability of teachers to ‘get to the heart of the school process’ (Weare and Nind 2011, 61), such work suggests that the most sustainable models of school-based mental health provision will be those that centrally involve school staff in delivery. The emphasis in the

research literature on ‘fidelity-at-all-costs’, however, may create challenges in relation to local ownership and the professional autonomy of teachers.

One final consideration is the balance to be struck between universal and targeted/indicated provision. Educational policy in this area tends to support a model whereby universal, preventive provision is supplemented by targeted programmes for students considered to be at-risk and intensive, indicated intervention for those already experiencing difficulties. This is the model recommended by the World Health Organisation (2004), and variants of it can be found across the English speaking world (e.g., England [Department for Education and Skills 2005], Australia [Australian Government Department of Health and Ageing 2009], USA [Sugai and Horner 2006]) and elsewhere. The work just cited calls attention to the need to achieve balance between universal, targeted and indicated intervention (e.g., Adi et al. 2007; Weare and Nind 2011), though there has been very little empirical investigation of this fundamental issue (Humphrey 2013). To our knowledge, only one study has examined the outcomes of combinations of provision at different levels (e.g., universal only, indicated only, combined) and it yielded equivocal results (Sheffield et al. 2006). So, although it makes intuitive sense that a well integrated, multi-level model of provision would be the most effective means of supporting vulnerable and other pupils, confirmatory evidence is lacking.

The TaMHS initiative in England

Launched in 2008, TaMHS was a large-scale initiative to embed targeted mental health support in schools across England (Department for Children, Schools and Families 2008). The overall aim was to develop innovative, locally crafted models to provide early intervention and targeted support for children (aged 5–13) at risk of developing (or already experiencing) mental health problems, and their families. The TaMHS formed part of the English government’s wider programme of work developed to improve the psychological well-being and mental health of children, young people and their families.

The aim of TaMHS was to build on existing whole-school interventions and focus on need of pupils at risk of, or experiencing, mental health problems. The TaMHS was specifically developed to build on universal and small-group elements of a previous programme rolled out nationally that was developed to support children’s social and emotional learning (Social and Emotional Aspects of Learning [SEAL] [see Humphrey, Lendrum, and Wigelsworth 2013, this issue]) and to provide more targeted and intensive support that was complimentary (see Figure 1).

Selected schools in every local authority (LA) across England were involved and total funding reached £60 million nationally across a period of three years. Funding from TaMHS was available for LAs and schools and these could choose how best to use the funds to meet their needs. Thus, LAs and schools had the freedom to invest in training, support and consultancy for school staff and/or additional frontline practitioners to work with staff and pupils and/or voluntary sector provision and/or associated management activity. With a phased approach, 25 pathfinder local authorities began TaMHS in April 2008, 55 local authorities joined in April 2009, and the remaining 71 in April 2010. By March 2011, between 2500 and 3000 schools were involved in delivering TaMHS projects. To aid delivery of the project, the Department for Education¹ commissioned the National CAMHS Support Service (NCSS) to provide ‘support and challenge’ to all participating LAs.

The TaMHS drew on the aforementioned body of research and represents a good example of Domitrovich and associates’ (2010) ‘integrated prevention model’. This framework is based on the view that a range of often inter-related individual and contextual factors

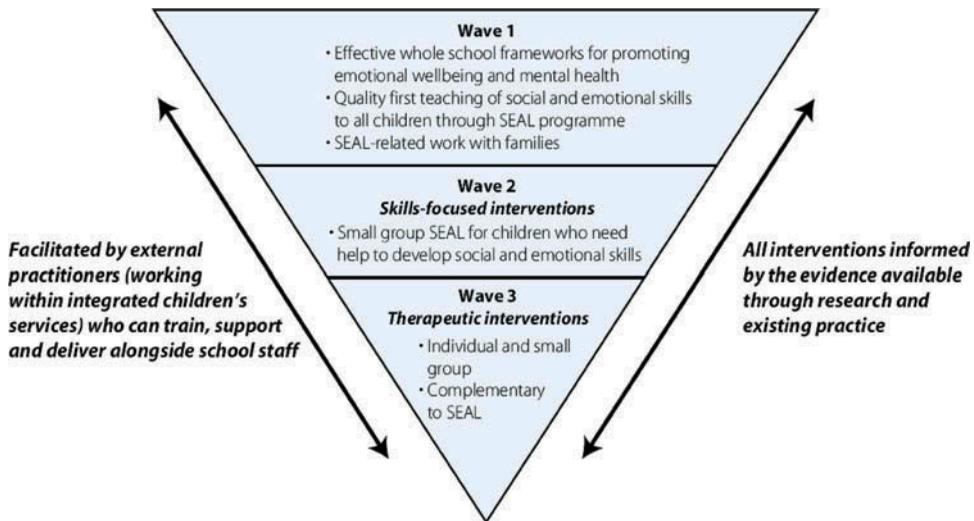


Figure 1. The waves model of prevention and intervention for SEAL/TaMHS.

can place children at risk of problematic development (e.g., temperament, family climate, neighbourhood cohesiveness). Thus, approaches to intervention focusing narrowly on a single risk factor or outcome domain are presumed less likely to be successful in promoting well-being by preventing and ameliorating problems than those that target multiple sources of influence. Furthermore, the model stipulates that effective school-based prevention should combine universal, school-wide approaches with targeted/indicated intervention for specific groups of students. Finally, it is assumed that an integrated intervention model, in which independent strategies or programmes are fused into a single, coherent framework in a co-ordinated manner, will exert synergistic effects. The TaMHS embraced these core principles by, for example, ensuring that all participating schools had a strong track record of universal provision and encouraging the integration of distinct strategies and programmes.

Support and guidance materials developed by TaMHS for schools reflected two guiding principles: (1) that the selection of interventions be informed by the evidence regarding ‘what works’ in school-based mental health provision and (2) that the programme should support strategic integration across agencies involved in the delivery of CAMHS. The latter would be achieved by promoting joint leadership and ownership, interdisciplinary teams and cross-site working (DCSF 2008). While these two elements were mandated at a national level, the emphasis of TaMHS was very much on local implementation and tailoring of support to local need. This was achieved by devolving responsibility of implementation to the participating LAs across England. Each LA developed their own bespoke project in conjunction with colleagues based in primary care trusts and in the voluntary sector to support a number of schools in their area through the provision of evidence-based targeted mental health support.

The scale and scope of the TaMHS project also allowed for the exploration of three additional approaches – at the level of the local authority or school – to supporting school-based mental health provision. At the LA level, booklets were delivered that were designed to support project start-up based on learning from the first year of implementation in the first 25 ‘pathfinder’ LAs. These booklets included information for LAs about setting up

steering groups, engaging with schools and formulating plans, while providing examples of good practice. Also at the LA level, Action Learning Sets (ALS) were implemented, which involved group meetings provided regionally to LA Leads, TaMHS workers and school staff in order for them to share learning and discuss challenges and solutions. Finally, at the school level, the provision of evidence-based self-help booklets was trialled. The booklets were developed to inform children of psychological, emotional and behavioural tactics to use to improve their well-being. They included advice grounded in empirical evidence. For example, the booklets provided instructions for some simple relaxation techniques to help children feel calm when stressed. Different booklets were developed for primary and secondary schools (primary: *How to get up and go when you're feeling low*; secondary: *I gotta feelin'²*).

National evaluation of TaMHS

In early 2008 a large, multidisciplinary research group (including the authors of this article) were commissioned by the English Department for Education (DFE) to conduct the national evaluation of the TaMHS initiative. This project – the largest of its kind to date – utilised a mixed methods design, incorporating a longitudinal observational study, a randomised controlled trial (RCT), an interview study of TaMHS stakeholders and in-depth case studies of a variety of implementation sites. The overall project was designed to address the following research questions (RQs):

- (1) What is the impact of TaMHS on mental health outcomes of pupils (when compared to provision as usual)?
- (2) Does the provision of additional support (e.g., ALS, LA booklets, pupil booklets) enhance the effect of TaMHS provision on pupils' mental health?
- (3) What different approaches and resources are used to provide targeted mental health in schools?
- (4) What school and individual factors are associated with changes in pupil mental health outcomes in schools implementing TaMHS?
- (5) How is TaMHS provision (and the support materials designed to enhance the impact of such provision) experienced by project workers, school staff, parents and pupils?

Ultimately, the goal of the research program was to inform future implementation, as well as to enhance understanding of school-based mental health provision more generally.

The TaMHS research programme was comprised of two primary studies, one naturalistic/observational and the second experimental (i.e., RCT). The first study involved schools in the 25 LAs originally selected as TaMHS 'pathfinders', and was itself comprised of two components. The first, quantitative aspect of this work involved the measurement of child mental health and the factors affecting it in a sample of c. 20,000 pupils in over 350 schools. The second, qualitative component of the observational study involved interviews with TaMHS stakeholders (e.g. policy advisors, school staff, parents, pupils and LA TaMHS staff) and in-depth case studies of select TaMHS sites.

The final major TaMHS study consisted of an RCT study, which involved schools in LAs who came into the project from 2009 onwards. The sample included over 30,000 pupils attending over 550 schools. Random allocation to treatment conditions took

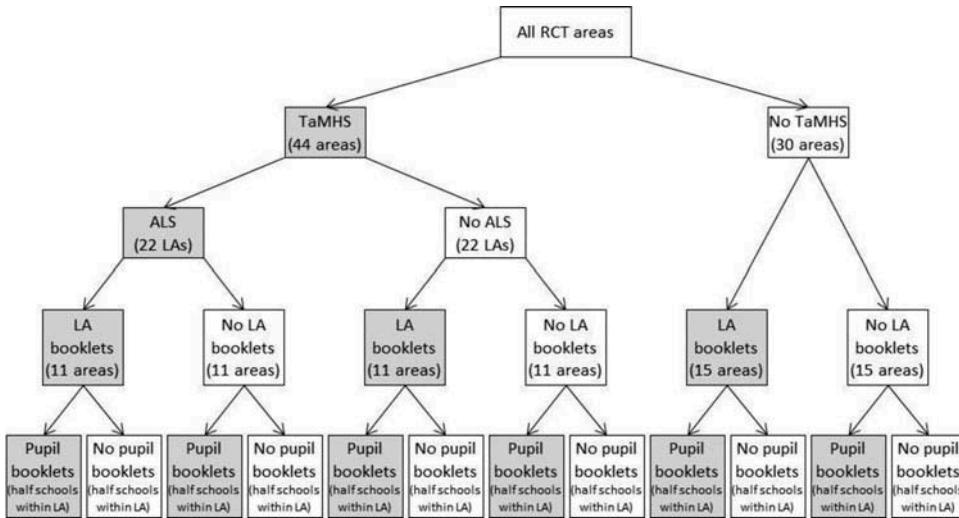


Figure 2. Random allocation for the RCT component of the TaMHS evaluation.

place at both LA and school levels. The conditions that were randomised across the RCT included:

- (1) whether the area received TaMHS or not (TaMHS versus no TaMHS)
- (2) whether LAs were invited to attend ALS or not (ALS versus no ALS)
- (3) whether LAs received booklets designed to support project start-up or not (LA booklets versus no LA booklets)
- (4) whether schools received evidence-based self-help booklets for pupils or not (pupil booklets versus no pupil booklets).

In the interests of clarity, the random allocation protocol is depicted in [Figure 2](#).

Mental health in both the RCT and the naturalistic longitudinal study was assessed primarily via pupil self-report, but supplemented with teacher and parent informant-report surveys that included both well-established measures (e.g., the Strengths and Difficulties Questionnaire [Goodman 1997]) and a bespoke measure developed and validated by the TaMHS research group – the Me and My School measure (Deighton et al. 2012).

Implementation and experience of TaMHS

Schools in both the first and second components of the overall evaluation completed annual school co-ordinator questionnaires designed to examine the nature and range of approaches to mental health provision they implemented through TaMHS. Insight regarding the initial TaMHS provision based on the school co-ordinator surveys is reported in full in Vostanis et al. (2012). In summary, schools reported providing a very diverse range of approaches, from which 13 categories were identified:

- Child-focused support:
 - (1) one-to-one psychological therapy (e.g., counselling, behavioural and cognitive behavioural psychotherapy, interpersonal psychotherapy)

- (2) small-group work, including group-based versions of the above interventions
- (3) creative and physical activity to support well-being (e.g., drama, music, art, yoga)
- (4) information and advice-giving (e.g., advice lines, leaflets, texting services web-based information)
- (5) peer support techniques
- (6) behaviour for learning and structural support for pupils
- (7) universal social and emotional learning approaches (e.g., SEAL)
- Parent-focused support
 - (8) providing information about available services
 - (9) focused support to manage stress and other emotional reactions
 - (10) training to improve skills and confidence in relation to parenting
- Staff-focused support
 - (11) supervision and consultation for staff
 - (12) staff training
 - (13) counselling and support for staff experiencing stress and other emotional issues.

Schools reported implementing different combinations of these approaches to varying degrees throughout the project. Across all schools, mental health support was generally provided by teachers and other internal staff (e.g., teaching assistants), with a smaller proportion relying on external professionals for this purpose. However, this varied as a function of time, phase of education and difficulties. For example, there was an increase from 2008 to 2010 in secondary schools in externally-led provision for pupils with externalising problems. In terms of training, there were decreases over time in the number of schools reporting staff with no mental health training leading interventions, alongside an increase in reported use of trained staff for this purpose.

Other data captured through our exploration of the implementation of TaMHS yielded interesting insights into LAs and schools' adherence to the guiding principles outlined in the guidance and support materials. Both primary and secondary schools initially used approaches developed locally more often than nationally or internationally tested ones. Hence, the norm was practice-based-evidence (PBE) as opposed to evidence-based practice (EBP). In primary schools, however, there was an increase in the use of EBP approaches over time, concurrent with a decrease in use of PBE strategies. Interestingly, the converse was true in secondary schools. Perhaps unsurprisingly given the aforementioned challenges to professional autonomy and local ownership of 'top down' interventions, no schools reported using approaches that involved following a rigorous protocol or manual, which remained true throughout the life of the project. The most frequently endorsed category in this aspect of TaMHS implementation was work that was, 'based on a plan but open to adaptation', perhaps indicating that the optimal delivery model for school-based mental health provision is one which provides a balance between prescriptiveness and flexibility.

The link between schools and specialist health provision was also explored via school co-ordinator report. Schools implementing TaMHS used more positive links with specialist mental health services than those not implementing TaMHS.

In terms of stakeholders' experience, it was notable that staff, pupils and parents were all positive about the experience of embedding mental health in schools. The different viewpoints captured from different perspectives each provided useful insights. Those involved in the implementation of TaMHS noted that one fundamental challenge involved

addressing differences in philosophy and working practice between agencies, and this challenge was itself exacerbated by the lack of and thus need for a common language between schools and CAMHS. Factors that facilitated success included integration in schools, for example: bringing all mental health support activities into the school setting, building on previous initiatives and being sensitive to the existing context in terms of understanding what has already worked, what issues need addressing and what current ways of working look like. As one TaMHS worker noted:

I think one of the principles was around the idea of not replicating what was already there, but finding out what was already there and building on that, and building capacity and starting with interventions that people had already valued, rather than trying to find something totally new and starting afresh. (TaMHS management team, interview)

School staff were generally enthusiastic about TaMHS and identified examples of positive change, which they ascribed to the project. Key facilitators identified included having specialist mental health workers based in schools:

Putting staff into schools, it's as simple as that. That is the significant difference, having somebody that you can quickly speak to without a long rigmarole of referral and a long waiting time with a perhaps you will, perhaps you won't get some support is actually people that you can say, xx, I've got a problem with this child, can you help us out? (School staff member, interview in TaMHS school)

Surveys of parents revealed that they regarded schools as the key point of contact for concerns about mental health issues and regarded teachers as the key group to turn to when worried about their child's mental health. Parents also saw teachers as the persons most helpful in these situations. Parents were generally positive about TaMHS and particularly stressed the importance of good communication in working with schools on mental health issues for their children:³

I mean every teacher that I've spoken to or associate. . . . They seem to have endless amounts of time to talk to you. They never hurry you. It's lovely. (Parent of child in TaMHS school, interview)

In the large annual survey of pupil experience, most pupils indicated they had access to mental health support in schools, with those with more difficulties having accessed more help. Pupils also showed an awareness of a range of approaches available in their schools and an appreciation of the ways these could help:

Remember it isn't just for people who are getting bullied it is also for people who want to improve their behaviour. (Male pupil, focus-group participant in TaMHS primary school)

TaMHS efficacy

Multi-level modelling of data from both the longitudinal, observational study and the RCT provided data pertinent to the impact of TaMHS on pupil mental health. Although the former is limited in terms of causal conclusions that can be drawn, it nonetheless provided useful indicators and trends that could be fed forward to the latter study. For primary schools, the longitudinal work revealed decreases in both emotional and behavioural difficulties – as assessed by pupil and teacher surveys – over the three years of the evaluation.

The secondary school picture was more mixed, with pupil reports revealing a decrease in emotional but not behavioural difficulties, but no change in either according to teacher report.

In terms of factors associated with changes in pupils' mental health over time, school reports of giving information to pupils in secondary schools proved to be positively related to improvements in the mental health of children with behavioural difficulties. However, in primary schools this same provision was associated with a smaller (rather than larger) reduction in emotional problems. In terms of inter-agency working, school reports of both the use of a shared interagency assessment framework, the Common Assessment Framework and good links with specialist health-based CAMHS proved to be positively associated with improvements over time in secondary school children's behavioural problems.

Findings from the RCT indicated that TaMHS provision benefited children with behavioural difficulties in primary schools but no evidence of such emerged in the case of older age groups or for emotional outcomes in primary school. An additional finding from the RCT was that the evidence-based, self-help materials (i.e., pupil booklets) led to more pronounced improvements in behavioural problems for primary school children when coupled with TaMHS implementation, but not when they were provided in the control LAs. Important to note, however, was that there was some evidence that these same pupil packs were associated with reduced improvement in emotional difficulties for pupils in primary school coupled with Action Learning Sets for staff.

Discussion

The TaMHS initiative represented a major effort by the previous English government to improve the psychological well-being and mental health of children, young people and their families. In many respects it was a unique – even innovative – approach to school-based mental health provision, bucking as it did the trend towards heavily manualised, 'programme-for-every-problem' approaches to intervention that have dominated the field (Jones and Bouffard 2012). The approach instead embraced an integrated model (Domitrovich et al. 2010) and offered a robust framework for action that still respected the requirement for implementation that could be tailored to local need. This seems to be where the field is now headed – with examples of initiatives that embrace a similar philosophy and approach beginning to emerge in Australia (e.g., the KidsMatter programme [Slee et al. 2009]), the USA (e.g., the School-Wide Positive Behavioural Interventions and Supports framework [Horner et al. 2009]) and elsewhere, with equally positive findings in regard to the potential to influence pupil well-being in a meaningful way.

Our national evaluation of the TaMHS project yielded a number of key findings that have implications for both future implementation efforts and the broader field of school-based mental health provision. Given the finding from the RCT that targeted mental health in primary schools reduced behaviour problems of children showing signs of behavioural difficulties, we recommend that primary schools continue to focus on behavioural problems to prevent later escalation and the huge societal costs that can come from these conditions when not appropriately treated at an early stage (Scott et al. 2001).

The fact that TaMHS was more effective in tackling behavioural than emotional difficulties in primary schools may reflect the greater awareness of and priority afforded to externalising difficulties in schools. Teachers are typically more successful at appraising children's behavioural difficulties than their emotional ones (Kolko and Kazdin 1993),

likely due to the differential salience of these types of problems in relation to issues of classroom management and climate (Atzaba-Poria, Pike, and Barrett 2004). Thus, they may be better at identifying the group of children with behavioural difficulties requiring additional support than those with emotional problems. Furthermore, schools are more accustomed to dealing with behavioural problems as part of general classroom management so may also be more experienced in and thus able to give effective support to children with these kinds of problems.

The finding that the impact was clearly more pronounced in children of primary school age reinforces calls for earlier intervention to address mental health difficulties before they become entrenched and less responsive to intervention (e.g., Allen 2011). However, the contrasting systemic and relational contexts of primary and secondary schools may also have influenced the effects detected. Secondary schools are typically much larger than primary schools, which in itself can present organisational and management challenges when it comes to implementing a mental health program (Lendrum, Humphrey, and Wigelsworth 2012). Primary schools adopt a child-focused philosophy that is arguably more amenable to mental health promotion than the subject-oriented approach that typically characterises secondary schools. It should also be noted that research suggests that teachers in secondary education can also be more resistant to non-academic interventions than their primary school counterparts (Lendrum, Humphrey, and Wigelsworth 2012; Weare and Gray 2003). Given this, a challenge for the future involves identifying effective means of increasing the 'buy in' in secondary schools. One way to do this might include placing greater emphasis on the relation between children's mental health and academic attainment (e.g., Masten et al. 2005).

Correlational findings from the longitudinal, observational study suggest a key focus for work with secondary schools may involve fostering their links with specialist external resources, whether in health or elsewhere, and putting effort into signposting these resources to young people rather than necessarily trying to provide the direct services themselves. The fact that reports of good links with specialist mental health services proved to be positively associated with improvements over time in behavioural difficulties of secondary school pupils suggests the policy of seeking to establish closer links between specialist CAMHS and schools should continue to be pursued. The finding under consideration also suggests that a focus on developing shared assessment frameworks and common language should be encouraged.

Provision of self-help information booklets for pupils was found – in the RCT – to enhance the well-being of children with behavioural problems in primary schools when those schools provided targeted mental health. A note of caution emerged, however, given the finding that giving booklets to pupils in primary schools was associated with deterioration in well-being for children with emotional problems in the context of staff having received action learning sets. We have no explanation for how this finding should be interpreted and, therefore, suggest it should be treated with caution.

Conclusion

The TaMHS project represented a major financial and political investment in school-based mental health provision at the end of the previous English government's tenure. It was arguably innovative in its approach, offering a framework for action based rather than a prescriptive, 'one-size-fits-all' approach. This gave schools and LAs freedom – providing certain guiding principles were evidenced (e.g., increased use of EBP approaches, links with CAMHS) – to develop models of provision that were tailored to local need. Our

national evaluation of TaMHS provided a somewhat mixed picture of the relative success of this model. On the one hand, some of the headline findings were very positive and spoke to the impact of TaMHS on children's mental health outcomes. However, several analyses yielded null results, suggesting areas for improvement and refinement. One possible issue here is the EBP versus PBE conundrum in schools. Although our evaluation demonstrated an increase in the use of EBP through the course of the project in certain contexts (e.g., primary schools), on the whole schools did not engage with this as fully as was hoped. There are a whole range of reasons why this may be the case, but awareness (e.g., do schools know which approaches are supported by strong empirical evidence?) and access (e.g., are schools able to acquire the appropriate training, materials etc.?) are two immediate contenders. Given this, we might look to the Australian KidsMatter programme (see Slee et al. 2009) as an example of how more precise guidance can be helpful. In contrast to the documentation provided to schools in the TaMHS project, the Kidsmatter resources provide participating schools with a guide to over 70 available interventions, with information covering the areas of focus, evidence base, theoretical framework, structure, points of contact (e.g., organisations, training providers) and other factors to enable them to make informed choices that suit their local context and needs (Humphrey 2013).

Notes

1. The Department for Education (DFE) is the English government's education arm. At the time of the project it was titled the Department for Children, Schools and Families, but has also been called the Department for Education and Skills.
2. PDFs of booklets are freely available from <http://www.ucl.ac.uk/ebpu/publications>
3. It should be noted that the parent sample was drawn from a select group of parents who indicated they would be willing to take part in qualitative interviews so may not be representative of the views of all parents.

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