

Me and My School: Findings from the National Evaluation of Targeted Mental Health in Schools 2008-2011

A collaboration between:

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This research report was commissioned before the new UK Government took office on 11 May 2010. As a result the content may not reflect current Government policy and may make reference to the Department for Children, Schools and Families (DCSF) which has now been replaced by the Department for Education (DFE).

The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.

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ACKNOWLEDGEMENTS

With thanks to the pupils, parents, teachers, school staff, local area TaMHS staff and policy advisors who contributed to the online surveys and interviews.

With thanks to the Office for Public Management (OPM) and the National CAMHS Support Services (NCSS) for liaising with the research team throughout the Me and My School research project.

With thanks to the Department for Education (previously Department for Children, Schools and Families) for providing information and support throughout.

GLOSSARY

CAF, Common Assessment Framework	The Common Assessment Framework is a shared assessment approach for use across all Children's Services and all local authority areas in England. It aims to help early identification of need and promote co-ordinated service provision.
CAMHS	Child and Adolescent Mental Health Services
Clinical cut-off (or clinical threshold)	Threshold of mental health problems (either emotional or behavioural) significant enough to warrant specialist mental health support as indicated by a score on a mental health measure or questionnaire
DCSF	Department for Children, Schools and Families (former name for Department for Education)
DfE	Department for Education (formerly known as Department for Children Schools and Families)
DoH	Department of Health
LA	Local Authority
Longitudinal study	Longitudinal studies are typically used to track events or phenomena over time through repeated measurement of the same individuals across years. Typically longitudinal studies do not involve any manipulation of conditions (such as those carried out in RCTs) and, therefore, are correlational in design.
M&MS, Me & My School	A child self-report questionnaire developed for the evaluation of TaMHS, includes emotional and behavioural difficulties subscales.
Multilevel modelling (MLM)	Much of the data that is collected for social and psychological studies is clustered or hierarchical in nature, e.g. pupils who are “nested” in schools who are “nested” in Local Authorities. Multilevel modelling takes into account similarities or clusters in the data, allowing us to model repeated data across time points within pupils, within schools.

NICE National Institute for Health and Clinical Excellence

Randomised Controlled Trial (RCT) A Randomised Controlled Trial (RCT) is a scientific trial that involves random allocation of those involved to specific conditions. After this allocation, those in each condition are followed up in the same way to observe if any differences are apparent between the two groups. Because of the random allocation, it is likely that any differences between groups are caused by the different conditions that have been allocated.

SDQ, Strengths and Difficulties Questionnaire A well established mental health measure covering emotional symptoms, conduct problems, peer relationship problems, hyperactivity/inattention and prosocial behaviour. Exists in child self-report, parent report and teacher report versions.

SENCo Special educational needs Co-ordinator

TaMHS, Targeted Mental Health in Schools A government programme that aimed to help schools deliver timely interventions and approaches in response to local need that could help those with mental health problems and those at increased risk of developing them (including looked after children).

EXECUTIVE SUMMARY

Background

The Me and My school project was a research project commissioned by the Department for Children, Schools and Families (DCSF, now the Department for Education, DfE) in 2008 as the national evaluation of the Targeted Mental Health in Schools (TaMHS) programme. The programme formed part of the Government's wider programme of work developed to improve the psychological wellbeing and mental health of children, young people and their families. The aim was that TaMHS would help schools deliver timely interventions and approaches in response to local need that could help those with mental health problems and those at increased risk of developing them (see Chapter 1 for a more detailed description of the TaMHS programme).

Aims and Objectives

This research set out to answer five key research questions:

1. What is the impact of TaMHS provision relative to provision as usual when evaluated using random assignment of areas to TaMHS vs. provision as usual?
2. Does the additional provision of support materials when randomly assigned enhance the effect of TaMHS provision on pupil mental health?
3. What different approaches and resources are used to provide targeted mental health in schools?
4. What factors are associated with changes in pupil mental health for schools implementing targeted mental health during the course of a three year longitudinal study?
5. How is targeted mental health provision (and the support materials designed to enhance the impact of such provision) experienced by project workers, school staff, parents and pupils and what lessons are there for future implementation?

Methodology

Two studies were undertaken: a longitudinal study (2008-11) and a Randomised Controlled Trial (RCT; 2009-11). A mixed quantitative and qualitative methodology was used (the evaluation methodology is described in Chapter 2).

Sample

Longitudinal study sample

2,687 primary school pupils across 137 primary schools and 2,311 secondary pupils across 37 secondary schools provided self-reports on their mental health in all three years (2008, 2009 and 2010).

41 primary schools and 13 secondary schools provided information on mental health provision in their schools across these three years.

Between 780 and 1,842 parents reported on their children's mental health each year.

Between 3,671 and 6,971 teachers reported on their pupils' mental health each year.

Qualitative interviews were conducted with 11 policy makers, 26 TaMHS staff, 31 school staff 15 parents and around 50-60 pupils about their views and experience of mental health in schools.

Randomised Control Trial sample

7,330 primary school pupils across 270 primary schools and 5,907 secondary pupils across 82 secondary schools provided online self-reports of their mental health in 2009 and 2010.

2,857 and 1,606 parents reported on their children's mental health in 2009 and 2010 respectively.

15,980 and 9,322 teachers reported on their pupils' mental health in 2009 and 2010 respectively.

Sample characteristics are described in Chapter 2.

Findings

The findings relating to each research question are considered in turn below (and an overall summary is also provided).

Research Q 1: What was the impact of TaMHS provision relative to provision as usual when evaluated using random assignment of areas to TaMHS vs. provision as usual?

TaMHS provision resulted in a statistically significant decrease in problems in primary – but not secondary – school pupils who had behavioural problems at the outset, but had no effect on primary or secondary school pupils who had emotional difficulties at outset. These conclusions are based on comparison of children in schools in Local Authorities that, on a randomized basis, did and did not implement TaMHS.

Research Q 2: Did the additional provision of support materials when randomly assigned enhance the effect of TaMHS provision on pupil mental health?

- 1) The random allocation of evidence based mental health self-help booklets to pupils in TaMHS schools enhanced the general effect of exposure to TaMHS on primary school pupils with behaviour problems. That is, it resulted in a statistically significant additional decline in their behaviour problems over time. This conclusion is based on comparison of primary school pupils with behaviour problems at the outset randomly assigned to TaMHS who, on a random basis, did or did not receive evidence based mental health self-help booklets.
- 2) The dual provision of evidence based mental health self-help booklets to students and Action Learning Sets for the TaMHS project team resulted in a significantly smaller decline in emotional difficulties for primary school pupils who had emotional difficulties at outset in comparison to the decline experienced by similar children who did not receive these booklets and whose project teams did not take part in action learning sets. However it is important to note that this effect was much less pronounced than was the effect of the positive impact of the booklets for children with behaviour problems (see conclusion 1 above).

- 3) None of the other support conditions was found to be significantly related to pupil mental health outcomes.

Research Q 3: What different approaches and resources are used to provide targeted mental health in schools?

- 1) Thirteen categories of mental health work in schools were identified: 1) Social and emotional development of pupils, 2) Creative and physical activity for pupils, 3) Information for pupils, 4) Peer support for pupils, 5) Behaviour for learning and structural support for pupils, 6) Individual therapy for pupils, 7) Group therapy for pupils, 8) Information for parents, 9) Training for parents, 10) Counselling for parents, 11) Consultation for staff, 12) Counselling for staff and 13) Training for staff.
- 2) The most strongly endorsed category in both primary and secondary schools (apart from promotion of social and emotional development which all schools had to be doing as part of selection criteria for TaMHS implementation) was work on behaviour management in relation to behavioural difficulties.
- 3) There was little change over time in the proportion of schools engaging in the 13 types of mental health work.
- 4) Mental health support was reported to be provided principally by teachers rather than mental health professionals.
- 5) Over time schools reported increasing amounts of specialist mental health input.
- 6) Pupils with behavioural problems were more likely to see a mental health professional than those with emotional problems; and this was true in both primary and secondary schools.
- 7) The majority of both primary and secondary schools reported using approaches developed locally rather than those that had been internationally tested; and no primary or secondary schools reported using approaches that involved following a rigorous protocol or manual.

- 8) Schools indicated high use of educational psychology and other school-based resources for troubled pupils rather than direct referral to specialist CAMHS.
- 9) Use of the CAF increased over time in both primary and secondary schools.
- 10) Though relations with CAMHS were reported to be relatively poor and limited at the start of the evaluation (2008), they improved over the three years of the study.

Research Q 4: What factors were associated with changes in pupil mental health for schools implementing targeted mental health during the course of a three year longitudinal study?

Change over time:

- 1) Over time and irrespective of whether primary pupils were in TaMHS or other schools, primary school pupils' levels of both emotional and behavioural problems declined significantly across the three years of the study; this was true according to both teacher and pupil reports.
- 2) Secondary school pupil levels of emotional problems also showed significant reductions across the three years of the study, but this was so only according to pupil self-reports, not teacher reports.
- 3) Secondary school pupils' levels of behavioural problems showed no significant change across the three years of the study based on pupil self-report though teachers reported increased levels of problems.

Factors associated with differential change:

- 1) For secondary school pupils with behavioural problems at the outset, greater reported provision of information to pupils was associated with greater improvements in mental health outcomes over time.
- 2) For primary school pupils with emotional problems, greater provision of information to pupils was associated with less pronounced reductions in emotional problems.

- 3) Greater school reported use of CAF was associated with greater reductions in mental health problems for pupils with behavioural problems over time in secondary school.
- 4) Schools reporting good links with CAMHS experienced greater declines over time in secondary school children's behavioural difficulties.

Research Q 5: How was targeted mental health provision (and the support materials designed to enhance the impact of such provision) experienced by project workers, school staff, parents and pupils and what lessons are there for future implementation?

- 1) TaMHS workers were extremely positive about the initiative and felt it worked best when TaMHS was fully integrated into schools. They highlighted challenges to finding a common language to use between mental health providers and schools. They also expressed concern about ensuring long-term funding and the embedding of the effort in the school over the longer term.
- 2) School staff were positive and enthusiastic about TaMHS. They identified a number of examples of positive change which they ascribed to the project. In particular they valued having TaMHS workers based in the school, people who they could consult regularly regarding children they had concerns about.
- 3) Parents tended to identify schools as the key point of contact for concerns about mental health issues. In particular they identified teachers as the key group they turned to if worried about their child's mental health. Teachers were also regarded as the ones who provided the most help in these situations in comparison with other groups such as family doctor and family friends.
- 4) Parents were generally positive about TaMHS and stressed the importance of good communication in working with schools on mental health issues for their children.
- 5) Pupils were not asked specifically about the TaMHS project but were generally aware and positive about support available from counsellors and peers mentors and others within the school.
- 6) Pupils reported high levels of contact with sources of mental health support in schools and those with the greatest difficulties reported the greatest contact.

- 7) Primary school children showed slightly more positive ratings of this kind of support than secondary schools pupils.
- 8) Pupils with greatest difficulties tended to rate their experience of support less positively than those with lower level of difficulties.
- 9) Pupils who saw the evidence based mental health self-help booklets rated them positively, with the primary school booklet being rated more positively than the secondary school booklet.
- 10) A particular challenge identified by some TaMHS workers, school staff and parents was the danger of new TaMHS provision substituting rather than supplementing existing provision within schools.

Summary of implications and issues for further consideration

Targeting Mental Health in Primary schools

It may make sense to prioritise mental health work with primary school pupils in relation to behavioural problems to have maximum impact before problems become too entrenched.

It may be helpful for primary schools to continue to work on ensuring positive school environment, particularly in relation to intra and inter staff and pupil relationships, as a way of contributing to improvement in behavioural problems in pupils.

It may be worth considering further use of evidence based self-help materials for primary school pupils at risk of or with behavioural difficulties.

Caution should be taken when giving information to pupils in primary school with emotional problems to ensure the material does not impact negatively.

Primary schools may like to consider how best to ensure they do not overlook children with emotional problems in terms of accessing specialist mental health help.

Targeting Mental Health in Secondary schools

It may make sense to prioritise improved inter-agency working (such as by use of systems such as the CAF) as ways to help address behavioural problems in pupils in secondary school.

It may be beneficial to prioritise improved relationships and referral routes between schools and specialist CAMHS as ways to help address behavioural problems in pupils in secondary school.

It may make sense to prioritise the provision of materials to help young people find and access such support help address behavioural problems in pupils in secondary school.

Secondary schools may like to consider how best to ensure they do not overlook children with emotional problems in terms of accessing specialist help.

Evidence based practice

It may be helpful for schools to be encouraged to consider using more manualised approaches with a clear evidence base as these have been found in the literature to have the greatest impact, though this needs to be combined with need for local ownership to aid uptake.

Inter-agency working

It may be important to ensure that schools retain a role in being able to refer their pupils for appropriate help given the fact that parents identify them as the key point of contact and good advice for their concerns about their children.

Educational psychologists appear to be a key group to work with in relation to mental health provision in schools and their potential role in aiding links between schools and specialist CAMHS.

Strong links with specialist CAMHS and good use of inter-agency working (as demonstrated by high use of the CAF) should be encouraged, especially in secondary schools where they are associated with reduction in behavioural problems for pupils with problems.

Future implementation of policy

It may be helpful to ensure that in any future roll out of mental health provision in schools attention is paid to ensuring a common language and as full integration as possible of services in schools.

When implementing interventions such as this one on a large scale, it may be of benefit to determine beforehand how best to avoid displacing existing support and to how such support can be sustained, for example by not requiring that provision be “innovative” or “new” and rather allowing areas to draw on existing good practice.

Future research

It is important to note the evaluation team have still to consider association of TaMHS involvement with later academic attainment levels – this will be reviewed when relevant academic attainment level data is available in 2012.

CHAPTER 1: WHAT WAS TAMHS AND WHY WAS IT IMPLEMENTED?

Targeted Mental Health in Schools as a government policy initiative¹

The Targeted Mental Health in Schools (TaMHS) programme, funded by DfE and its predecessor (DCSF), ran between 2008 and 2011. The programme formed part of the Government's wider programme of work developed to improve the psychological wellbeing and mental health of children, young people and their families. Selected schools in every local authority (LA) were involved in this £60 million programme, the aim of which was to develop innovative, locally determined models to provide early intervention and targeted support for children (aged 5 to 13) at risk of developing mental health problems and their families.

The aspiration was that TaMHS would help schools deliver timely interventions and approaches in response to local need that could help those with mental health problems and those at increased risk of developing them (including looked after children).

TaMHS supported the duty of schools to promote pupils' well-being and built on existing universal work in schools to promote pupils' social and emotional development. For instance, TaMHS built on the Social and Emotional Aspects of Learning (SEAL) programme, which aimed to help all children and young people to develop social and emotional skills and provided targeted support which could be run by school staff for those pupils who could benefit from more support (see Figure 1.1).

¹ Information provided by DfE

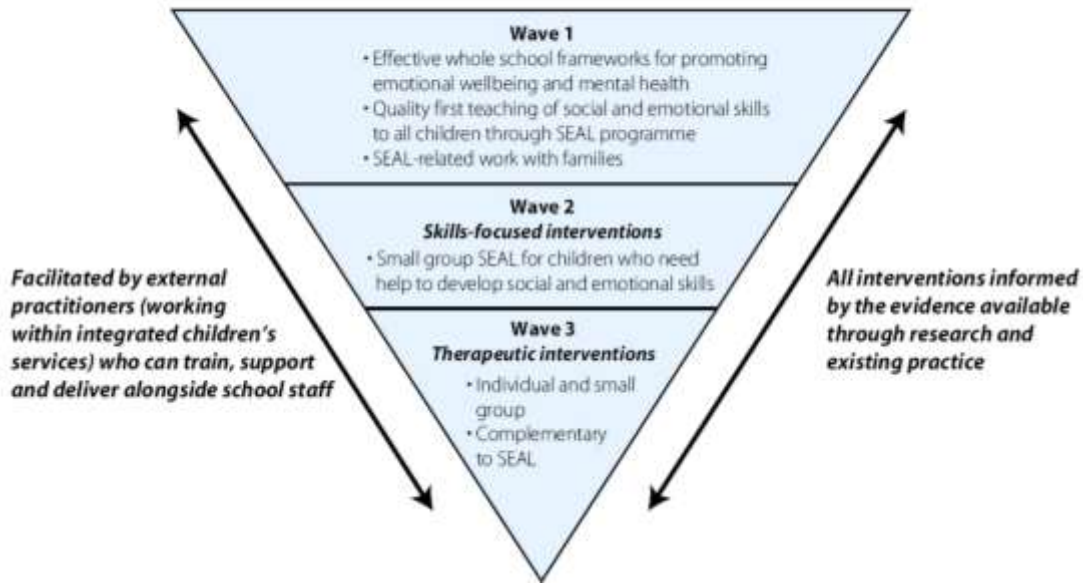


Figure 1.1: Three waves of mental health and emotional well-being support (taken from DCSF, 2008).

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 2,500-3,000 schools were involved in delivering TaMHS projects.

TaMHS funding was available for LAs and schools to choose how best it would meet their needs. LAs and schools could choose whether to fund 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. LAs developed a range of different approaches to how they would implement TaMHS in their area (see OPM, 2009 for models of practice). The majority of LAs (142) involved the voluntary sector, with 24 out of 25 phase 1 pathfinders and 54 out of 55 phase 2 pathfinders reporting using voluntary sector providers delivering services. The majority of these were from smaller local voluntary organisations.

Two key drivers for change were particularly envisaged as part of the TaMHS model (DCSF, 2008):

- 1) Promotion of greater strategic integration – TaMHS set out to ensure all agencies involved in delivering mental health services for children and young people (for example, local authorities, PCTs, other health trusts, the voluntary sector) were working together,

strategically and operationally, to deliver flexible, responsive and effective early intervention mental health services for children and young people.

- 2) Implementation of evidence-informed practice – TaMHS aimed to ensure interventions for children and families at risk of or experiencing mental health problems and delivered in and through schools were planned according to local needs and in particular grounded in our increasing knowledge of ‘what works’ (DCSF, 2008).

Social economic context of TaMHS

TaMHS was often instituted in areas of significant deprivation. 14 of the first 25 pathfinders were amongst the most deprived nationally. The majority of LAs reported using deprivation as a key factor in school selection. By 2011, when 151 LAs were delivering TaMHS, around 50-60% of the schools involved had been selected on the basis of high proportions of Free School Meals (FSM) intake (a key deprivation proxy measure).

Implementation and support

To deliver the project, DCSF commissioned the National CAMHS Support Service (NCSS, a government support agency) to provide ‘support and challenge’ to all local authorities implementing TaMHS. NCSS was an established team of CAMHS Regional Development Workers (RDWs). Each TaMHS LA was assigned a designated lead from within the NCSS who supported the local authority throughout the project.

Government policy since TaMHS

From 2011, the new DfE Early Intervention Grant (EIG) brings together funding (£2.2bn in 2011-12) for early intervention and preventative services for children, young people and families. This includes funding which, based on their local priorities, LAs can use to provide early intervention and targeted support for children at risk of developing mental health problems and their families.

In addition DfE will be providing support to build the capacity of the voluntary and community sector to support early intervention in mental health (DfE, 2011).

Why was TaMHS implemented?

Epidemiological studies indicated that as many as 10% of school-aged children have clinically recognisable mental health problems, the most common being anxiety and depression (Green et al, 2005). Studies have shown that the majority of such children do not reach appropriate services (Rutter et al, 1970; Ford, et al, 2005; Green et al, 2005), a problem with potentially far-reaching consequences. For instance, conduct disorders amongst children tend to persist into adult life, including later drug abuse, antisocial behaviour and poor physical health (Broidy et al, 2003). Moreover research published in 2004 suggested a substantial increase in the mental health needs of children and young people in the last 30 years (Collishaw et al, 2004).

There had been a growing interest in making mental health services more accessible and in particular on the key role of schools in both signposting and providing mental health promotion and prevention work (Attride-Stirling et al, 2001). Teachers and schools were recognised as often being the first outside the family to identify children's problems and many parents depend on their guidance for help-seeking. There was also some evidence that more disadvantaged children and those who do not traditionally access specialist services may find help in schools more acceptable (Armbuster et al, 1997; Weist et al, 1999).

Furthermore, many schools themselves recognised the importance of mental health for the school context and stress the importance of this for academic achievement. This view is supported by research literature, which suggested that high levels of behavioural problems in particular are associated with poor academic performance (e.g., Jimerson et al, 1999). In particular, behaviour problems appear to undermine a child's ability to perform well in class (Egeland et al, 1990; Fergusson et al, 1993; Masten et al, 2005).

A range of school-based approaches using both individual and group cognitive-behavioural therapy, nurture groups, social-skills training, peer-mediated interventions, behavioural strategies and coping skills had been found to have positive effects on mental health outcomes (Fonagy et al, 2002; Wolpert et al, 2006; Schucksmith et al, 2007). A series of systematic reviews of school-based approaches in primary schools undertaken to support the development of NICE guidelines provide extensive information about current evidence relating to effective interventions. In particular programmes which involve training for teachers as well as parent involvement (e.g., PATHS) demonstrated a positive impact on children's emotional wellbeing. Multi-component interventions involving pupils, parents and school staff appeared to have the greatest impact on violence and bullying in schools interventions (Adi et al, 2007a). Furthermore, long term interventions integrated into

classroom teaching appeared to be effective in the long term compared to delivery of short term interventions (i.e., effects lasted longer, see Adi et al, 2007b).

Classroom based interventions, school level behaviour management and whole school bullying prevention programmes were also found to be effective in reducing violence and bullying, although the extent of positive effect and how long the effect lasted varied. Interventions aimed at these kinds of problems seemed to be most beneficial for high risk children (Adi et al, 2007b). Other reviews identified part and whole school approaches with positive effects on general school environment, as well as children's interpersonal skills, prosocial conflict resolution and overall better mental health outcomes (Wells et al, 2003). Targeted interventions that have been identified as being particularly effective include Cognitive Behavioural Therapy (CBT) based approaches for emotional difficulties (with less positive effects on comorbid children); peer mentoring and buddying for reducing aggressive behaviour and problem solving skills for conduct problems (Shucksmith et al, 2007). However, there was not enough evidence from this collection of reviews to clearly determine whether teacher versus psychologist delivered interventions were more effective (Adi et al, 2007a).

In terms of what was actually being implemented on the ground in the UK, the range of interventions in schools varied widely from voluntary sector counselling initiatives such as Place2B, to parenting interventions (Hoover-Dempsey et al, 2005; Corboy & McDonald, 2007) to whole school approaches. In some areas there was use of Primary Mental Health Workers (PMHWs) in schools, in others one-stop-shops at community schools were available (Tisdall et al, 2005). There was evidence of training in CAMHS to school nurses as well as use of CBT based whole class or small group interventions such as FRIENDS (used in some areas as part of TaMHS) and resiliency programmes (Seligman et al, 2009). Educational psychologists were a key part of mental health support in schools (Window et al, 2004) but there were also growing numbers of family support workers, teaching support staff and others involved in psycho-education strategies (Haraldsson et al, 2008). However, when joint initiatives were employed locally, they were often disjointed or lacked generalisable outcomes with no evidence base (Pettit, 2003; Sloper, 2004; DoH, 2005).

CHAPTER 2: EVALUATION METHODOLOGY AND POPULATIONS SAMPLED

Research aims and design

The Me and My school project was a research project commissioned by the Department for Children, Schools and Families (DCSF) (now the Department for Education DfE) as the national evaluation of the TaMHS programme.

The aim of this research was to explore the impact of this programme and find out which approaches appeared to be the best ways for schools to help children.

It aimed to address the following questions:

1. What is the impact of TaMHS provision relative to provision as usual when evaluated using random assignment of areas to TaMHS vs. provision as usual?
2. Does the additional provision of support materials when randomly assigned enhance the effect of TaMHS provision on pupil mental health?
3. What different approaches and resources are used to provide targeted mental health in schools?
4. What factors are associated with changes in pupil mental health for schools implementing targeted mental health during the course of a three year longitudinal study?
5. How is targeted mental health provision (and the support materials designed to enhance the impact of such provision) experienced by project workers, school staff, parents and pupils and what lessons are there for future implementation?

Two studies were undertaken: Study 1, a longitudinal study, and study 2, a Randomised Controlled Trial (RCT). In addition a number of products were developed based on learning from study 1. These included the development of support materials for LA leads and evidence based self-help booklets for children (see Appendix 1 for details).

What is a longitudinal study?

Longitudinal studies are used to track events or phenomena over time through repeated measurement of the same individuals across years. Typically longitudinal studies do not involve any manipulation of conditions (such as those carried out in RCTs) and, therefore, are correlational in design. This particular approach was used for our first study because it was not possible to randomly allocate which LAs became the initial pathfinder sites for TaMHS and so a longitudinal design allowed us to look at changes in levels of mental health problems in the same sample of pupils across years and explore what factors were associated with those changes (such as deprivation, school climate and school-based mental health support).

The TaMHS longitudinal study was a naturalistic study following 25 Local Authority (LA) areas selected by DCSF as 'pathfinders' to be the first to begin their TaMHS projects. This overall sample included approximately 20,000 pupils in 25 LAs, across over 350 schools over three academic years (2008-10, see Appendix 2).

As in a longitudinal study it is not possible to randomly allocate conditions (in this case, TaMHS or no TaMHS), an attempt was made to create a pseudo control group by asking LAs to select schools to participate in the evaluation who were not implementing TaMHS. However, across the three years of the study only nine primary and three secondary schools that had originally been classed as comparison schools provided data every year. Comparisons between the TaMHS group and this pseudo control group revealed no differences in the extent of mental health support, or in the outcomes attained. These schools were not a randomly selected control group and this could mean that they were systematically different from other schools nationally who were not receiving TaMHS. The fact that these schools elected to be comparison schools and remained part of the evaluation for three years perhaps suggests that they are especially committed to mental health support and, therefore, did not provide a suitable comparison. Owing to the similarity of these schools to the TaMHS schools in the study and their hypothesized commitment to mental health in schools they were eventually included in the overall sample.

Limitations of the longitudinal study design

A longitudinal design had to be adopted for the first study involving the first 25 pathfinder areas because these were already selected by DCSF so could not be randomly selected. While this kind of design allows consideration of associations between a range of factors and changes in children's mental health outcomes over time, it does not allow use to draw conclusions as to the causal relationships among these factors.

Qualitative component of the longitudinal study

The longitudinal study also included three key qualitative studies:

1. An exploratory study which examined the underlying premises of the TaMHS initiative as it was understood, practised and experienced by project designers, implementers and beneficiaries at the outset and its meaning for all those involved and the challenges raised in its implementation.
2. A multi-site case study of alternative education facilities, including special schools and pupil referral units was also carried out to consider whether these particular facilities had taken different approaches to mental health support.
3. A selection of in-depth case studies including a set of four schools, selected on the basis of change in the aggregated pupil scores across years, were carried out to explore theories of change and other emergent themes.

This qualitative work allowed us to draw out key themes from the perspective of those working as part of core TaMHS teams (TaMHS workers such as project leads and primary mental health workers), school staff, parents and children.

Limitations of the qualitative component of the longitudinal study

Given the large number of schools and geographical areas involved in the project, the number of individuals and schools involved in the qualitative studies was comparatively small. Therefore, it is not possible to confidently generalise from the sample used; instead this information has been used to identify key themes and issues relating to barriers and facilitators of implementation.

What is a Randomised Controlled Trial (RCT)?

A Randomised Controlled Trial (RCT) is a scientific trial that involves random allocation of those involved to specific conditions. After this allocation, those in each condition are followed up in the same way to observe if any differences are apparent between the groups. Because of the random allocation, it can be concluded that any differences between groups are caused by the different conditions that have been allocated. This approach was used for our second study because it allowed us to randomly allocate TaMHS provision to areas involved in the second and third phases of the project primarily to see whether TaMHS provision had a significant impact on children's mental health outcomes.

The TaMHS RCT involved LAs being randomly assigned to different conditions that vary in the type of support they offer (see Figure 2.1). Conditions were:

1. Whether LAs were funded to begin the TaMHS project in 2009 or one year later (TaMHS vs. no TaMHS)
2. Whether LAs were invited to attend Action Learning Sets or not (ALS vs. no ALS)
3. Whether LA leads were allocated to receive booklets designed to support project start-up or not (LA booklets vs. no LA booklets)
4. Whether schools were allocated to received evidence based self-help booklets for pupils or not (pupil booklets vs. no pupil booklets)

It included over 30,000 pupils in 73 LAs, across over 550 schools over two academic years (2009-10; see Table 2b, Appendix 2).

Description of approaches trialled as part of the RCT in addition to TaMHS

LA booklets

LA booklets were developed for LA leads involved in the RCT based on learning derived from information gathered from the first year of the longitudinal study. They included information about setting up steering groups and working teams, and advice about engaging with schools and formulating project plans as well as example of good practice. Booklets were randomly allocated to half of the LAs involved in the RCT. 274 schools (52.7%) were in LAs that received the LA booklets and 246 (47.3%) in LAs that did not receive LA booklets.

Action Learning Sets (ALS)

ALS were group meetings provided regionally to LA leads, TaMHS workers and school staff in order for them to share learning, and discuss challenges and solutions. Action Learning Sets were trialled because they were initially offered to pathfinders involved in the first wave of TaMHS (those in the longitudinal study) who reported finding them useful. ALS were randomly allocated to half of those taking part in the RCT who were in the condition allocated to begin TaMHS in 2009. Out of schools who received TaMHS in 2009, 171 schools were in areas that received Action Learning Sets and 180 schools were in areas that did not receive them.

Evidence based self-help booklets

These booklets were self-help materials developed to give children strategies to feel better if they were experiencing emotional or behavioural difficulties. The booklets included advice based on evidence based principals (e.g., CBT strategies) and were developed in collaboration with children and young people. Different booklets were developed for primary and secondary aged pupils. These booklets were randomly allocated to half of the schools

involved in the RCT. 259 schools (49.8%) of the schools were allocated the pupils booklets and 261 schools (50.2%) did not receive them.

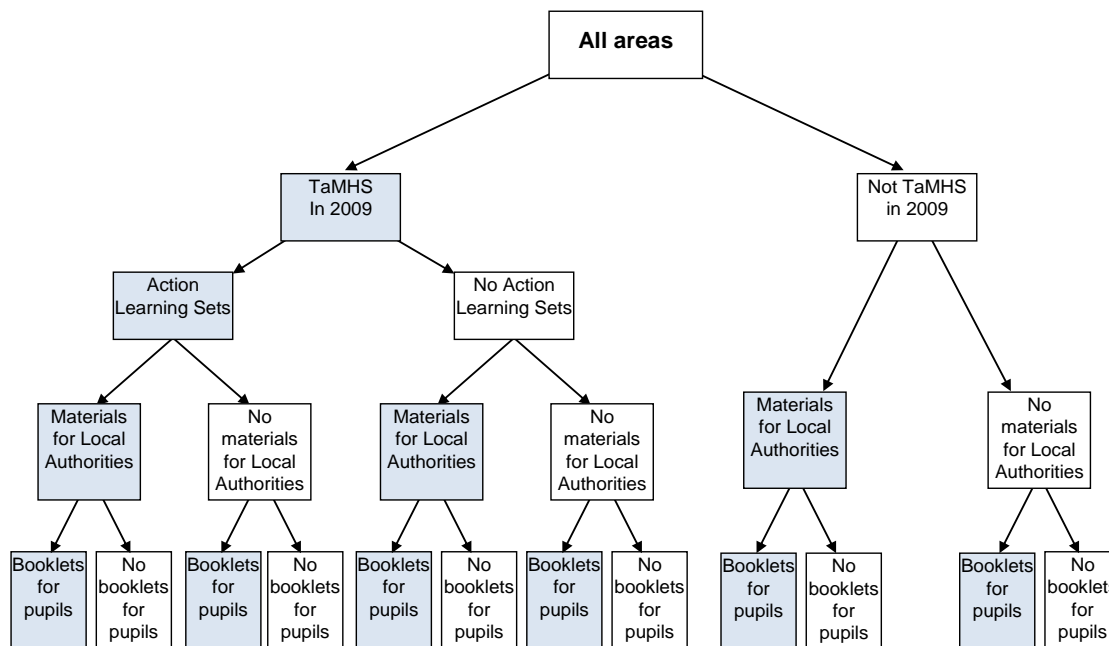


Figure 2.1: Random allocation for the RCT

Limitations of the RCT

Whilst being able to randomly allocate areas to receive TaMHS in 2009 or not to receive it until 2010, and to trial a number of other conditions at the LA or school level (e.g., Action Learning Sets, information packs for LA leads and booklets for pupils) allowed for some control of extraneous factors, the level at which the conditions were allocated (i.e., at the school or LA level) was quite distal to the outcome of interest (individual pupils' mental health scores) and, therefore, was less likely to have a large impact. Also, an RCT works best when participants have no knowledge of whether they are in the intervention group or the control group. This was not possible in this RCT and could have led to schools in the 'control' condition implementing interventions themselves, which may have affected the outcome of the RCT. This has been known to occur in other schools based studies of interventions (Groark & McCall, 2009).

Measures used²

One particular challenge with the scale of the evaluation was how to measure children's mental health across years of the study. Typically, measurement relies on responses to questionnaires from parents, teachers, children or clinicians. The latter group were not relevant to our population because very few were accessing specialist help but the other sources of information were incorporated into the design for the evaluation, which drew on parent, child and teacher perspectives. While information was collected from all three of these reporters there were some practical and theoretical parameters for the use of these different perspectives.

Teacher reports have often been used for research relating to general population mental health, where the school setting has been the point of access to the population of interest (as in this evaluation). Research suggests that teachers are accurate reporters of children's behavioural difficulties (e.g. aggression, conduct disorder); however, they are less well able to provide accurate information on children's emotional difficulties (e.g. depression anxiety), perhaps due to the differential salience of these types of problems within the classroom (Atzaba-Poria, Pike & Barrett, 2004; Gardiner, 1994; Stanger & Lewis, 1993). Concentrating only on use of teacher reports to assess whole classes year on year, using full questionnaires was judged likely to introduce excessive burden to teachers and, therefore, to carry cost implications for schools.

Parent reports have also been employed routinely in mental health outcomes evaluation. They have advantages because they can be accessed irrespective of the setting and are often relied upon when children are considered too young to provide self-reports (e.g. Levitt, Saka, Romanelli, & Hoagwood, 2007). However, there may be some possibility of bias due to parents own mental health status (Conrah, Sonuga-Barke, Stevenson & Thompson, 2003) and parents' lack of awareness of emotional difficulties (Verhulst & Van der Ende, 2008). Crucially, there are also particular difficulties recruiting and retaining parent respondents, particularly from some families where there are complex mental health issues (Littell et al, 2005). Relying on parent report, therefore, runs the risk of drop out from the very group that are most likely to have mental health problems; the group of interest for this evaluation.

There are strong arguments for the use of child self-report as a key perspective. Recent UK policy and legislation has placed increasing emphasis on the importance of the child's

² Full measures are provided in Appendix 1

perspective across the full range of situations and conditions (e.g. DfES, 2004; Children Act, 2004) and the importance of the contribution of children's own views to understanding child mental health problems and what might constitute successful strategies to alleviate these has been stressed (Raby, 2007). It has been argued that children are the most practical source of data from universal settings where more general populations are concerned (Levitt et al, 2007). The possibility of eliciting child self-report has also been extended by recent developments in terms of 1) research concerning the age at which a child develops accurate self-perceptions and 2) the development of online questionnaires with sound available making the administration of child-self report measures with younger age groups a more viable option (Merrell & Tymms, 2007).

However, there are limitations to the use of child self-reports of psychological adjustment. In particular: 1) younger children may be more likely to give socially desirable responses about their own mental health than other reporters may be; 2) children with a range of behavioural and emotional problems may be less self-aware of these than others around them; 3) young children are less likely than other reporters to be able to read text-based self-report measures or to understand the language or the concepts used in self-report measures; 4) younger children are reportedly less consistent in their self-perception in relation to mental health difficulties and typically respond based on 'the here and now' rather than based on relatively stable levels of psychological adjustment (Roy, Veenstra & Clench-Aas, 2008).

The approach taken for this evaluation was to use child self-reports of mental health as the key indicator of mental health outcomes but to also validate this approach using parent and teacher reports. In order to ensure that younger children's reports of mental health were most accurately assessed, a measure was developed that aimed to a) use simple language suitable for young children, b) use recent developments in web technology to ensure the measure was interactive and child-friendly and c) provide audio accompaniment for younger children who may require some assistance with reading. Information about the initial validation of this measure is provided in Appendix 4.

1) Me and My School (M&MS)

The M&MS measure (Wolpert et al, 2010; Deighton et al, 2010) was developed to consist of 24 statements to which children respond "sometimes", "always" or "never" depending on the level of agreement with each statement. Developed as an instrument suitable for use with a wide age range of children (age eight years and above), the measure was designed to capture general wellbeing as well as being a screening tool for more problematic symptoms.

It was developed because there was no brief child self-report measure in existence at the time of the evaluation that was suitable for use with children as young as eight years old (e.g., self-report SDQ only available from the age of 11). The questionnaire broadly focuses on emotional and behavioural difficulties and for the purposes of this report a subset of 12 emotional difficulties and six behavioural difficulties items were used (see Appendix 3 and Appendix 4 for details). Emotional difficulties items include “I feel lonely” and “I cry a lot”, behavioural difficulties items include “I lose my temper” and “I hit out when I am angry”. The measure shows good internal consistency ($\alpha = .79$) for behavioural and emotional scales.

2) School climate

All pupils were asked to complete a seven-item measure relating to school climate. Example items include “At this school we care about each other” and “We feel safe in school”. Responses options were “always”, “sometimes” and “never”. Internal consistency for this measure was good ($\alpha = .81$).

3) Pupil SDQ

Each pupil in the secondary school age group completed the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). This is a behavioural screening questionnaire for young people consisting of 25 items divided into five scales (emotional symptoms, conduct problems, peer problems, hyperactivity and pro-social behaviour). Example items include “I am often unhappy, down-hearted or tearful” and “I usually do as I am told”. Items are rated on a scale of 0 (not true) to 2 (certainly true). A ‘total difficulties’ score is calculated by summing four of the subscale scores (emotional symptoms, conduct problems, hyperactivity/inattention and peer relationship problems). Internal consistency for this measure was acceptable (α between .60 and .72 across subscales). This measure was used to validate the Me and My School Measure to allow development of appropriate clinical cut off points that could be used across both primary and secondary school and to provide parent and teacher measures that could be compared with pupil report.

4) Parent Questionnaire

The parent questionnaire was made up of two sections: the SDQ and questions about help sought by parents if they were concerned about their child having emotional or behavioural

difficulties. The parent version of the SDQ has items that correspond to those used in the child version and yields the same five subscales and total difficulties score. Example items include “often fights with other children or bullies them” and “easily distracted, concentration wanders”. As with the child version, items are rated on a scale of 0 (not true) to 2 (certainly true). The parent SDQ also contained an impact supplement, which aims to assess the extent to which the problems experienced affect home life, friendships, classroom learning, leisure activities and the family as a whole. For the parent SDQ scales, the internal consistency was good (α between .66 and .81 across subscales).

Additional help questions asked parents if they have ever been worried because their child seemed to be ‘unhappy’ or ‘disruptive’. If the response was ‘yes’ they were asked if they had sought help and from whom they sought support (a family member, friend, teacher, doctor and/or specialist). They were also asked to rate each source of support on how helpful they were.

5) Teacher Questionnaire

Teachers assessed the children’s emotional and behavioural adjustment for all pupils in their class using a simple measure rated 0-4 with which they rated each child as having no difficulties to severe difficulties.

In addition teachers were invited to complete the teacher version of the SDQ on four children each year. These four children were chosen in year 1 of each study (RCT and longitudinal) based on the following criteria:

1. selection of one child with emotional problems but not behavioural problems (as identified by the short measure of difficulties completed on the whole class)
2. selection of one child with behavioural problems but not emotional problems (as identified by the short measure of difficulties completed on the whole class)
3. selection of one child with emotional problems and behavioural problems (as identified by the short measure of difficulties completed on the whole class)
4. selection of one child with neither emotional problems nor behavioural problems (as identified by the short measure of difficulties completed on the whole class)

Where possible, these children were followed across different years of the study. Where the same children were no longer available in subsequent years, teachers were asked to complete SDQs on a new set of children, again based on the criteria above.

Similar to the child and parent SDQ, this questionnaire has 25 items, which generate five subscales: emotional symptoms, hyperactivity, conduct disorder, peer problems, and pro-social behaviour. Items are scored as being not true (0), somewhat true (1) and certainly true (2). The Teacher SDQ showed good internal consistency (α between .61 and .85 across subscales). The teacher SDQ was used to explore correlations between teacher report, parent report and pupil self-report

6) School Co-ordinator Questionnaire

Schools completed an online school level questionnaire regarding their current or proposed strategies within the school aimed at supporting pupils' mental health (see Appendix 3 for full questionnaire). The questionnaire was designed to elicit types of help and interventions used by the school for children with behavioural and emotional problems.

The online questionnaire was completed by a designated member of school staff, normally a head, SENCo or deputy head. Two vignettes were presented at the beginning of the questionnaire describing the characteristics of a child with behavioural difficulties (Child A) and another child with emotional difficulties (Child B). For each vignette there were items addressing how 'Child A' or 'Child B' would be helped and by whom within the school. There were also items relating to how the child's family would be helped and by whom. Each item was rated either "yes" (scored 1) or "no" (scored 0). In addition, there were several general questions pertaining to the use of the Common Assessment Framework (CAF) and local child mental health services.

In addition from 2009 onwards all schools were asked to categorise their main ways of working in terms of 13 categories of approach derived in 2008-9 and to report how the interventions were selected, the main target group and the level of training of the facilitators.

Examples of questions from the schools questionnaire include:

The person or people in our school(s) who help pupils with emotional and behavioural difficulties are in the main:

- *members of school staff with no specialist mental health training*
- *members of school staff with some specialist mental health training*

- *mental health specialists*

The ways of helping pupils with emotional and behavioural difficulties are in the main:

- *new and have not been tried before*
- *tried before locally and seem to help*
- *tried before nationally or internationally and found to help*

Analysis used

Analysis for the current report drew on a range of qualitative and quantitative data analytic techniques.

Qualitative analysis

The qualitative study was based on a framework approach (Ritchie & Spencer, 1993; Miles & Huberman, 1994) and was used to identify key learning to influence future policy development. This approach involves sifting and sorting the raw data into central issues and themes. These issues and themes are partly determined by the original research aims (and topic guides) but is also responsive to other emergent themes not defined at the outset (for full details see Ritchie & Spencer, 1993). Qualitative analysis was aided by the software programme NVivo.

Quantitative analysis

A range of statistical analyses were carried out to analyse the quantitative data, including simple group comparisons and correlations. However, the main longitudinal and RCT analyses were carried out using multilevel modelling (MLM).

What is multilevel modelling (MLM)?

Much of the data that are collected for social and psychological studies have multiple levels. For example, schools are made up of many children and each child can provide data on several separate occasions. This multilevel structure has an impact on how questionnaire responses relate to each other. For instance, children in one school are likely to have more similar responses to each other than they are to children in different schools. Likewise, one

child's responses to a questionnaire across a number of years are likely to be more similar to each other than they are to another child's scores on the same questionnaire. Multilevel modelling takes into account these similarities or clusters in the data, allowing us to model repeated data across time points within pupils and within schools.

MLM was carried out to estimate links between mental health outcomes and individual characteristics such as gender, ethnicity, socio-economic status and attainment, and school level variables such as interventions, school climate and use of the common assessment framework (CAF).

MLM was also used to investigate whether there were differences in children's mental health outcomes based on each condition of the RCT. The four RCT conditions that were explored were: 1) whether schools belonged to the TaMHS or no-TaMHS group 2) whether the LA received booklets or not 3) whether the LAs participated in Action Learning Sets or not and 4) whether schools were given evidence based self-help booklets or not. Latent trait scores (see Appendix 5 for details) were used as outcomes. Quantitative analyses were carried out in a range of software packages including SPSS, MPlus, MLWin and R.

Populations sampled

Quantitative populations

There were two distinct populations drawn on for the quantitative work (see Figure 3.1): those involved in the longitudinal study and those involved in the Randomised Controlled Trial (RCT).

Those involved in the longitudinal study were LAs, schools, teachers, children and parents belonging to the 25 LAs who began their TaMHS projects in 2008. Those involved in the RCT were LAs, schools, teachers, children and parents belonging to the 74 LAs who were randomly allocated to begin their TaMHS projects either in 2009 or in 2010, although one of these areas declined to participate, leaving 73.

The representativeness of these samples, and subsamples used for analysis in this report are discussed in Appendix 2.

Qualitative populations

There were three distinct aspects to the qualitative work carried out.

1. An exploratory study carried out in the first year of the longitudinal study involving policy advisors, TaMHS project leads, TaMHS staff, school staff and parents. Participation numbers are provided in Table 2.1.

Table 2.1: participation summary for the qualitative exploratory study

Participant Group	No. of interviews	School Type
Policy advisors	11	N/A
School staff	9	6 primary, 3 secondary
Parents	11	6 primary, 5 secondary
TaMHS staff (including project leads)	17 (learning sets)	N/A

2. A multi-site case study including interviews with TaMHS project leads, TaMHS staff and school staff. Participation numbers for this case study are provided in Table 2.2.

Table 2.2: participation summary for the multi-site case study

Participant Group	No. of Interviews	School Type
Project leads	4	N/A
School staff	5	2 short stay schools 3 special schools
TaMHS staff	1	N/A

3. In-depth case studies including interviews with project leads, school staff, TaMHS workers, voluntary agency workers, peer mentors, parents and focus groups with children. Participation numbers for these case studies are provided in Table 2.3.

Table 2.3: participation summary for the in-depth case studies

Participant Group	No. of interviews/ focus groups	School Type
Project leads	4	N/A
School staff	17	2 primary, 2 secondary
TaMHS workers	4	N/A
Voluntary agencies	6	N/A
Peer mentors	1	N/A
Parents	4	N/A
Children (class-based activities)	4 classes of children (12-24 children per class)	2 primary, 2 secondary

Challenges of the research

This evaluation was acknowledged as complex and ambitious from the outset and key challenges were identified which the researchers sought to address but limitations necessarily remained which are noted throughout.

Challenge of identifying what TaMHS was on the ground

Documenting this wide range of interventions being used on the ground both at LA and school level was recognised as a major challenge from the outset. LAs and schools had complete freedom to choose whatever approaches or interventions they judged best. Interventions or approaches tend to be developed and agreed by enthusiastic local groups or individuals and named accordingly. Even where a common terminology was used it was difficult to ascertain if it meant the same thing in different areas. Moreover, schools and LAs might choose to stress a range of activities that were planned but that might not actually occur in reality due to challenges in implementation or other factors. Finally, interventions tend to wax and wane with particular schools and authorities so that it is hard to track change over time.

The TaMHS project itself was very complex in nature and varied significantly from one school to the next in terms of the kinds of interventions employed, who was delivering mental health support, whether approaches were whole-school or focused on one to one or group work, what problems were being targeted and what age groups were being worked with. Because of this diversity, it was very hard to capture a) exactly what specific schools had on

offer to support mental health and b) exactly who was being worked with. Information about this was sought from school staff (in the case of what was offered) and children (in the case of who had received support) but given the complexity of each of these issues, it is possible that responses were not always accurate.

Challenge of detecting impact

It was recognised from the outset that detecting the impact of additional funding as part of one initiative might be difficult, given that so many other parallel activities were occurring within schools.

Moreover, in situations like TaMHS where an initiative is being trialled alongside a range of existing approaches, there may be issues with 'additionality' of what the new programme is providing. The risks are of 'deadweight', 'displacement' and 'substitution'. Deadweight involves using resources to promote activity that would in fact have occurred anyway. Displacement concerns the allocation of existing capacity to implement the new programme or initiative at the detriment of capacity elsewhere. Substitution occurs when an organisation replaces one activity for another similar activity to take advantage of government support (HM Treasury, 2003).

An additional issue that made evaluation of impact challenging was the short timescale between starting the project and evaluation. Existing literature suggests projects often need at around three years to start to be meaningfully implemented and for impacts to be seen (Groark & McCall, 2009).

CHAPTER 3: MENTAL HEALTH SUPPORT IN SCHOOLS- WHAT WAS PROVIDED?

Summary of findings

Mental health support

- The vast majority of schools from the longitudinal study (98%-100%) reported providing some form of mental health support for children with either emotional or behavioural problems across all years of the study.

Who provided the mental health support?

- In primary schools mental health support was generally reported to be provided by teachers, rather than mental health professionals, but schools reported increasing amount of specialist mental health provision from 2008 to 2009.
- In secondary schools the percentage of schools identifying mental health professionals as the key person to work with a child with behavioural problems was higher than for primary schools and also increased from 2008 to 2010.

What sort of mental health support was provided?

- Schools reported providing a very diverse range of approaches that often were locally defined and named.
- From this diversity, thirteen categories of mental health work in schools were identified: 1) Social and emotional development of pupils, 2) Creative and physical activity for pupils, 3) Information for pupils, 4) Peer support for pupils, 5) Behaviour for learning and structural support for pupils, 6) Individual therapy for pupils, 7) Group therapy for pupils, 8) Information for parents, 9) Training for parents, 10) Counselling for parents, 11) Consultation for staff, 12) Counselling for staff and 13) Training for staff.
- The most strongly endorsed category of work being done in both primary and secondary was work on promoting emotional skills and work on behaviour management in relation to behavioural difficulties. A substantial number of schools indicated they had individual therapy and peer support available, with smaller numbers reporting providing information to pupils. Relatively few schools indicated that they were doing extensive work with either parents or staff. There was little change from 2009 to 2010 in the numbers of schools indicating they were implementing the various types of support being offered.

Evidence based practice

- Both primary and secondary schools reported using approaches developed locally rather than those that had been internationally tested.
- No primary or secondary schools reported using approaches where they followed a rigorous protocol or manual.

Inter-agency working

- Schools indicated high use of educational psychology and other school based resources for troubled pupils rather than direct referral to specialist CAMHS.
- Use of the CAF increased over time in both primary and secondary schools.
- In terms of reported relations with specialist CAMHS these were generally rated as relatively poor and limited at the start of the evaluation (2008) but improved over time.

Key background information³

In the UK over recent years there had been an increasing range of school-based interventions to improve mental health. The types of interventions selected, the ways these are implemented and by who varied widely from school to school. There was no clear typology of school-based interventions in the UK. There was, however, literature about 'under what circumstances' school-based mental health interventions are most effective. Literature reviews highlighted 'necessary conditions' for successful outcomes involving: programme design (e.g., clarity of rationale, promotion of effective teaching strategies); programme co-ordination (e.g., school-wide co-ordination; partnerships with families and wider community, sense of common purpose); educator preparation and support (e.g., formal staff training); and programme evaluation (e.g., data collection relating to implementation and impact) (Kam et al, 2003).

Furthermore, successful mental health promotion programmes have been found to be underpinned by a school environment that fosters warm relationships, encourages participation, develops teacher and pupil autonomy, and promotes clarity about boundaries, rules and expectations (Weare & Gray, 2003; OFSTED, 2005). Difficulties encountered in implementation include the perpetuation of a narrow and decontextualised 'programmes and packages perspective', poor management of resources (e.g., time, staff), and insufficient

³ For literature and further details refer to Chapter 1

attention to the qualities of staff carrying out different aspects of implementation and intervention (Elias et al, 2003).

Research suggested that there remained much room for improvement in schools and allied staff's ability to recognise and respond to social, emotional and psychological difficulties in pupils (NICE, 2004; Weist et al, 2007). A key issue suggested was the lack of understanding and common language across mental health and education services – barriers that could prevent effective, integrated service provision. This could be particularly challenging where schools often have a long history of poor experiences when dealing with services like CAMHS citing slow response times and poor communication which may make them sceptical of working together (Ford & Nikapota, 2000; Attride-Stirling et al, 2001). Whilst attempts had been made in LAs to improve joint-working, such as the development of a joint forum between schools and specialist CAMHS to discuss and assess complex cases (William et al, 1999), these were often not well integrated nor nationally available (Pettit, 2003).

However, where effective multi-agency collaboration had been instituted schools had been able to create effective and sustainable programmes (Meyers & Swerdlik, 2003). In particular, feedback from specialist staff to teachers had been found to enhance teachers' implementation skills and promotion of intervention programs (Corboy & McDonald, 2007). It had also been found that positive school climate (strong leadership, positive school commitment) played a role in effective implementation of mental health programmes in schools (Corboy & McDonald, 2007; Larsen & Samdal, 2008).

Evaluation methodology relevant to this chapter

Findings presented in this chapter draw on quantitative data provided by schools in each year of the longitudinal study (for details of the school coordinator questions see description in Chapter 2).

Sample

41 primary schools and 13 secondary schools that had completed the school co-ordinator survey in all three years were used for all the school level year-on-year comparisons and analyses in this chapter. Because the sample for this survey is small, all findings are presented based on numbers responding rather than percentages.

The questionnaire was generally completed by Special Educational Needs Co-ordinators (SENCOs: 37-48%) along with head teachers and teachers (19-33%) who generally rated themselves as sure or very sure in their answers (80-87% in primary; 90-100% in secondary across years).

Information on the representativeness of this sample can be found in Appendix 2 and tables supporting all figures presented in this chapter can be found in Appendix 6.

Findings

Mental Health support in schools

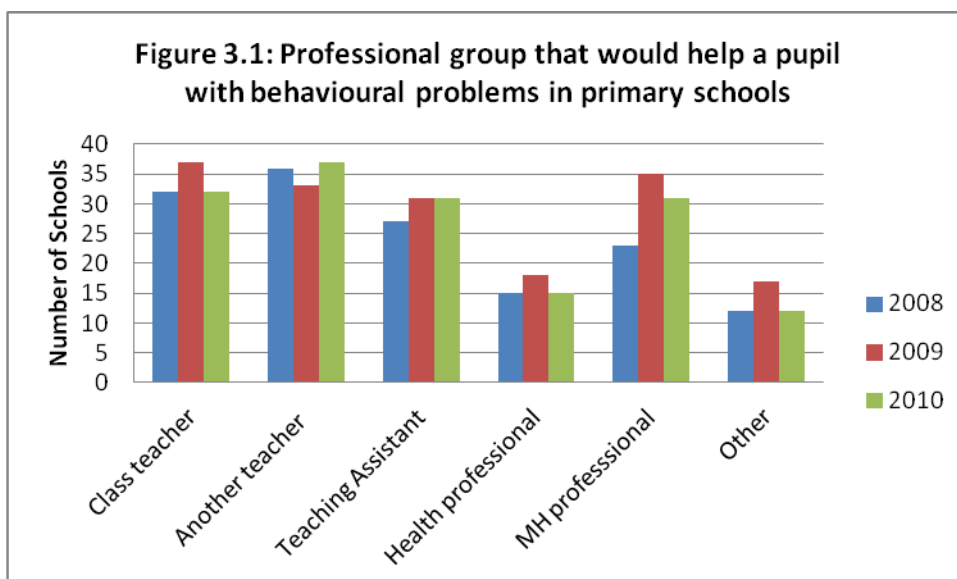
As part of the school co-ordinator survey, two vignettes were presented describing the characteristics of a child with behavioural difficulties (Child A) and another child with emotional difficulties (Child B). For each vignette there were 13 items addressing how 'Child A' or 'Child B' would be helped and by who within the school. There were also items relating to how the child's family would be helped and by whom (see Appendix 3 for the full questionnaire).

Based on these vignettes presented to schools, the vast majority of primary and secondary schools indicated that they would provide mental health support to both the child with emotional and the child with behavioural problems as described in the questionnaires (98-100% primary schools and 100% of secondary schools).

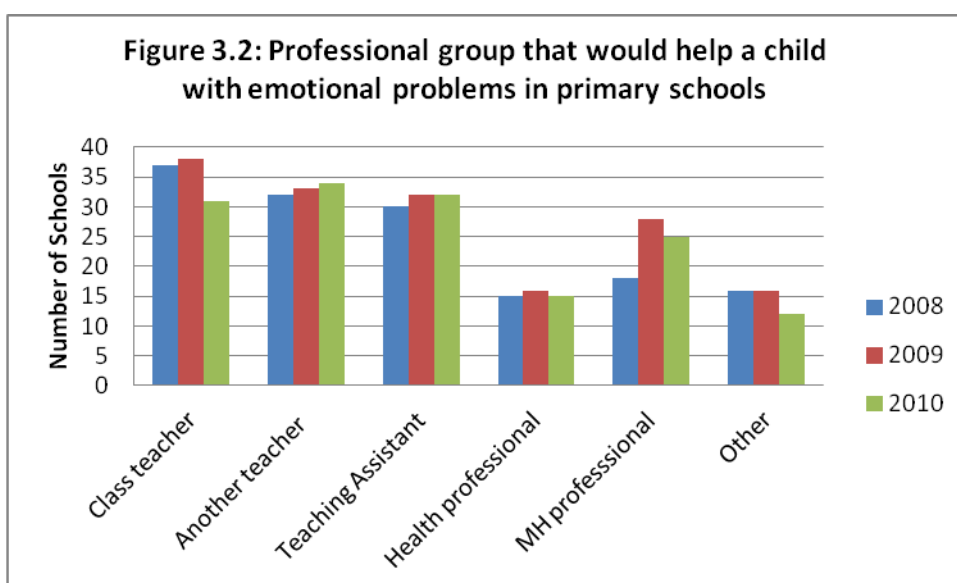
Who provided this support?

Schools were asked about who would be delivering support to children with behavioural or emotional difficulties (based on the vignettes). Response options included teachers, teaching assistants, and health and mental health professionals⁴. A range of 'other' professional groups were also suggested, examples of professionals falling into this category include family support workers and learning mentors. In primary schools the most likely person to help a child with behavioural problems was a teacher with increasing numbers of schools indicating mental health professional input between 2008 and 2009 (see Figure 3.1).

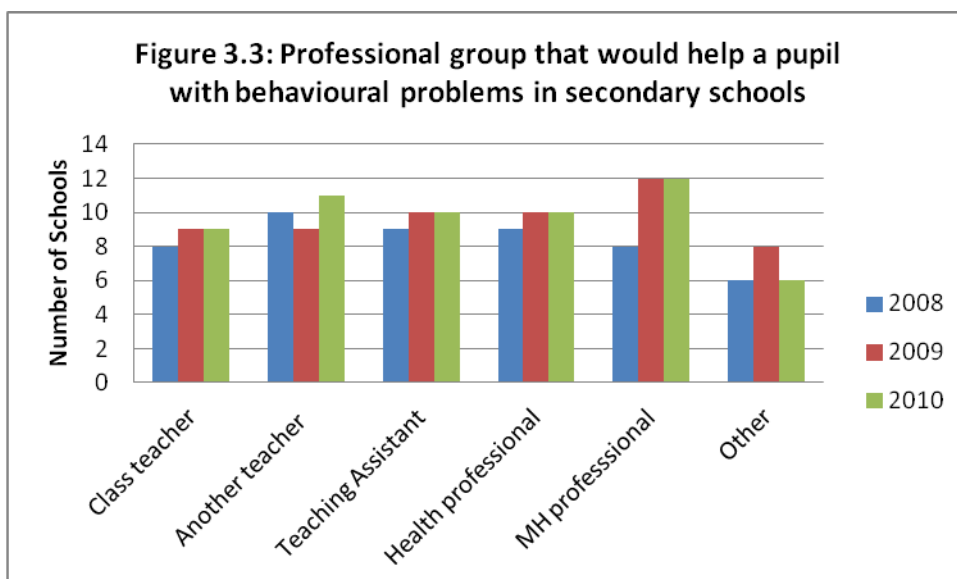
⁴ NB respondents could select more than one option



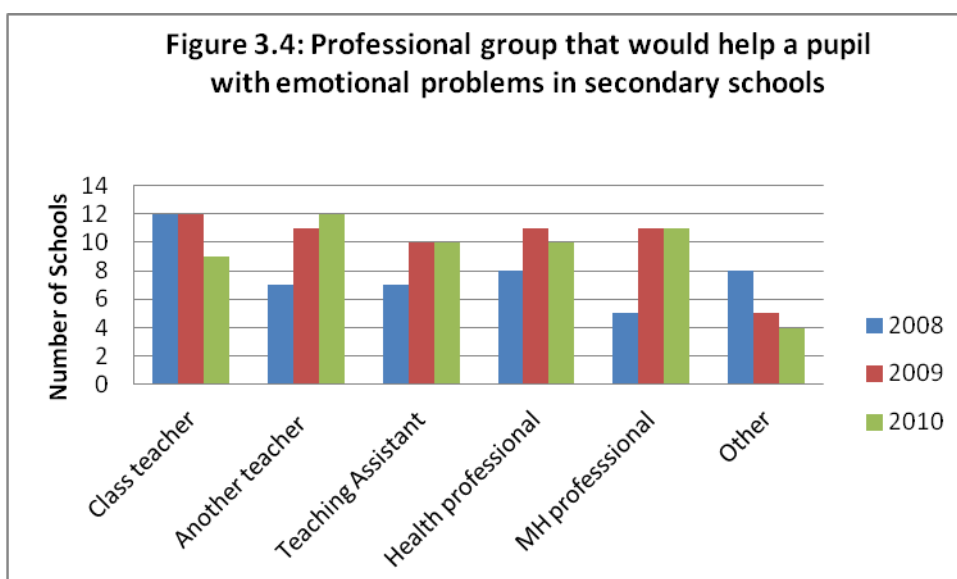
For emotional problems the pattern was similar but with fewer primary schools indicating specialist mental health input (see Figure 3.2).



In secondary schools the proportion of schools identifying mental health professionals as the key person to work with a child with behaviour problems was higher than for primary schools and the proportion indicating teacher led help was smaller (see Figure 3.3). Again there was an increase in the number of schools indicating use of mental health specialist provision over time.



For emotional problems more secondary schools indicated teacher led help than for behavioural problems but again there were increasing numbers of schools indicating mental health professional input across time (see Figure 3.4). In fact across primary and secondary schools for emotional and behavioural difficulties there was an increase in use of mental health professionals from 2008 to 2009, which may have corresponded with the introduction of TaMHS workers to some schools. There was no further increase observed in use of mental health professionals, and in some cases a slight reduction, from 2009 to 2010. One possible explanation of this is that areas had limited resources towards the end of the project.



The fact that these results suggest more specialist mental health provision is available in secondary schools is perhaps no surprise given their larger size and resources. However, it does highlight the emphasis being placed in schools on teacher-provided mental health

support particularly in primary school, but also in secondary schools for pupils with emotional problems.

The finding that in both primary and secondary schools the child with behavioural problems was more likely to be offered specialist mental health input in contrast to the pupil with emotional problems is in line with the literature which identifies the increased emphasis and focus of schools on behaviour difficulties, and may suggest the need to ensure that those pupils with emotional difficulties who are not presenting behavioural problems for schools also receive specialist help when required.

However it should be noted that the relative advantages of teacher led or specialist led interventions are not entirely clear. A meta analyses of school based social and emotional learning interventions found that teacher led interventions were more successful than multi-component interventions (school staff and outside specialists) and the authors hypothesize that this may be due to the fact that multi-component programs have more implementation problems (Durlak et al, 2011).

What sort of mental health support was provided?

Schools reported a wide variety of interventions and types of support. These were often locally named and locally defined. A published list of all the different types of intervention reported as offered across all participating areas in TaMHS runs to over 500 different named interventions (NCSS, 2010). Appendix 7 lists the range of interventions reported across the four case study schools explored as part of the evaluation, this alone runs to 46 different interventions.

Using qualitative data from iterative discussion in 2008-9 with TaMHS and school staff in LAs, 13 categories of school-based mental health support for pupils, families and school staff, were derived. These are outlined in table 3.1 along with examples of the sort of work encompassed in each category.

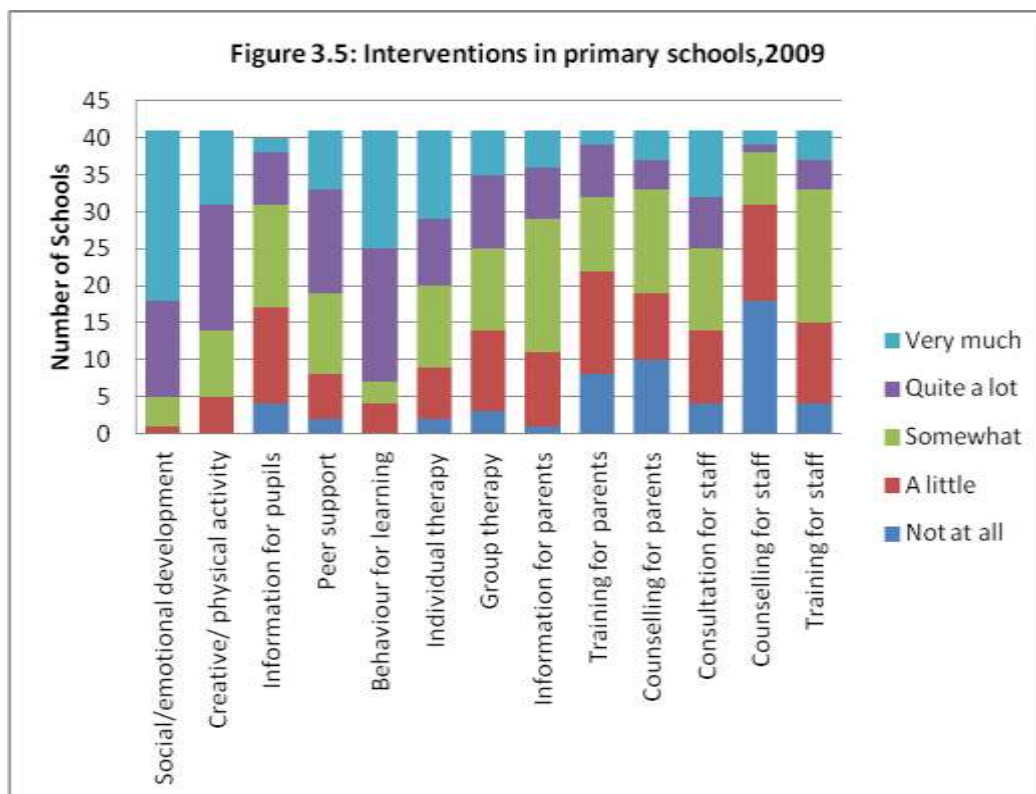
Table 3.1: Descriptions of the 13 categories of school based mental health support for pupils, staff and parents.

Category	Description	Types of work included
1. Social and emotional skills development of pupils	Focuses on developing skills and emotional health in children building on whole school or group approaches as a way to ensure the needs of those with specific difficulties were also met.	Social and Emotional Aspects of Learning (SEAL) programmes, Nurture groups and Circle time
2. Creative and physical activity for pupils	Activities that focused on physical and creative activities designed to build up skills and emotional health again with the view that these would help those children with emotional and behavioural difficulties.	drama, music, art, yoga, outward bound activities
3. Information for pupils	Materials and processes for providing information for children to help them access appropriate sources of support.	advice lines, leaflets, texting services, internet based information
4. Peer support for pupils	Schemes to allow pupils to help each other and support those in particular with emotional and behavioural difficulties.	buddy schemes, peer mentoring
5. Behaviour for learning and structural support for pupils	This category included processes and structures put in place by the school to modify pupil behaviour in such a way to reduce behavioural problem and increase emotional health.	behaviour support, behaviour management, celebrating success, lunchtime clubs, calm rooms
6. Individual therapy for pupils	This category consisted of the range of therapeutic interventions being offered to individual children with emotional or behavioural difficulties.	counselling, cognitive and/or behavioural therapy, psychotherapy
7. Group therapy for pupils	This category comprised the range of therapeutic interventions being offered to groups of children with emotional or behavioural difficulties.	interpersonal group therapy, cognitive and/or behavioural therapy groups
8. Information for parents	This category covered a range of materials and processes for providing information for parents to help them access appropriate sources of support.	leaflets, advice lines, texting services, internet based information
9. Training for parents	This category covered a range of programmes offering training to parents.	parenting programmes such as Webster Stratton and Triple P programmes
10. Counselling/support for parents	This category covered a range of programmes offering support to parents.	individual work for parents, family therapy, family SEAL – can include children and parents or just parents, or a combination
11. Training for staff	This category covered a range of approaches to training staff.	specific training from a mental health professional
12. Supervision and consultation for staff	This category covered a range of approaches to providing consultation or supervision of staff in relation to working with children with emotional or behavioural difficulties.	on-going supervision or advice from a mental health professional
13. Counselling/support for staff	This category covered a range of approaches to providing support for staff in relation to working with children with emotional or behavioural difficulties.	provision to help staff deal with stress and any emotional difficulties

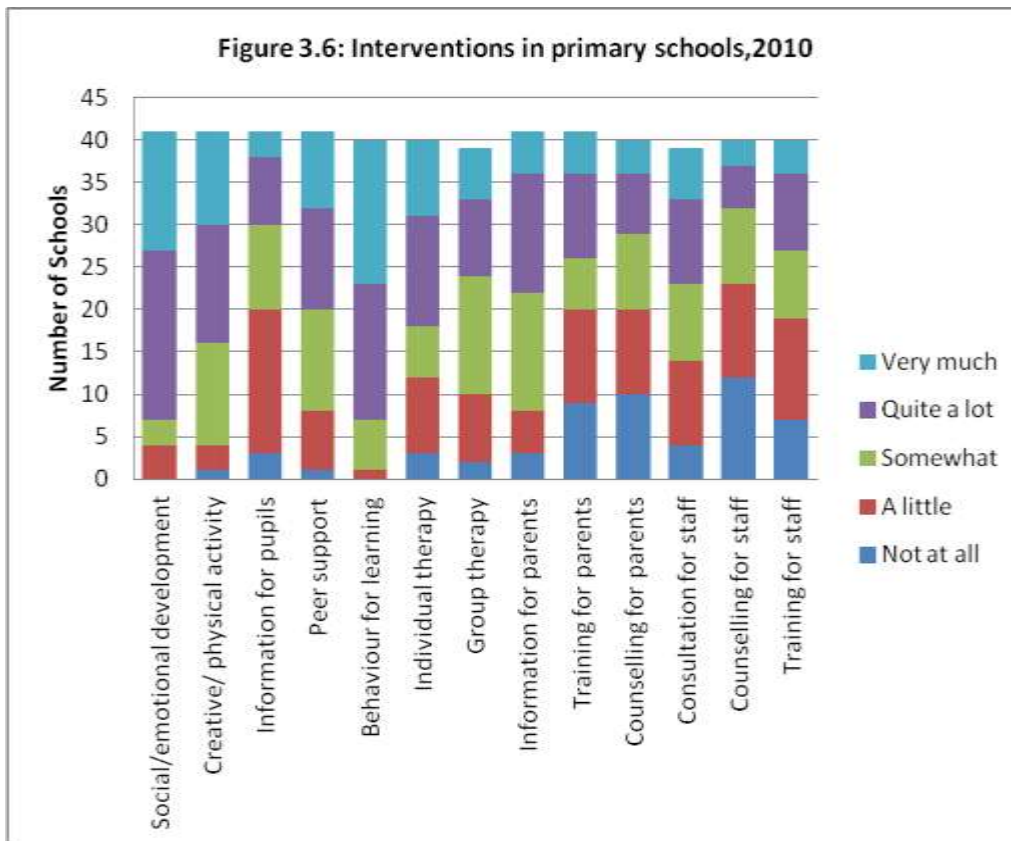
These 13 categories were used to capture the range of mental health provision in schools in 2009 and 2010. These were rated by schools on a 0-5 scale, defined as: 0=not available; 1=not at all; 2=a little; 3=somewhat; 4=quite a lot; 5=very much.

The types of interventions used and the extent of their application across 2009-10 and primary and secondary schools, are presented in Figures 3.5-3.9 below.

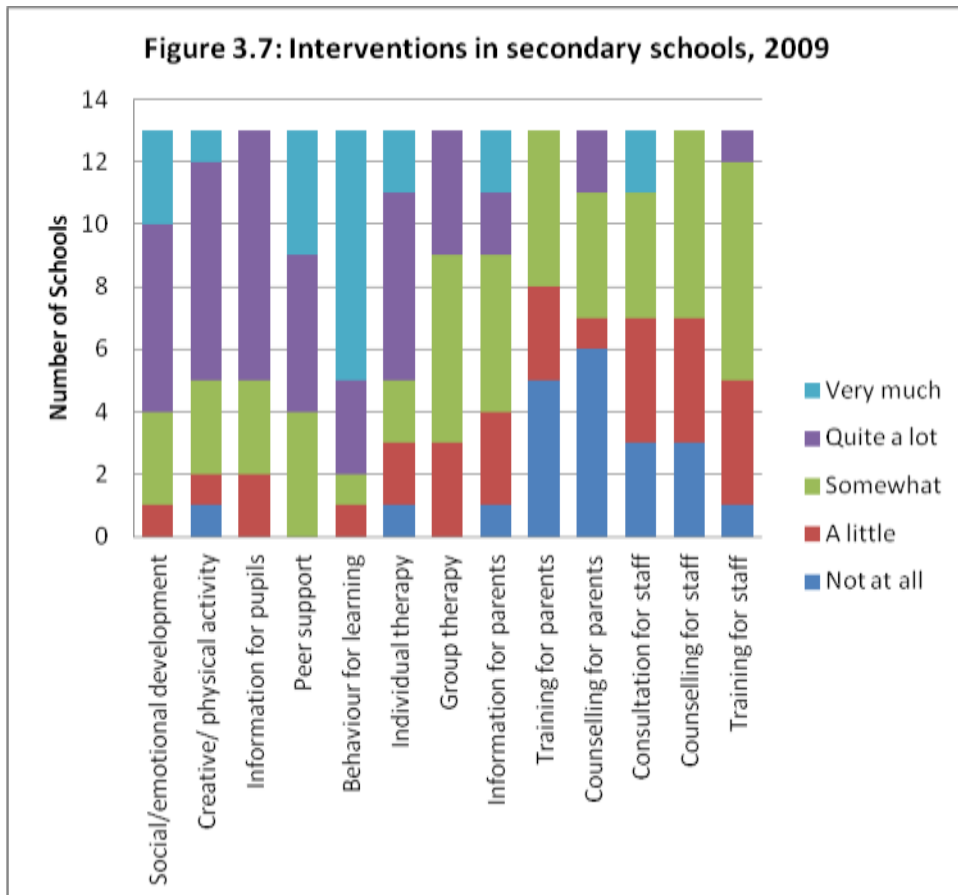
In primary schools in 2009 the most common approach used to a great extent was social and emotional developmental facilitation, which is not surprising given that it was a requirement for involvement in the project that schools must be already providing some work in this area. After that the most commonly highly endorsed area of working was behaviour for learning followed by individual therapy, creative interventions and peer support (see Figure 3.5 below).



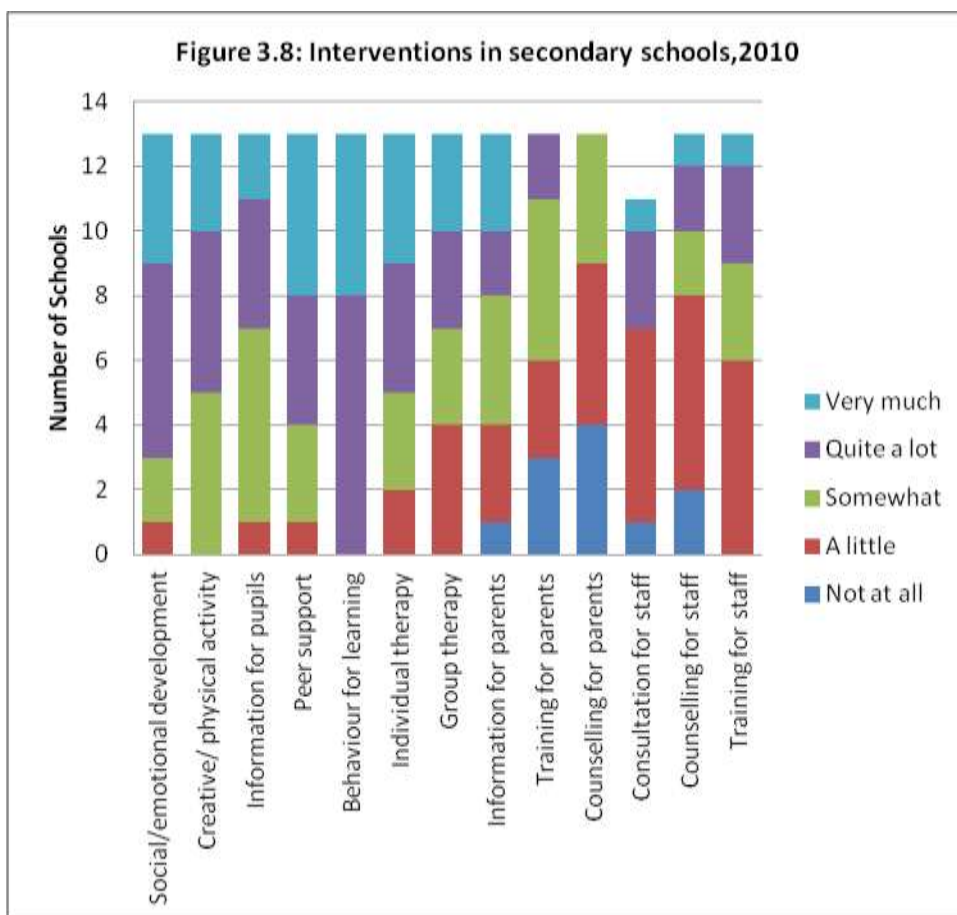
In 2010 the pattern of categories of mental health support in primary schools is broadly similar (see Figure 3.6 below).



In the sample of 13 secondary schools in 2009, the most common category of mental health support in 2009 was behaviour for learning with peer support and individual therapy following on (see Figure 3.7).



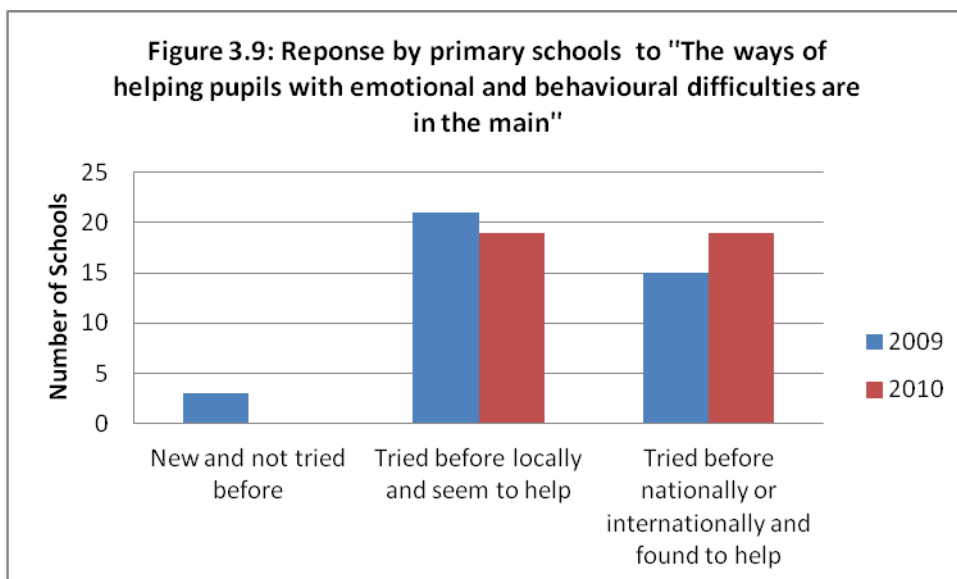
In 2010 the pattern of support available in secondary schools was similar (see Figure 3.8), though there did seem to be a slight drop off in staff focused mental health support such as training.



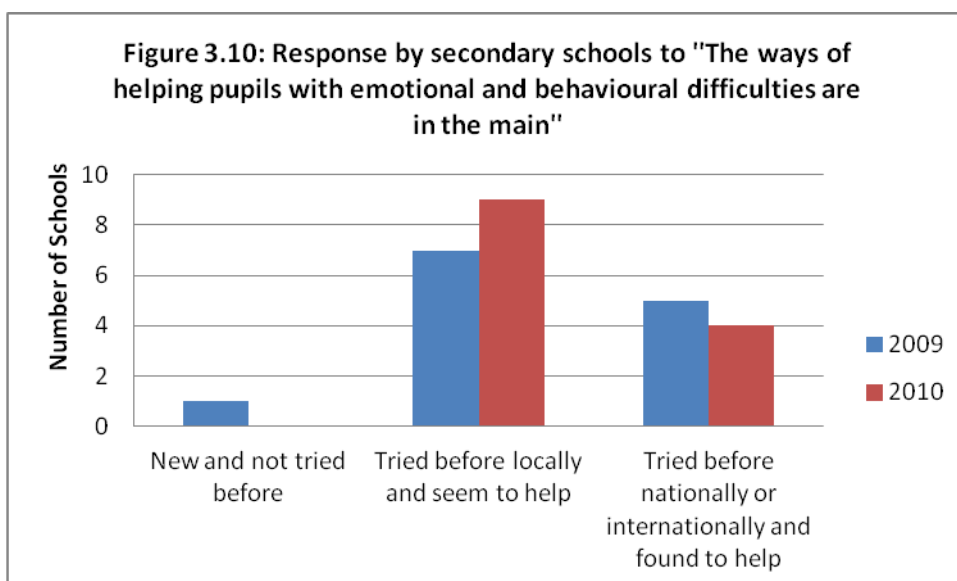
Across primary and secondary schools, the least common activities were training and counselling for parents and staff. The most common activities were social and emotional learning and behaviour for learning. However, there were some distinctions between primary and secondary schools' provision. Peer support was more common in secondary schools, as was information for pupils.

Extent of evidence based practices

Responses indicated that primary schools favoured approaches that drew on local evidence and were open to adaptation (see Figure 3.9). However, there was an increase in the number of schools who indicated they were using an approach that drew on a national or international evidence base in 2010, but small numbers mean this may just be variation in reporting.

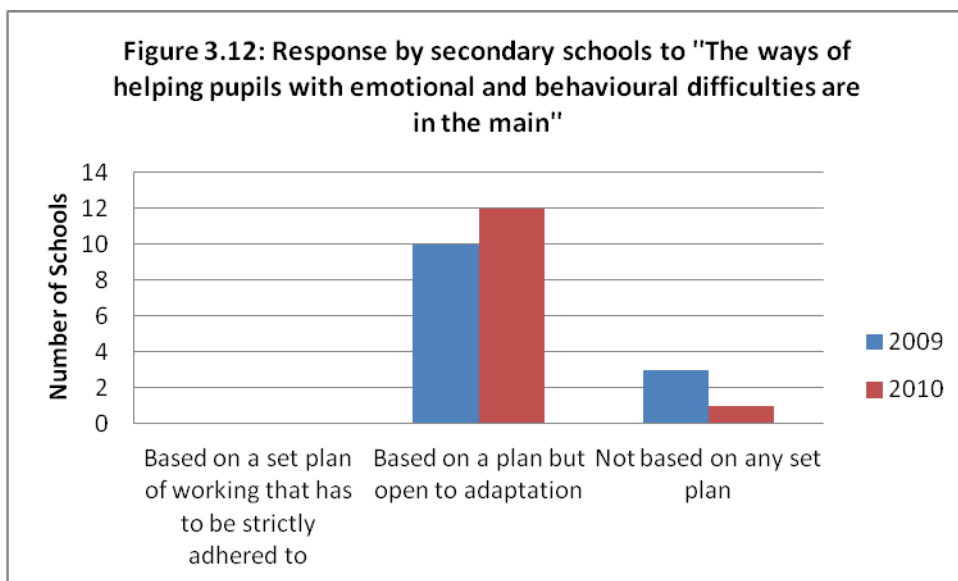
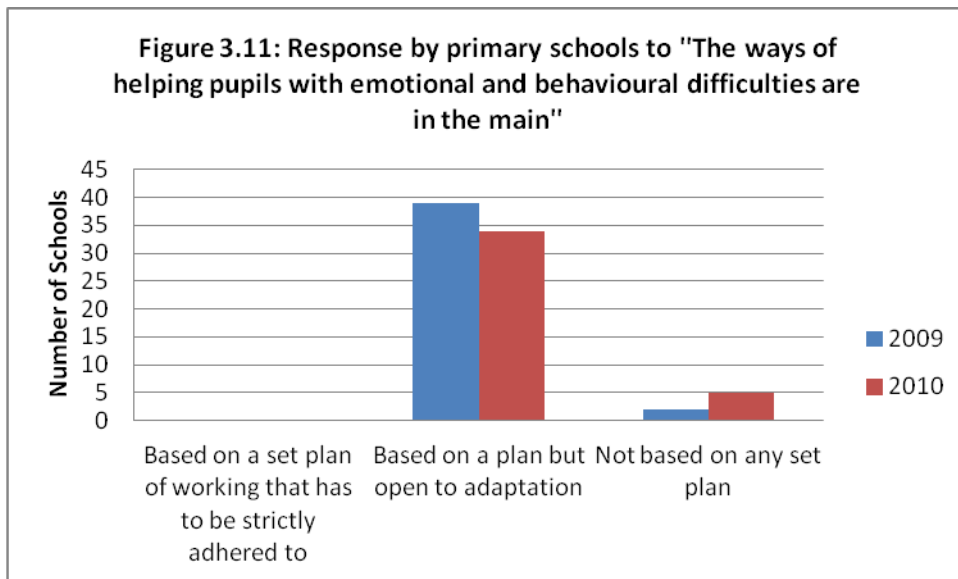


In secondary schools the pattern was very similar to that for primary schools with few schools reporting complete innovation but focussing on locally trialled methods with a slight decrease in internationally tested approaches over the year, but again the small numbers mean this may be just reporting variance (see Figure 3.10).



A striking feature was how few schools either primary or secondary indicated they used approaches based on a set plan of working (such as a manualised approach) that involved strict adherence to instructions and protocols (see figures 3.11 and 3.12). No primary or secondary schools in 2009 or 2010 indicated that they had taken this approach, though the vast majority did indicate they were using some plan but one that was open to adaptation (see Figures 3.11 and 3.12). This finding has implications for areas use of evidence based practice also because many of the interventions recommended by the series of NICE guidelines (Adi et al, 2007a, b; Shucksmith et al, 2007) involve evidence based approaches

that require strict adherence to protocols and manual in delivery; adaptation on the ground potentially means that these interventions no longer represent what was recommended.



When asked about what sort of staff were the main providers of mental health support in schools⁵, the school responses indicated that the main providers were school staff rather than mental health specialists (see figures 3.13 & 3.14). Their responses indicated that as time progressed, use of school staff with no specialist training to deliver support became less frequent and use of school staff who had specialist training became more prevalent in both primary schools and secondary schools. It is possible that this reflects mental health training that was rolled out to many school staff as part of local TaMHS projects.

⁵Previous questions about staff providing mental health support relating specifically to the vignettes described previously. The question described here asked about provision more generally.

Figure 3.13: Response by primary schools to "The person or people in our school who help pupils with emotional and behavioural difficulties are in the main"

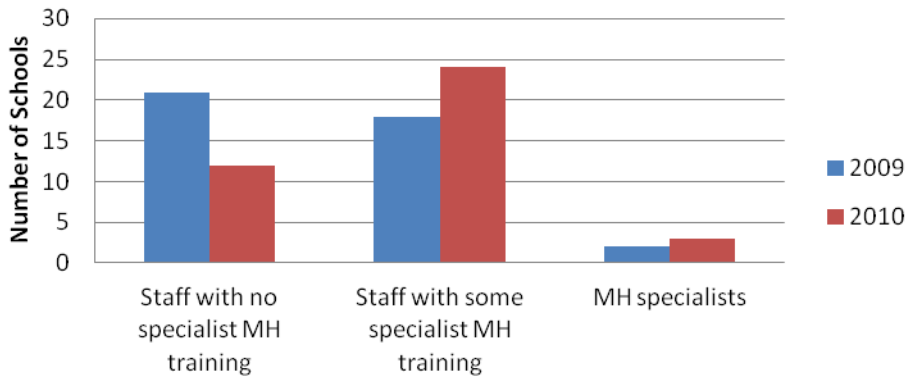
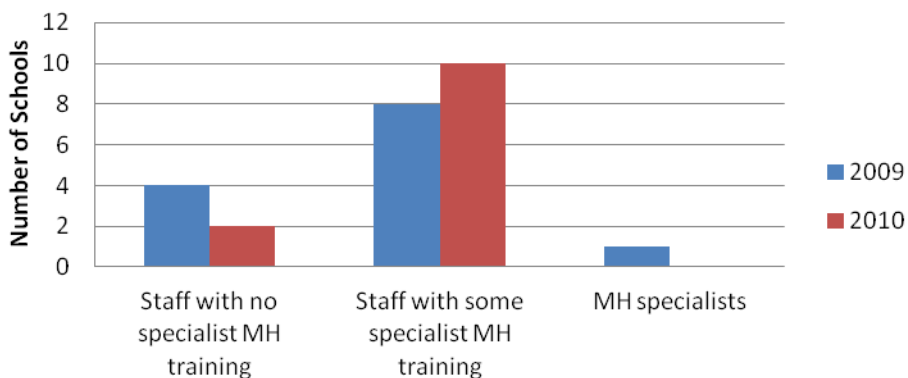
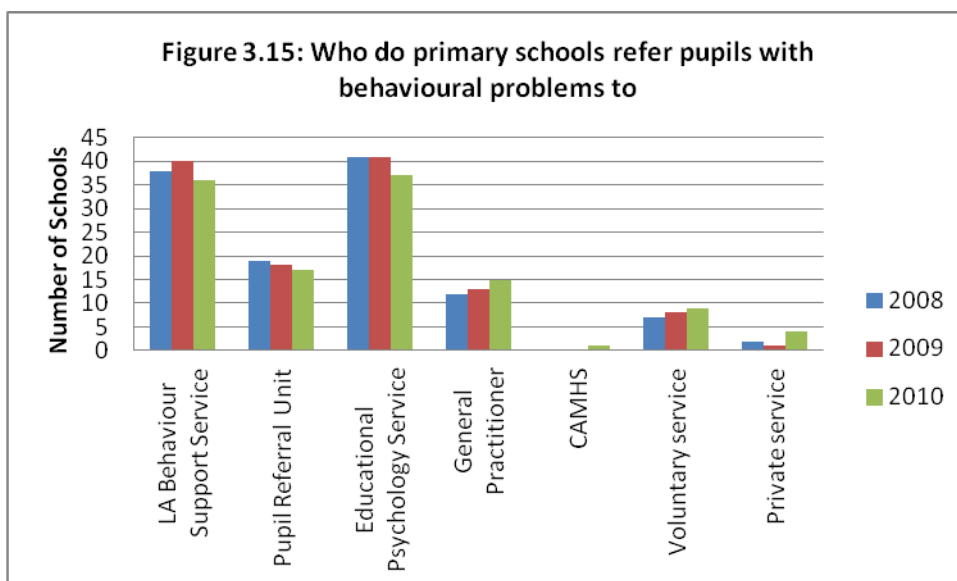


Figure 3.14: Response by secondary schools to "The person or people in our school who help pupils with emotional and behavioural difficulties are in the main"

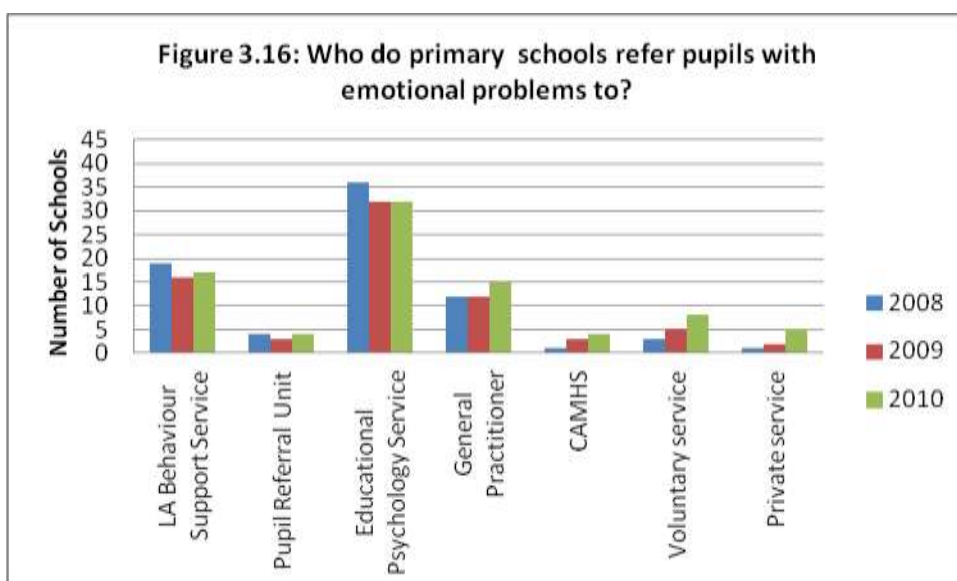


Extent of inter-agency working

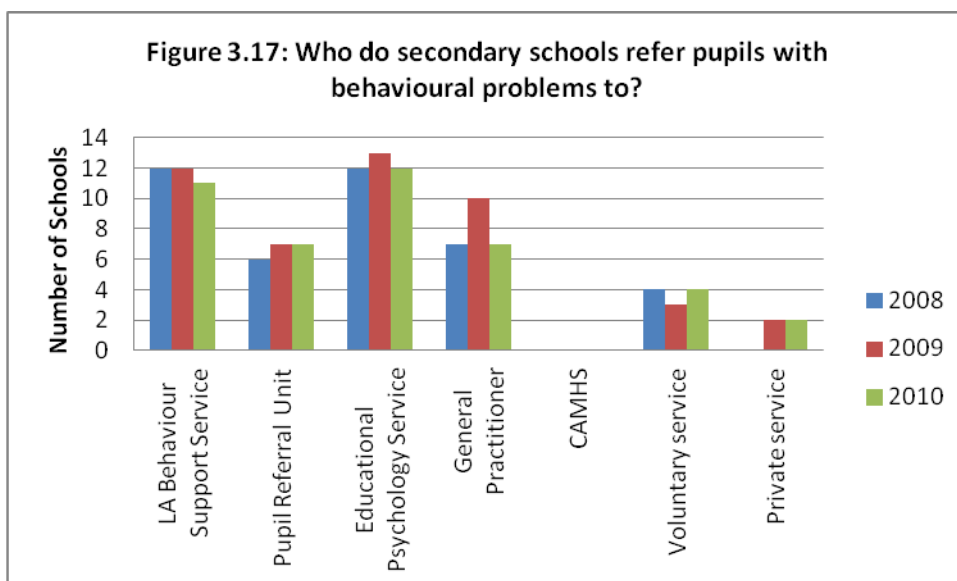
In terms of who schools refer pupils with behavioural difficulties to, primary schools' main point of specialist input appeared to be educational psychology or LA behavioural support teams for pupils with behavioural problems. Only 1 of the 41 schools reported referring to specialist CAMHS in 2010 (see Figure 3.15 below).



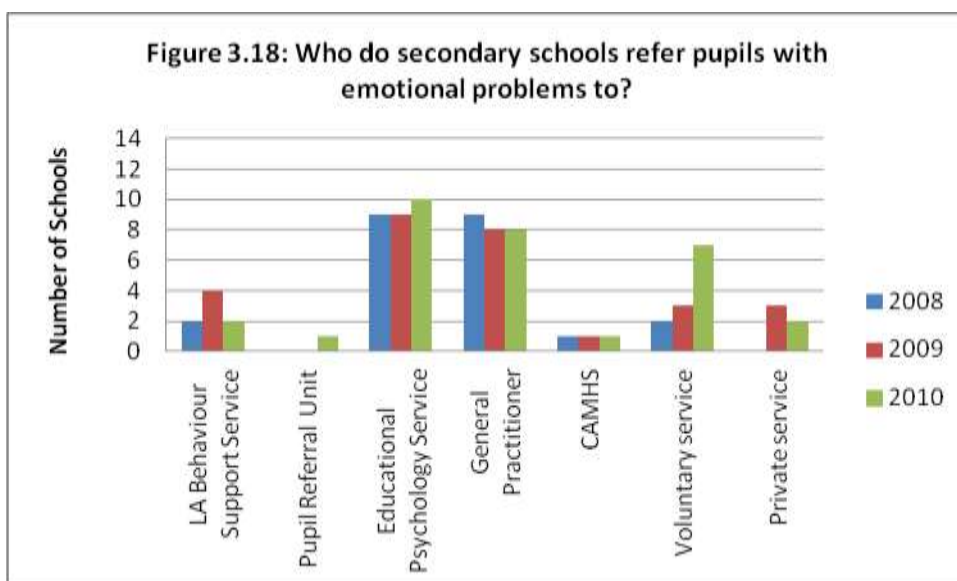
For pupils with emotional difficulties in primary schools, educational psychologists were the most referred to group, with some small increase in the number of schools reporting referral to specialist CAMHS, voluntary sector and private sector provision over the three years (see Figure 3.16).



In secondary schools there was a very similar pattern for pupils with behaviour problems as for primary schools, with educational psychology or LA behavioural support teams being the main point of referral (see Figure 3.17).



In terms of referral of pupils with emotional problems, educational psychologists were the most referred to group, but General Practitioners (GPs) were also frequently referred to (see Figure 3.18).

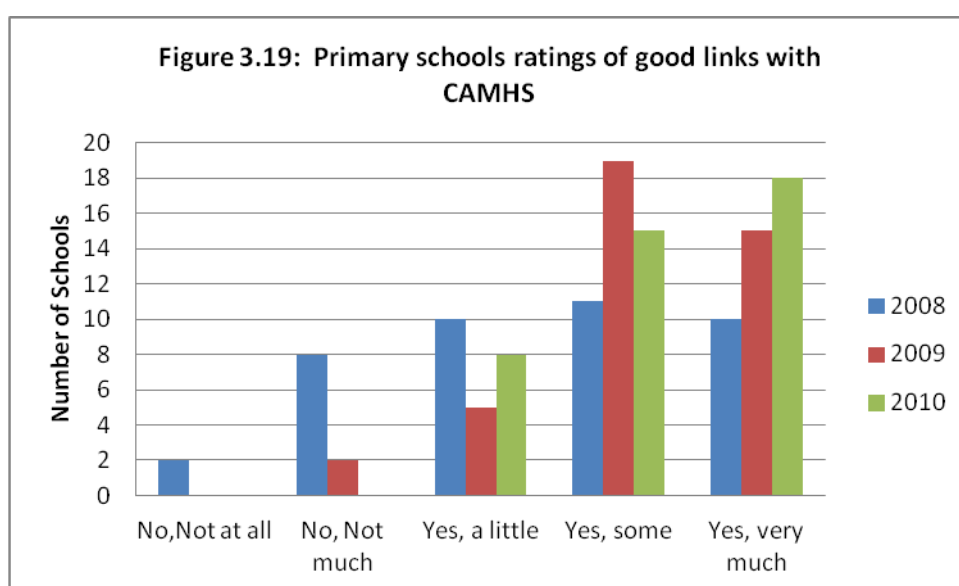


The overall pattern across primary and secondary schools highlights the potential importance of educational psychologists as part of the care pathway for pupils with both emotional and behavioural problems. The lack of direct referral to specialist CAMHS may also reflect local referral protocols which mean children are only able to be referred via a GP or educational psychologist. It is also apparent that, perhaps with the exception of the voluntary sector, there appears to have been very little change in the referral routes for children with emotional or behavioural difficulties across years of the project.

Links with specialist CAMHS

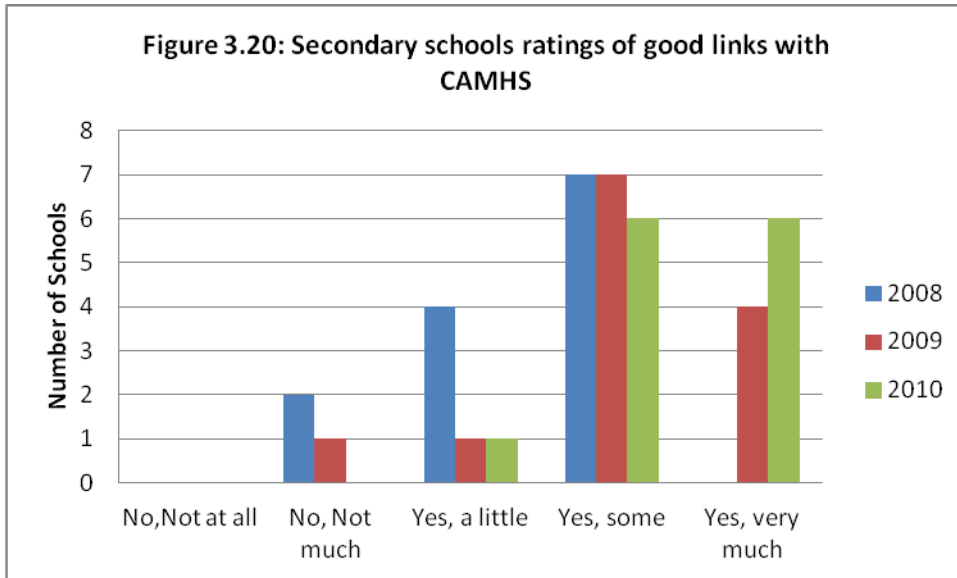
Interestingly although the schools reported very little direct referral to CAMHS across the three years of the study, they did report increased positive links with CAMHS during this period. This was true of both primary and secondary schools.

Primary schools reported limited links with specialist CAMHS at the outset in 2008, with approximately 25% of schools rating good links with CAMHS as not much or not at all, by 2010 this had fallen to 0%. On the other hand, in 2008 around 50% of schools reported some or very good links with specialist CAMHS but by 2010 this had risen to 80%. It is possible that this improvement is associated with attempts of local TaMHS projects to improve inter-agency working.



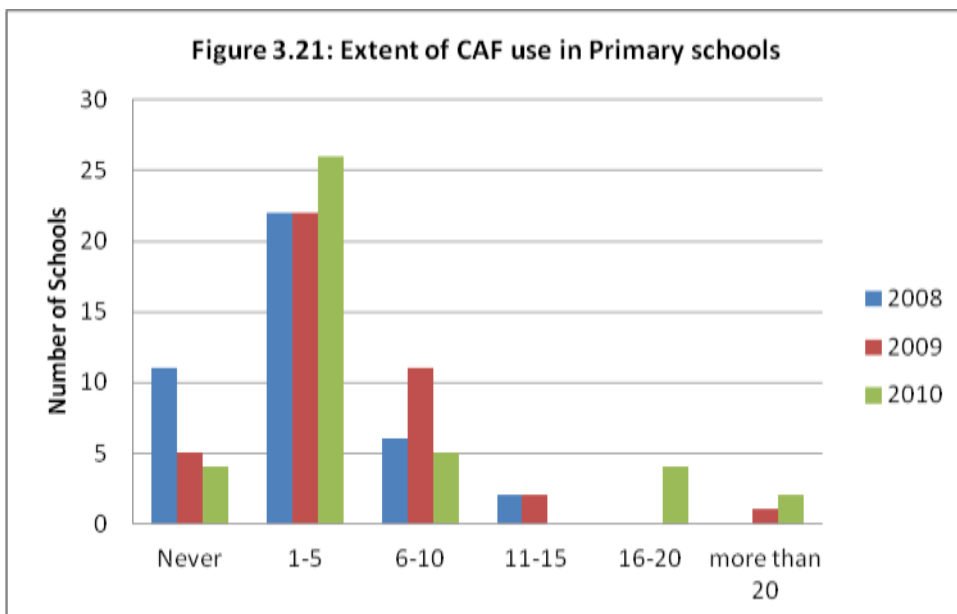
In terms of secondary schools (Figure 3.20) the pattern was similar with increased numbers of schools reporting more extensive links with specialist CAMHS over the course of the study.

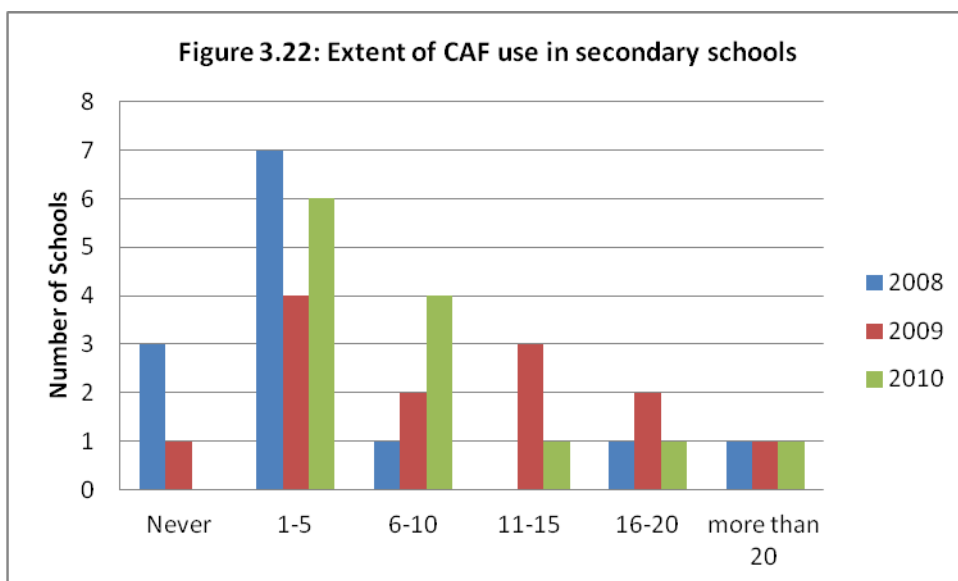
It is interesting to contrast these results about rating of links with CAMHS with the previous figures on referrals (3.15 to 3.18). It appears that while schools do not appear to be making many direct referrals to CAMHS they still rate their relationships with CAMHS as getting better over this period of time. One possible explanation is that schools are consulting and liaising with CAMHS but not referring children to them. Anecdotal examples of this kind of model in local TaMHS projects include a CAMHS consultation group set up in one LA for schools to consult and a designated phone line for schools to ring CAMHS for advice in another area.



Use of the Common Assessment Framework (CAF)

The CAF is a mechanism designed to allow schools and other agencies to coordinate their efforts in supporting children with particular needs. There was an overall increase in the number schools indicating they were completing at least some CAFs over the years of the study for both primary and secondary schools (see figures 3.21 and 3.22) and a drop in the number of schools who said they never used the CAF in the year leading up to the survey from 2008 to 2010. With the exception of a few primary schools, no schools appeared to be completing excessive numbers of CAFs.





Conclusions

It would appear that schools are providing a range of support for pupils and findings were quite consistent across primary and secondary schools. Most of this support is focussed on social development and behavioural management. Generally schools are using locally developed programmes and not adhering to strict programmes of work. Mental Health support in schools is mainly provided by school staff, increasingly with some training. Pupils with behavioural problems may be more likely to access specialist, mental health input than those with emotional problems. Educational psychologists may be a crucial point of contact in schools for specialist input for both emotional and behavioural problems. Schools are increasingly using the CAF as a way of coordinating across agencies.

Issues for further consideration

1. Schools should be encouraged to consider adhering more closely to manuals and protocols for evidence based interventions as these have been found in the literature to have the greatest impact, though this needs to be combined with need for local ownership to aid uptake.
2. Educational psychologists may be a key group to work with in relation to mental health provision in schools and their potential role in aiding links between schools and specialist CAMHS could be important.

CHAPTER 4: TAMHS WORKER, SCHOOL STAFF, PARENT AND PUPIL EXPERIENCE OF TAMHS

Summary of findings

TaMHS workers views:

- A key challenge identified was addressing differences in philosophy and working practice between agencies, and finding a common language between schools and CAMHS.
- Key facilitators included integration in schools and being sensitive to the existing context.

Staff views:

- School staff were generally enthusiastic about TaMHS and identified examples of positive change which they ascribed to the project.
- Key facilitators included having specialist mental health worker based in school.
- One key challenge identified was avoiding closing down or taking resources away from good projects to implement TaMHS.

Parent views:

- Parents identified schools as the key point of contact for concerns about mental health issues and identified teachers as the key group they turned to if worried about their child's mental health, and as the group that provided most help 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.

Pupil views:

- Pupils showed an awareness of a range of approaches available in their schools and an appreciation of the ways they could help. They regarded helpful conversations as key to this.
- Pupils indicated they had access to mental health support in schools and those with more difficulties had accessed more help.
- Pupils were positive about evidence based self-help mental health booklets received as part of support materials trialled as part of the RCT.

Key background information⁶

The school context can be viewed as an opportune context for interventions aimed at children for a number of reasons. Firstly, teachers and schools are often the first outside the family to identify children's problems and many parents depend on their guidance for help-seeking. In particular, there is evidence that more disadvantaged children and those who do not traditionally access specialist services may find help in schools more acceptable (Armbuster et al, 1997; Weist et al, 1999). Secondly, many schools acknowledge the importance of the link between emotional wellbeing and academic achievement, and as such are supportive of strategies to improve mental health in schools. Finally, using schools as a conduit for Tier 1 (low intensity) mental health support possibly avoids the danger of 'pathologising' everyday problems that children experience.

However, previous research has highlighted a number of issues in relation to the implementation of programmes such as TaMHS. In particular, difficulties occur where programmes are not sensitive to the context in which they are implemented, show poor management of resources and reflect a poor fit of staff qualities to delivery of the intervention. A meta analyses of school based social and emotional learning interventions suggests that interventions that were more focussed, sequenced, did not involve multiple components and were explicit in terms of aims and implementation had better outcomes (Durlak et al, 2011).

Furthermore, in situations where an initiative is being trialled alongside a range of existing approaches, there may be issues with 'additionality' of what the new programme is providing. The risks are of 'deadweight', 'displacement' and 'substitution'. Deadweight

⁶ For further literature refer to Chapter 1

involves using resources to promote activity that would in fact have occurred anyway. Displacement concerns the allocation of existing capacity to implement the new programme or initiative at the detriment of capacity elsewhere. Substitution occurs when an organisation replaces one activity with another similar activity to take advantage of government support (HM Treasury, 2003).

Care must be taken, therefore, to ensure that programmes that are introduced a) are sensitive to context and b) integrate well with existing provision, ensuring that what has already been put in place is not adversely affected.

Evaluation methodology relevant to this chapter

Quantitative information presented in this chapter is drawn from:

- Parent responses in the longitudinal study in 2008 (see Appendix 8 for details),
- Pupil responses in the RCT in 2010 (see Appendix 8),
- Qualitative responses in the longitudinal study in 2010 (see Chapter 2 for description and samples).

Representativeness for these samples can be found in Appendix 2.

Qualitative information is drawn from:

- Interviews with parents and school staff, and class-based focus groups with children undertaken as part of the case studies of 4 schools undertaken in 2010 as part of the longitudinal study.
- Interviews with school staff as part of the multi-site case study of alternative education facilities. For further details of the sample and methodology see Chapter 2.

Findings

TaMHS workers views

Main facilitators and barriers identified

Having a good mental health supportive framework to build upon emerged as one of the main facilitators of the TaMHS project. In the four case studies examples included a long established mental health pastoral team and having good CAF structures.

“I get the impression that the CAF infrastructure in [name of local area] is quite good. And that immediately TaMHS was sort of mapped into the CAF process so that children referred to TaMHS had to have a CAF. So that automatically set up that multi-agency system and process”

TaMHS worker

In addition, having a good system in place enabled the TaMHS workers to focus resources appropriately

“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

On-going good communication between TaMHS staff and schools, and project workers giving schools a role in the selection of interventions were themes that emerged in the interviews as leading to better working relationships. One TaMHS worker commented on the difference between two schools they worked in.

“If they gave me their support and they were... liaising with me... every day I was there, and we were working together, it went very well. But there were schools where they didn't bother. They came... I came to the school, and they said, here's the child; sort him out. That's it”

TaMHS worker

One of the key barriers to implementing mental health in schools arose from differences in philosophy, language and working practice between agencies. This was due to a number of factors including different working sites and working patterns, theoretical approaches and

priorities. Geographical spread of physical location had practical implications for file and data storage and also acted to support any sense of separation and differentiation of services.

“it gets even more complex, and then if you put in health boundaries, they’re different as well, so then if you’re having to try to incorporate children and young people’s health service and it may not be who they normally use to work in their school, it’s just been another barrier”

TaMHS worker

Views on additional support conditions of the RCT targeted at TaMHS workers

Action Learning Sets (ALS) and LA booklets were both elements of additional support randomly allocated as part of the RCT (see Chapter 2 for details) feedback on each of these two types of support was only collected from a very small number of LAs, feedback that was collected is provided in Appendix 8.

School staff experience of TaMHS

Generally across all case studies, comments from school staff indicated highly positive views about the TAMHS initiative:

‘...people have been able to see.... benefits straight away. So I think... it is going to be something that is very very, very good for us...’

School staff member

‘...having TaMHS worker with us it has really helped within the key stage she is working in. just to help teachers identify....any sort of change in behaviour or just maybe question or be aware of and to help her be aware of what is available in the school and then beyond the school...’

School staff member

School staff were often markedly enthusiastic about the initiative and particularly welcomed the extra capacity provided by specialist workers being placed in the school. They also felt that the level of awareness of mental health in schools has improved in the course of

TaMHS. Training was described as a particularly useful way of improving school staff's confidence in dealing with mental health issues. They reported better links with CAMHS as the TaMHS project went on and they felt they could identify positive results for individual children. These were described in terms of overall improvements in behaviour and attendance for groups of children but also often rested on particular accounts of change for individual children.

"We've actually developed quite a good contact with CAMHS now whereas we thought perhaps the TaMHS and the CAMHS might be a bit frosty to start with, but we've got a great record with them now."

School Staff

"I think [child's name] was a big success. [Child's name]... was in and out of school a lot... He really struggled, his levels weren't very good either. But we managed to get him all the way through, and then... I was asked to nominate him for [Name of the local award] award and he won it"

School staff member

"I'm talking literally about a child who would never come to speak to me particularly. Unless I was talking to him about work he wouldn't approach me about anything. Actually now we're doing an assembly. He has volunteered to come and do a dance in front of the whole school which I don't think he's done before, so sometimes it's little things that make big changes and knowing who those children are and identifying them"

School staff member

"It's much more improved now...One particular case there is a boy who is year six. The mum has been ringing social services up. She's had enough of him... School is his only mainstay. It's his only stable thing that he has. [TaMHS worker's name] has worked with this boy, formed a relationship, has encouraged mum to come in to school and for them to play together within school. It's a bit of a roller coaster relationship between the son and mum but this particular family were known on the estate so within this other school the work of this project is tremendously important and it makes a difference"

School staff member

In the multi-site case study in alternative education facilities, TaMHS was particularly welcomed as a way of helping these establishments increase the level of support on offer and facilitate referral for specialist help as relevant. The overriding impression from the interviews was one of enthusiasm and relief that these schools were being given the additional support needed.

'...they can sort of encompass all the stuff that we've not got time for, or we've not got the money for, or we would really like to do but nobody specializing in it and they are sort of all the add-ons that we wished we had that now we can have to make a difference...'

School staff member

Success and enthusiasm were only slightly dampened by concerns over what would happen when funding came to an end because real differences were already being seen and naturally schools and project managers wanted the benefits they were seeing to remain. Despite concerns that the interventions would soon be coming to an end the general attitude of interviewees was positive and upbeat with most expressing pleasure in the successes they felt they had already seen.

'...we've only been doing this for a few weeks, of having a CAMHS clinician in school, that parents can come and see, it has been quite phenomenal. We've got parents coming in and seeing her and they're the parents that I didn't expect would engage...'

School staff member

According to one school staff member, the most important benefit of the TaMHS project was not necessarily having a wide range of interventions but rather having TaMHS clinicians based in school who the students, parent and staff could go to for support and advice.

"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, Carol, I've got a problem with this child, can you help us out?"

School staff member

Gelder (1999) pointed out that parents, carers, and the general public tend to perceive their local CAMHS clinic as the place where 'nutters' go or where they may be blamed for their

children's difficulties. A common theme that emerged was interviewees' sense that having a TaMHS clinician based in the school enhanced parental engagement and involvement. School staff members stated that before TaMHS some parents had felt uncomfortable with the stigma that is often attached with the term 'mental health'. The parents mistrusted external services and professionals, particularly social services that they had no previous relations with or guidance from. On the other hand the TaMHS worker was seen as belonging to the school system rather than a separate source of support and this was identified as aiding parent uptake of offers of support.

"And they have... they're more reassured, the parents that they've got support to go along to these meetings and they're supported. It's much easier for them. And it seems a shorter process now to what it used to be. It used to be difficult before and it seems shorter. And we're more supported, the school"

School staff member

Clinical involvement in schools was also seen as aiding access to specialist CAMHS and supporting the school staff in filling out the CAF form.

"Yes, and multi-agency meetings which are hosted here which sort of keep those CAFs reviewed and essentially perhaps, you know, at the end might force them to be CAFs..."

School staff member

A key challenge identified was preventing paradoxical effects such as closure of existing good services to set up new services

"Things that were done during the TaMHS project were done beforehand as well, and in some cases with one agencies input, they were done better beforehand. It is not their fault it is because they had the funding from TaMHS and they had a certain amount of schools they had to go to, TaMHS basically told them you need to do this, you need to do this and they just didn't have the staff. A lot of other schools, I'm pretty sure, suffered as a result"

School staff member

There were documented instances of existing services being closed or resources withdrawn to make way for TaMHS services and a key point of learning was to ensure that there was clarity around what already existed and build on best practice rather than feeling the need to present new initiatives as starting afresh.

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 worker

Parent experience

Parents also reported generally positive views on the initiative. However, it was notable that they did not generally refer to specialist provision by name even where locally defined, but rather by the name of the particular provider or teacher (e.g., “Sally is great she...”).

A key theme that emerged was the centrality of good **communication** between the school and parents. When communication was felt to be working well this was highly valued by parents. One parent expressed gratitude when kept informed; another parent praised her “brilliant school” for having time to talk to her:

“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

However, parents could easily feel blamed if contacted about their child’s behaviour in a dismissive way:

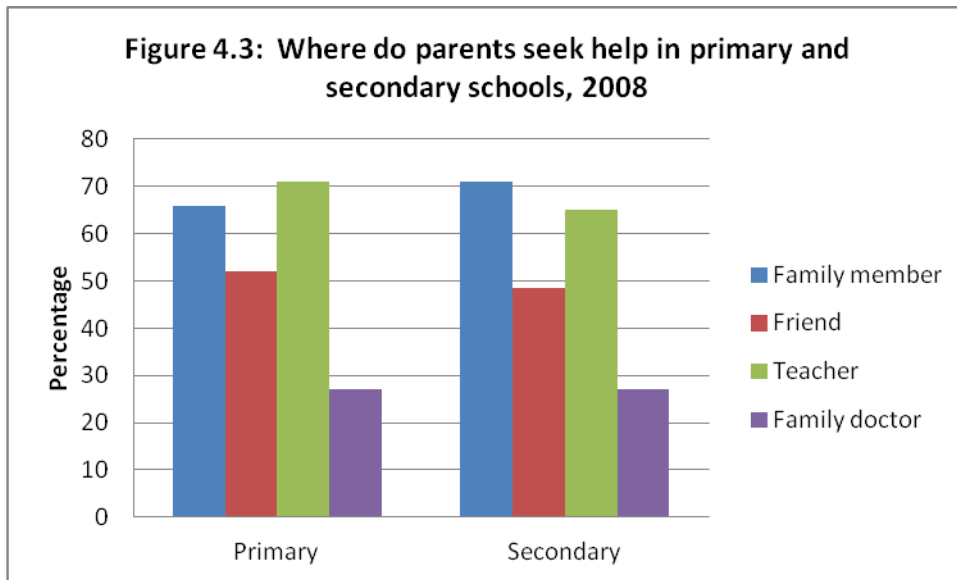
“she talked to me like I had just crawled from under a stone... “she’s done this. She’s done that”....she looked at me as if I was nothing”.

Parent

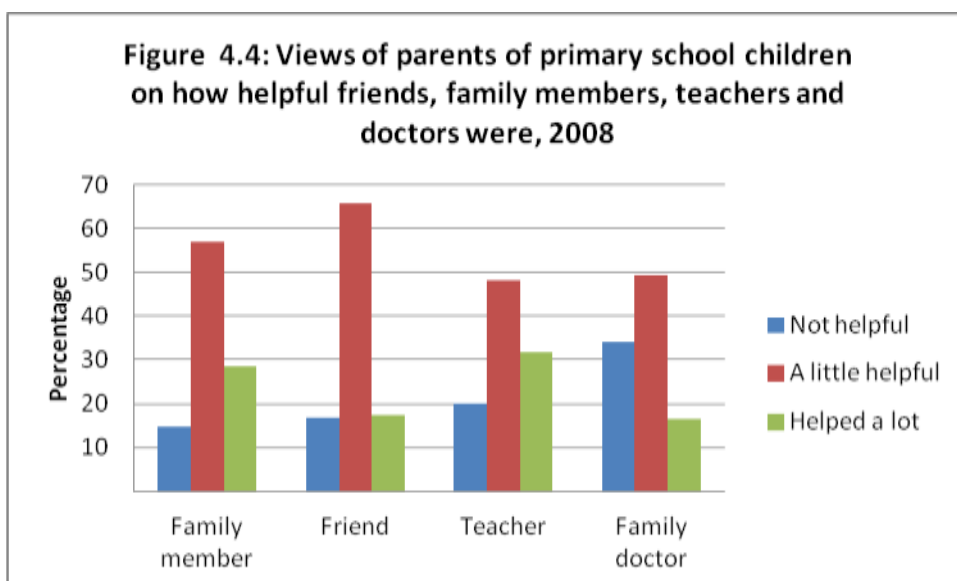
It is interesting to note in this context the quantitative findings from the parent report on the parent survey about parents looking to school staff for advice and support in relation to any concerns they might have about their child’s mental health. In the survey parents were asked whether they had ever sought help because they were concerned about their child having emotional or behavioural difficulties. Approximately 30% of parents across years indicated that they had sought help. These parents were asked whether they had accessed different sources of support about these concerns: family members, friends, teachers and doctors, and if so, how helpful they had found this support.

Figures presented here are for 2008 only. Responses in 2009 and 2010 followed a similar trend as shown here and tables with numbers and proportions for 2008, 2009 and 2010 can be found in Appendix 8.

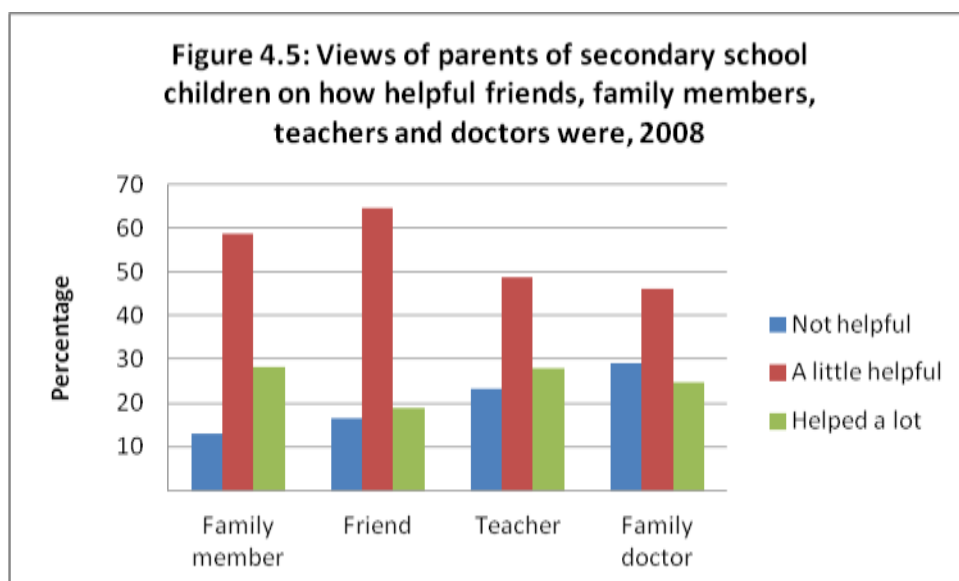
Parents of children in both primary and secondary schools reported that the most frequently used sources of support were teachers and family members, though the percentage seeking help from teachers was higher in the primary school group (see Figure 4.3).



In terms of how helpful these sources of support were, parents of primary school pupils were more likely to rate teachers and family members as having ‘helped a lot’ than other types of support. Whereas, GPs were more likely to be rated as ‘not helpful’ than any other group (see Figure 4.4).



For parents of pupils in secondary school the pattern was broadly similar (see Figure 4.5).



These findings highlight the central role of schools for parents in helping support and manage their child's mental health issues.

Pupil experience

In qualitative interviews secondary school pupils were aware of a range of support in their schools, such as tutor mentoring, peer mentoring, and support from the pastoral team. However, as with parents (and with primary school pupils), there was no spontaneous mention of specific mental health professionals such as counsellors.

When asked where they would prioritise further development the following suggestions emerged: improvements in buildings such as improving lavatories, provision of a common room, stress room or more equipment and greater amounts of more specialist input such as support relating to drugs.

Pupils identified key aspects of current existing approaches that they valued such as anonymity, a safe space to talk and availability of supportive peers or staff. Key issues that pupils raised included an emphasis on appropriate spaces to meet (such as the 'friendship bench' depicted in Figure 4.6⁷) and anonymity.

⁷ NB Name in poster relates to name of fictional child in vignette not the responding child's name

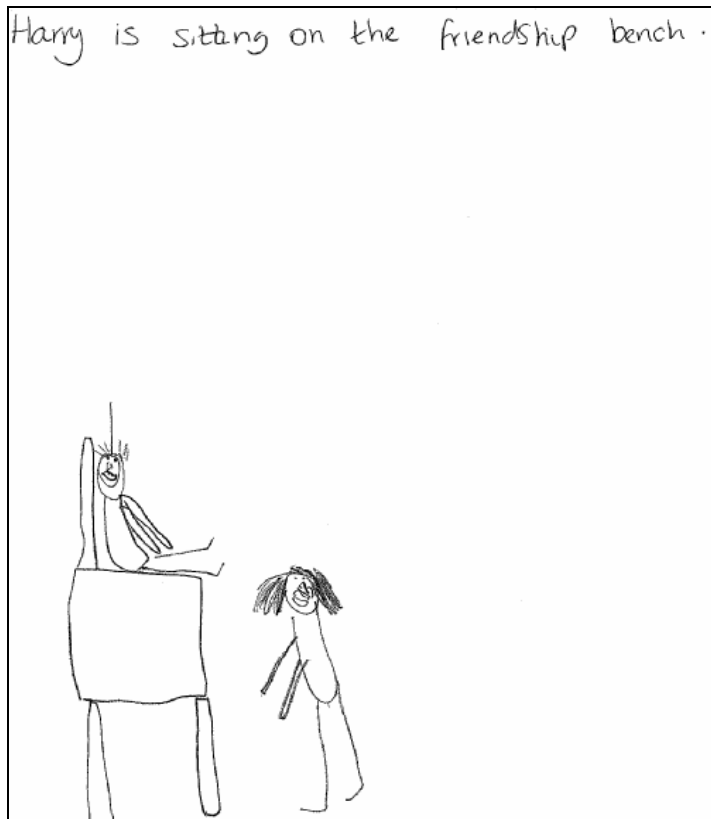


Figure 4.6: Example provided by a child of what a fictional vignette character with behavioural problems named “Harry” might be offered as support in his/her school.

Secondary school pupils stressed that support was open to all including those with difficult behaviour and that help might be important for those who were bullying as much as those being bullied such as they young person who wrote below “remember it isn’t just for people who are getting bullied it is also for people who want to improve their behaviour”. As with parents, a key theme stressed was communication and the support provided by pupils being able to have supportive conversations with relevant others. Some respondents also commented on the importance of schools linking with their parents (as described by one child in the poster shown in Figure 4.7⁸).

⁸ NB Name in poster relates to name of fictional child in vignette not the responding child’s name

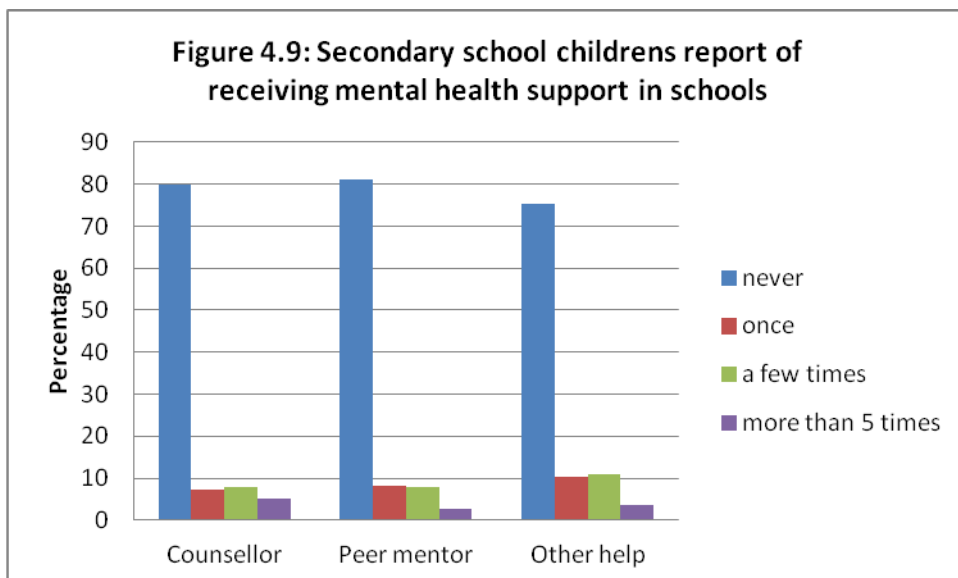
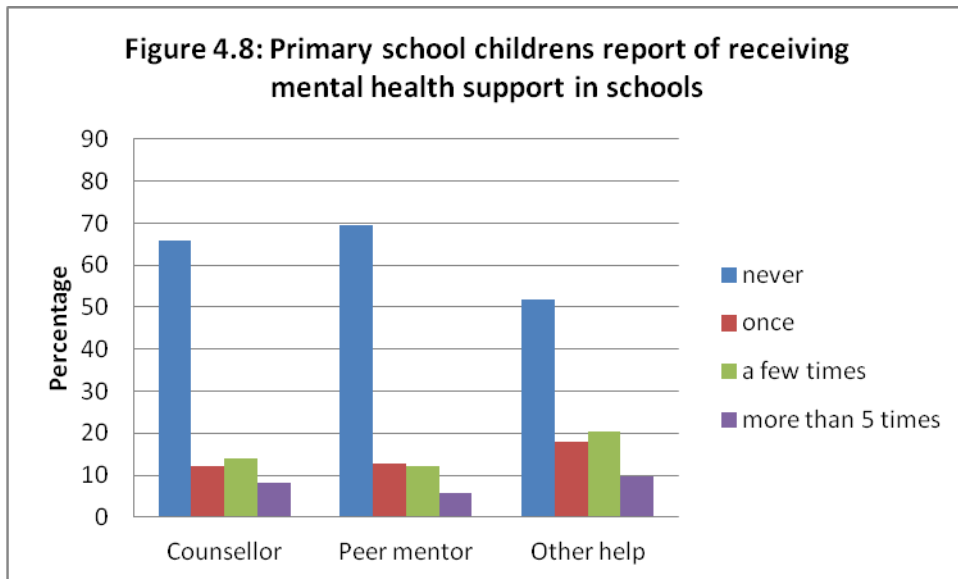


Figure 4.7: Example provided by a child of a range of support that might be offered in their school to a fictional vignette character with emotional problems called “Fatima”.

An implicit hierarchy of wellbeing emerged which ranged children from those needing help (“too many detentions, not enough merits, no friends, always in trouble, really depressed”) to those with high well-being levels (“loads of merits, no detentions, super happy, lots of friends and never in trouble”). This reflects some of key aspects that pupils linked to good mental health: friends, emotional state, not in trouble at school and attainment.

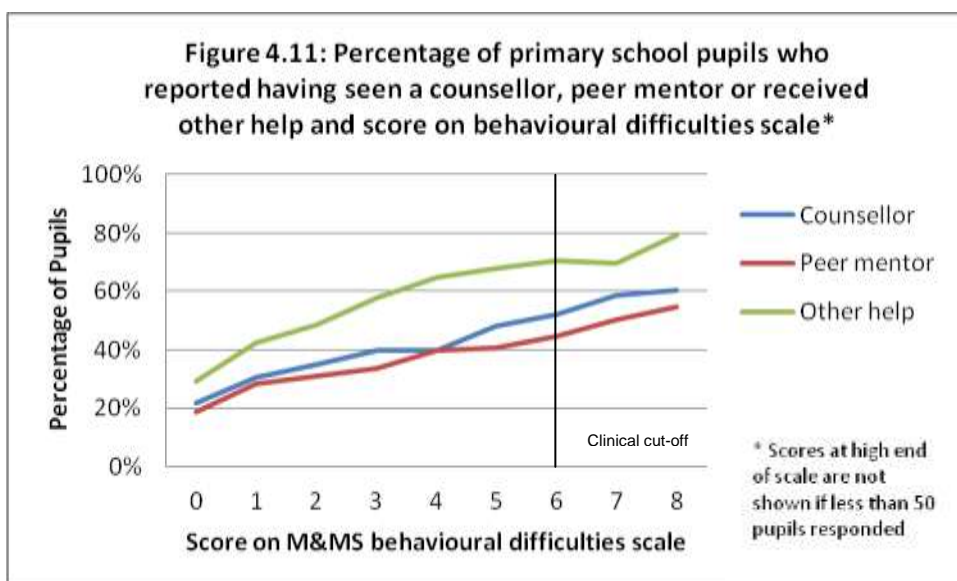
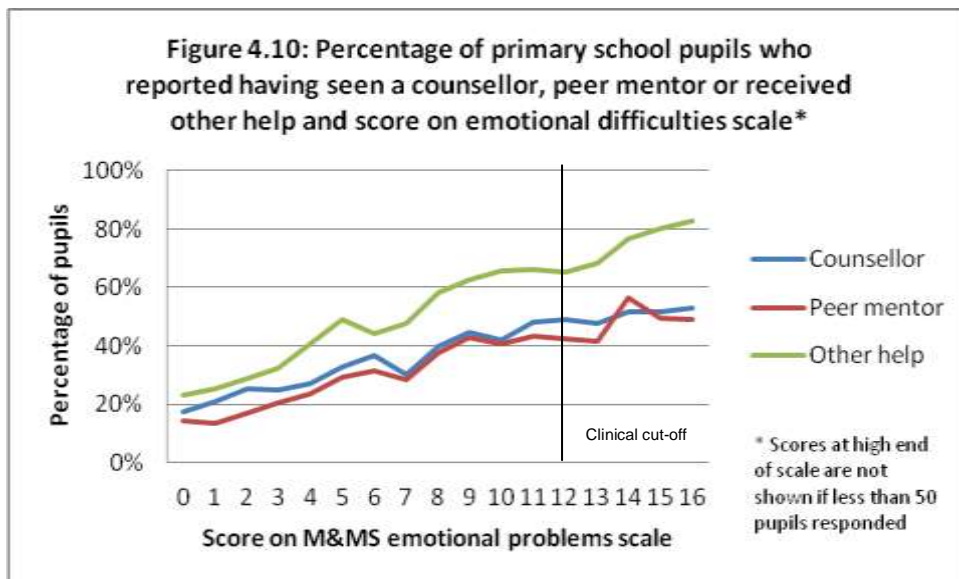
Whilst primary school pupils had a less articulated model than secondary school, they were still able to suggest a range of ways that mental health could and was supported in schools with a particular focus on the importance of friendships. Awareness for behavioural support and the school reward system was quite high and they were able to make several suggestions of what help would be available for the child with behavioural problems.

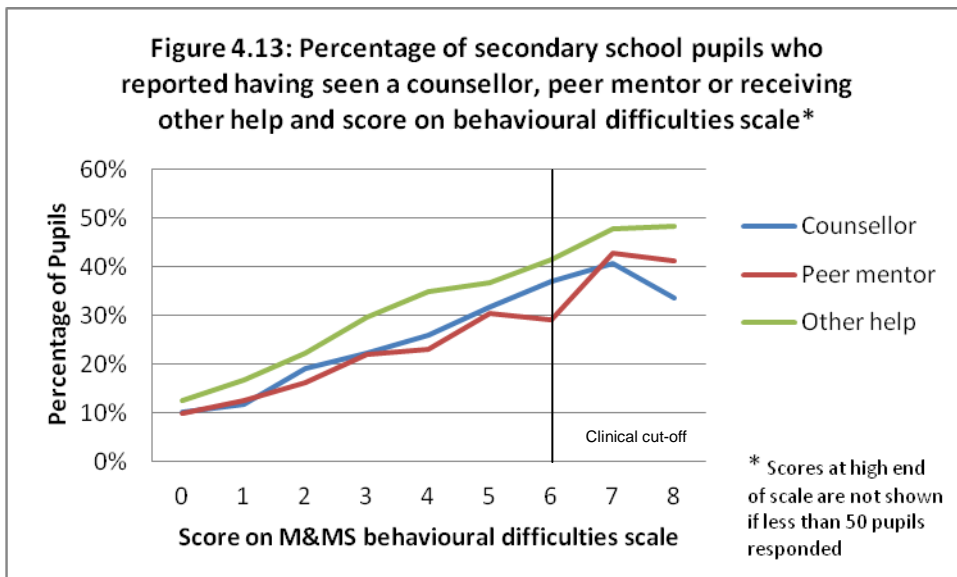
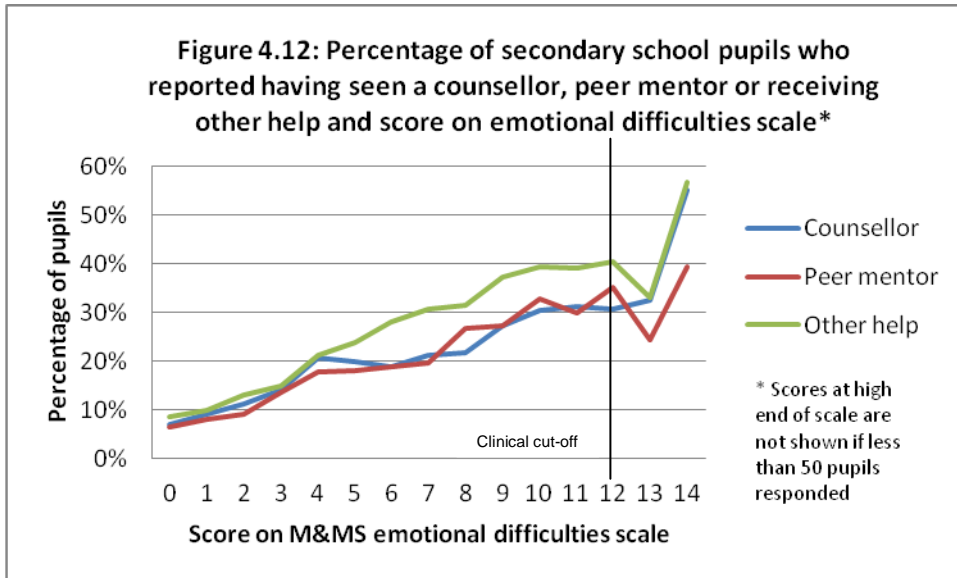
Turning to the quantitative data: children’s reports of mental health support received in school in 2010 indicated that approximately just over one in five of primary and just over one in ten of secondary school children reported having seen a counsellor more than once; just under one in five primary and just over one in ten secondary school pupils reported having seen a peer mentor more than once; and just under one in three of primary and just over one in seven secondary school children reported having received some other kind of mental health support in school.



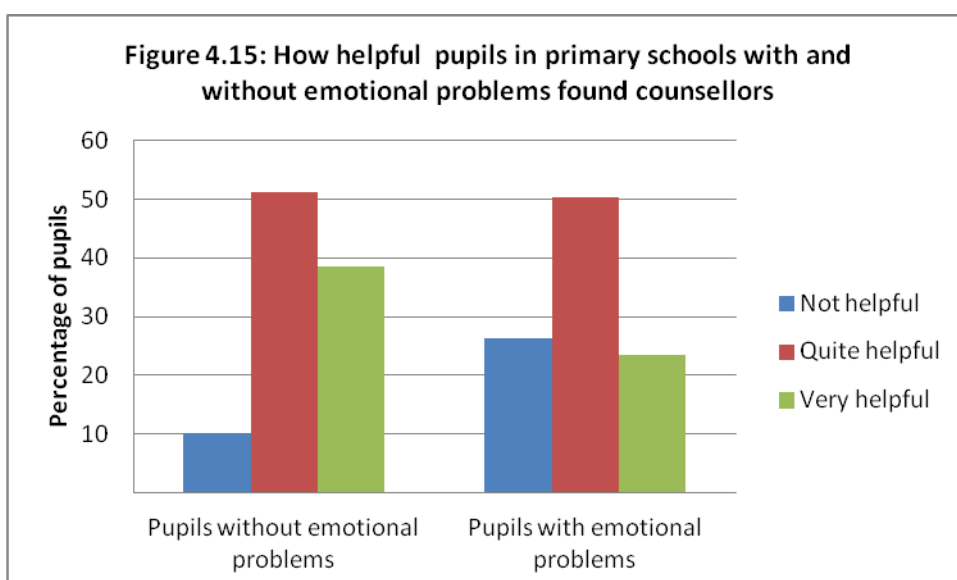
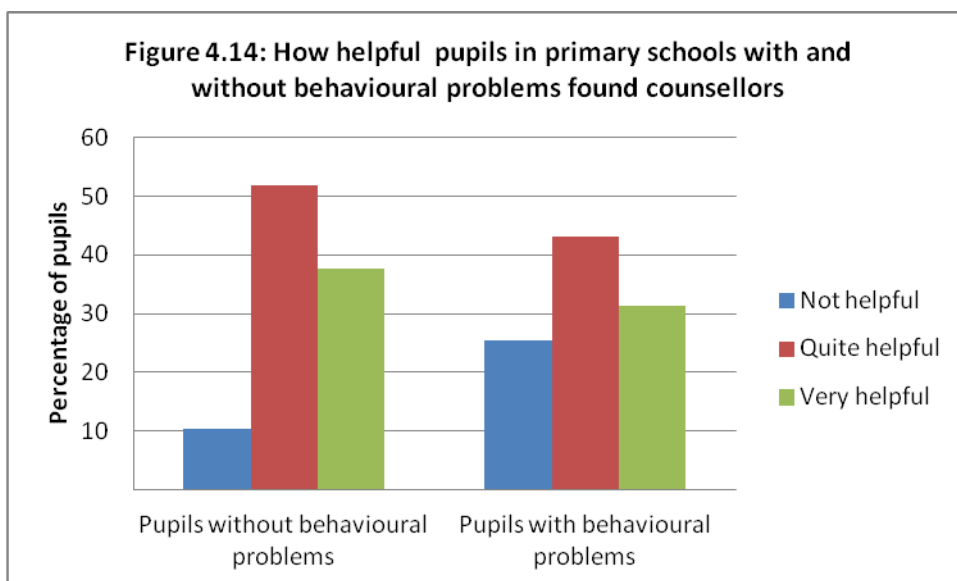
These proportions are higher than expected so it is possible that some children may have misinterpreted the question. However, it is interesting to note that those with higher levels of self-reported difficulties also reported more contact with specialist help. Figures 4.10-4.13 show the relationship between extent of emotional and behavioural difficulties (based on child self-report scores) and the proportion of children who said they had had help from

counsellor, peer mentor or some other support within school. From these graphs a general trend can be seen that the greater the extent of emotional or behavioural difficulties reported by the child, the more likely they are to be receiving this kind of help.

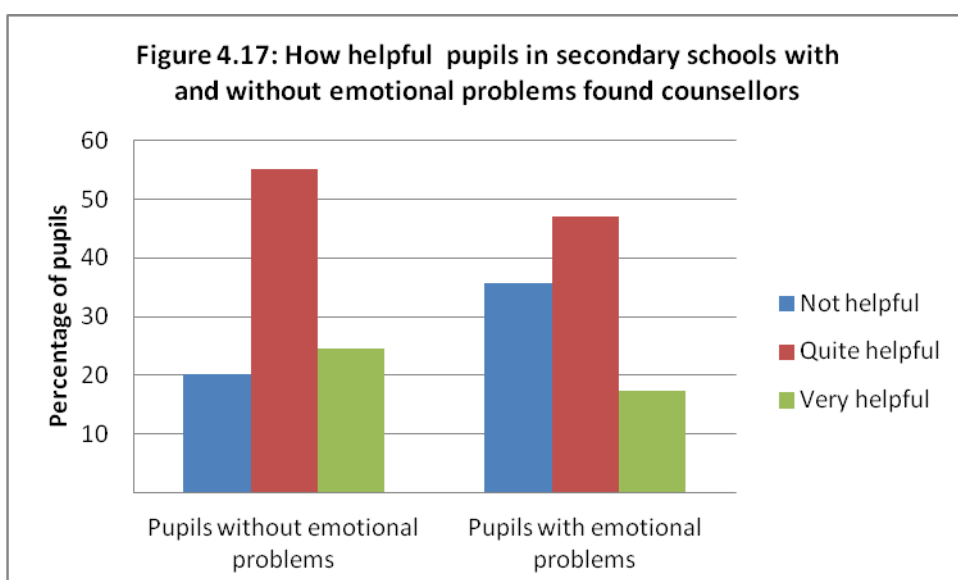
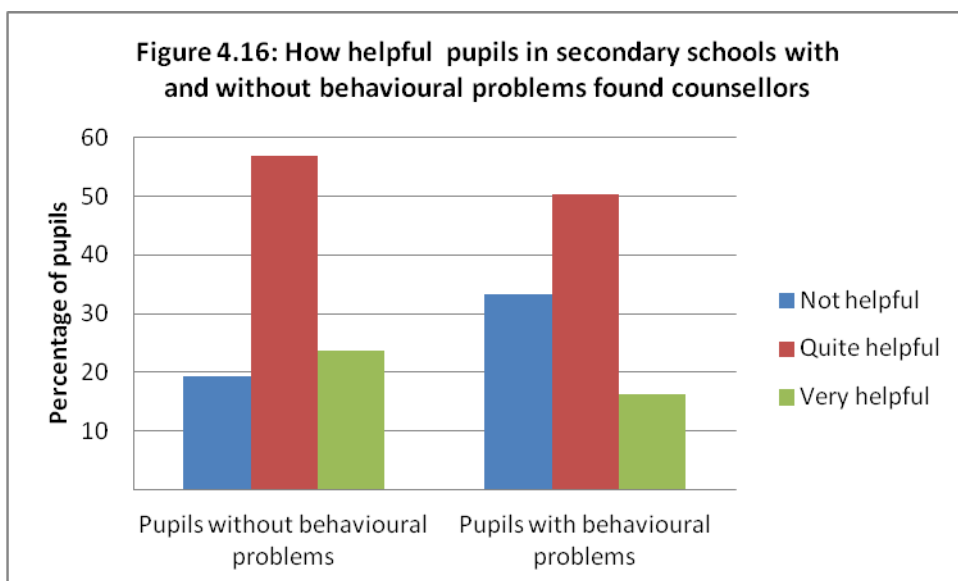




In terms of ratings of the help received, primary school pupils gave very positive responses, most endorsing “quite or very helpful” (see Figures 4.14 and 4.15). However, in both cases (emotional and behavioural difficulties) those with problems scoring above the clinical cut-off (threshold of significant mental health problems) rated the support received less positively than those below the cut-off.



The same pattern was observed for secondary school pupils – while ratings were positive overall, those scoring above the clinical cut-off for emotional or behavioural difficulties were less positive than those below (see Figures 4.16 & 4.17 and Appendix 8 for statistical comparisons). The reasons for this distinction are unclear, it may be because these kinds of intervention take more time to have an impact on those experiencing more severe difficulties, or are less effective with more severe problems but this cannot be discerned from the current analysis.



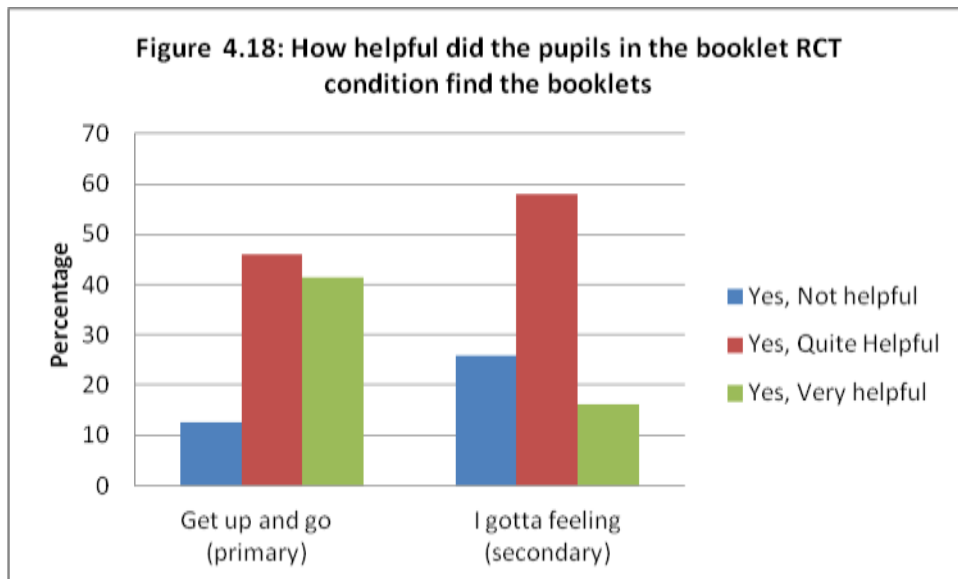
Furthermore, secondary school pupils showed slightly less positive ratings, with approximately one fifth of children endorsing “not helpful” for each category of support (see Figures 4.16 and 4.17, and Appendix 8 for statistical comparisons). The differences between the two groups may in part relate to increased ability of older children to make discriminative judgements.

Pupil views on mental health self-help booklets

Booklets for pupils were randomly allocated to half of the schools in the RCT. Two versions of the evidence based self-help booklet were developed: one aimed at primary aged children (How to get up and go when you’re feeling low) and one aimed at secondary aged pupils (I gotta feeling) (see Appendix 1 for details).

It was clear from responses that not all of those who had been randomly allocated to receive booklets had actually seen them (40.7% of primary schools children and 19.9% of secondary school children).

Based on those who had seen the booklets, findings suggested that the primary school booklet was seen as most useful with over 85% of children reporting that they found the booklet either quite or very helpful, compared to just below 75% of the secondary school group (see Figure 4.18).



Conclusions

School staff, were generally enthusiastic about TaMHS and identified examples of positive change which they ascribed to the project, in particular they valued having TaMHS workers based in the school, who they could consult regularly regarding children they had concerns about.

Interviewees reported that having TaMHS workers being based in school that could be easily accessed by school staff and reduced the stigma of access to support for parents and children was key. Other important factors considered to improve the implementation of TaMHS included having projects that showed an awareness of the context, that work undertaken built on existing provision and that any new work made use of existing structures (such as use of CAF).

A number of barriers to implementation were identified. There were issues of communication and engagement, which hindered progress. Sometimes these problems

were caused by practical issues such as geographical spread and transportation links but other causes included differences in philosophy and language between different agencies and their ways of working. There were also concerns that sometimes new provision had entailed the removal of valued existing provision, which is consistent with the issues of displacement and substitution noted in previous literature (HM Treasury, 2003). Finally some concerns were expressed about the sustainability of the work being carried out, given that funding would not be covering future years.

Parents identified schools as the key point of contact for concerns about mental health issues and identified teachers as the key group they turned to if worried about their child's mental health, and the group that provided most help in these situations. They were generally positive about TaMHS and particularly stressed the importance of good communication in working with schools on mental health issues for their children.

Pupils showed an awareness of range of approaches available in their schools and an appreciation of the ways they could help. They regarded helpful conversations as key to this. Children were also positive about support received from counsellors and peer mentors, though primary school children showed slightly more positive ratings of this kind of support than secondary schools pupils.

Pupils who had seen the evidence based self-help booklets rated them positively on the whole, though the booklet aimed at primary school pupils was seen as most useful.

Issues for further consideration

1. This is a valued initiative by staff, parents and pupils and seems to be a positive way forwards.
2. It may be important to address differences in philosophy and working practice between agencies to ensure successful implementation.
3. To avoid paradoxical negative effects such as displacement and substitution it may be important to ensure that there is no closure of existing good services to set up new services.
4. School staff were particularly positive about having specialist mental health workers based in the school.
5. Support accessed in schools (such as school counsellors and peer mentors) was

rated positively by children. More children with significant mental health problems received help when compared to those who did not have problems. However, those with problems rated the help received less positively than those who did not have problems.

6. Children rated the mental health self-help booklets favourably, though primary school children rated them more positively than secondary school children.

CHAPTER 5: RESULTS OF THE LONGITUDINAL STUDY

Summary of findings

The longitudinal study was used to explore the association between individual level factors (such as deprivation and gender), school level factors (such as school climate and mental health provision), and children's mental health outcomes in terms of levels of emotional and behavioural difficulties at a given time point and in terms of changes in levels of their emotional and behavioural difficulties over time. Findings are summarised below.

Mental Health problems over time

- Pupil self-report in primary schools indicated decreases in both emotional and behavioural difficulties over the three years of the evaluation.
- Teacher report in primary schools indicated decreases in both emotional and behavioural difficulties over the three years of the evaluation.
- Pupil self-report in secondary schools indicated a decrease in emotional difficulties over the three years of the evaluation but no decrease in behavioural difficulties.
- Teacher reports in secondary schools indicated no change in emotional difficulties and a slight increase in behavioural difficulties over 3 years.

Factors associated with change in mental health over time

- School reports of giving information to pupils in secondary schools were associated with improvements in outcomes for children with behavioural problems.
- School reports of giving information to pupils in primary schools were associated with less of a reduction in emotional problems.
- School reports of use of CAF were associated with improvement over time in secondary school children's behavioural problems.
- School reports of good links with CAMHS were associated with improvement over time in secondary school children's behavioural problems.

Factors associated with mental health levels in general

- Factors associated with fewer mental health problems overall for all groups included higher socio-economic status and higher academic attainment. Boys

were less likely to have emotional problems and girls were less likely to have behavioural problems.

Key background information⁹

Findings relating to time trends in mental health problems in children and young people have been mixed. A number of cross sectional studies indicate that younger cohorts of children tend to have lower levels of mental health problems and higher levels of wellbeing than older cohorts (Bernard et al 2007; Green et al, 2004; Merikangas et al, 2010). Such findings have led to conclusions that mental health problems increase with age on the whole. However, findings from longitudinal studies provide different indications. While the findings from some earlier longitudinal studies support the proposal that mental health problems increase as children get older (Hankin et al ,1998), more recent findings have demonstrated improvements in mental health problems as children in primary schools (Gutman & Feinstein 2008; Slee et al, 2009) and secondary schools get older (Humphrey et al, 2010).

In terms of interventions, research indicates that a range of school-based approaches including both individual and group cognitive-behavioural therapy, nurture groups, social-skills training, peer-mediated interventions, behavioural strategies and coping skills have a positive impact on children's mental health and wellbeing. There is also evidence to suggest that whole school programmes and multi-component interventions involving pupils, parents and school staff are effective for the prevention of violence and bullying. However, detecting the impact of intervention in a short period of time can be difficult because programmes can take a long time to implement and bed down. Consequently, it can take at least three years (possibly more) from the beginning of a large scale intervention for effects to be observed in child outcomes (Groark & McCall, 2009).

Evaluation methodology relevant to this chapter

The data used to carry out these analyses are drawn from the longitudinal study.¹⁰

⁹ For literature and further details refer to Chapter 1

¹⁰ Originally, the longitudinal study sample included 'comparison schools' as a control group for the schools involved in the TaMHS longitudinal study. However, comparisons between the TaMHS group and this group of schools revealed no differences in the extent of mental health support, or in the outcomes attained so these schools were included in the overall longitudinal sample. Details of the representativeness of this sample can be found in Appendix 2.

Measures presented here include child reports of their own emotional and behavioural difficulties based on the Me & My School (M&MS) measure, teacher reports of emotional and behavioural difficulties based on short reports, and child reports of school climate.

As described in Chapter 2, multilevel modelling (MLM) is often used for data that has multiple levels. For example, schools are made up of many children and each child can provide data on several separate occasions. This multilevel structure has an impact on how questionnaire responses relate to each other. For instance, children in one school are likely to have more similar responses to each other than they are to children in different schools. MLM takes into account these similarities or clusters in the data, allowing us to model repeated data across time points within pupils and within schools.

MLM was carried out in relation to the longitudinal study to estimate links between mental health outcomes and individual characteristics such as gender, ethnicity, socio-economic status and attainment and school level variables such as interventions, school climate and use of CAF (see Chapter 2 for explanation of MLM).

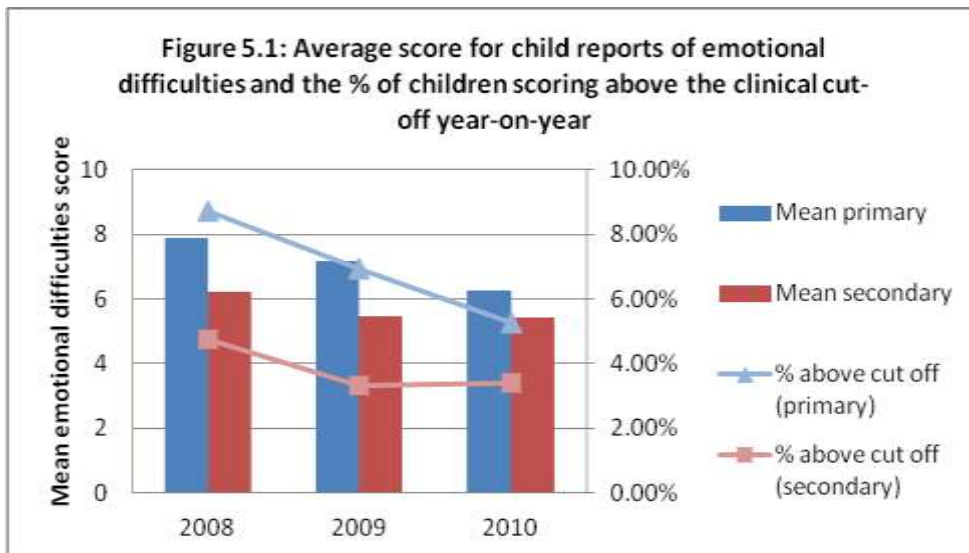
Findings

Changes in mental health difficulties over time

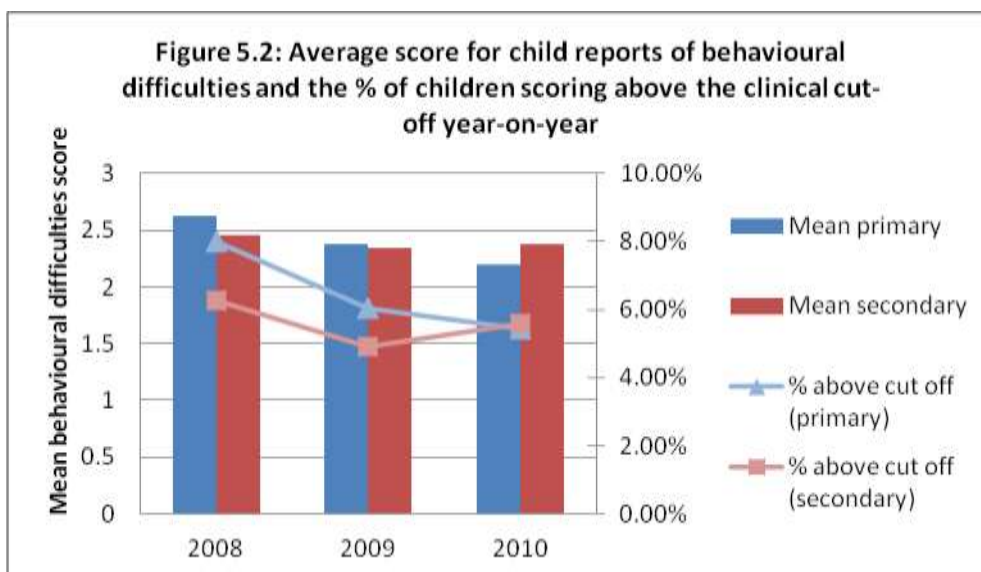
Children's self-reported emotional and behavioural difficulties showed a general downward trend for the whole population in primary school over the time of the evaluation (see Figures 5.1 & 5.2 for graphs, see Appendix 9 for further details).

Findings not only indicated a reduction in average pupil scores but also a reduction in the percentage of children scoring above the clinical threshold¹¹ for emotional difficulties in primary and secondary school children. However, improvements were most pronounced for primary school children.

¹¹Threshold of mental health problems significant enough to warrant specialist mental health support as indicated by a score on a mental health measure or questionnaire. See appendix 4 for details.

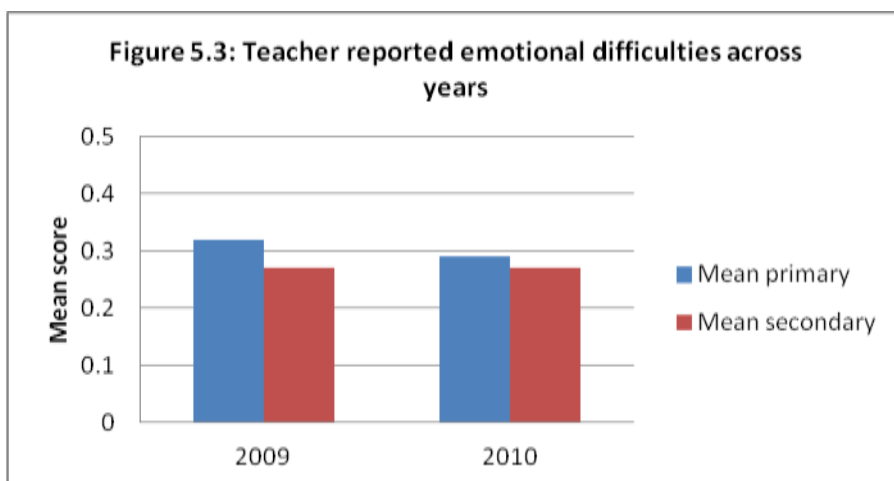


In terms of behavioural difficulties, primary school children showed a slight reduction over time in average scores and in the percentage of children scoring above the clinical cut-off. Behavioural difficulties for secondary school children, though slightly lower in 2009 and 2010 than in 2008, showed very little change over time (see Figure 5.2).

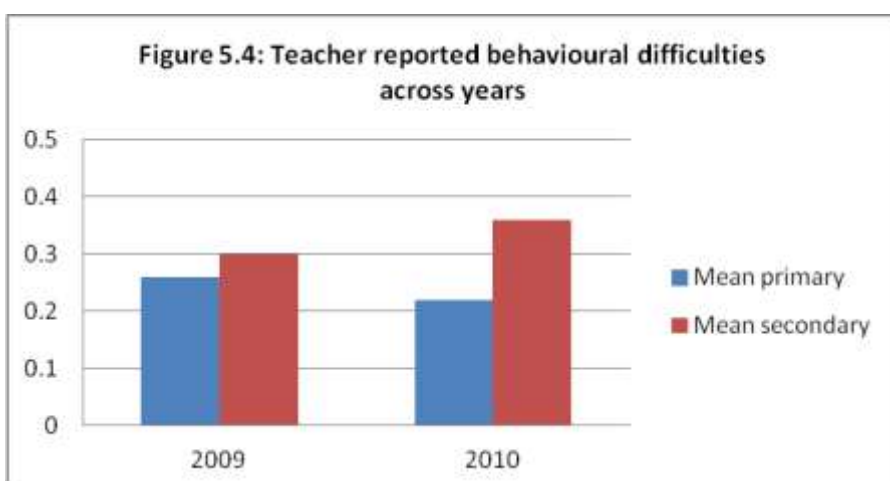


Teacher's short reports¹² of pupil's emotional difficulties in primary schools showed similar findings to that of the child-reported data, suggesting that children's emotional difficulties showed some reduction over time in primary schools. However, in secondary school pupils there was no change over time in teacher reported emotional difficulties (see Figure 5.3).

¹² Only two years of data are shown for longitudinal study as technical difficulties rendered the first year of short teacher report data unusable.



However, teacher reports of behavioural difficulties actually showed a decrease over time for primary school pupils and a slight increase over time for secondary school pupils (see Figure 5.4).

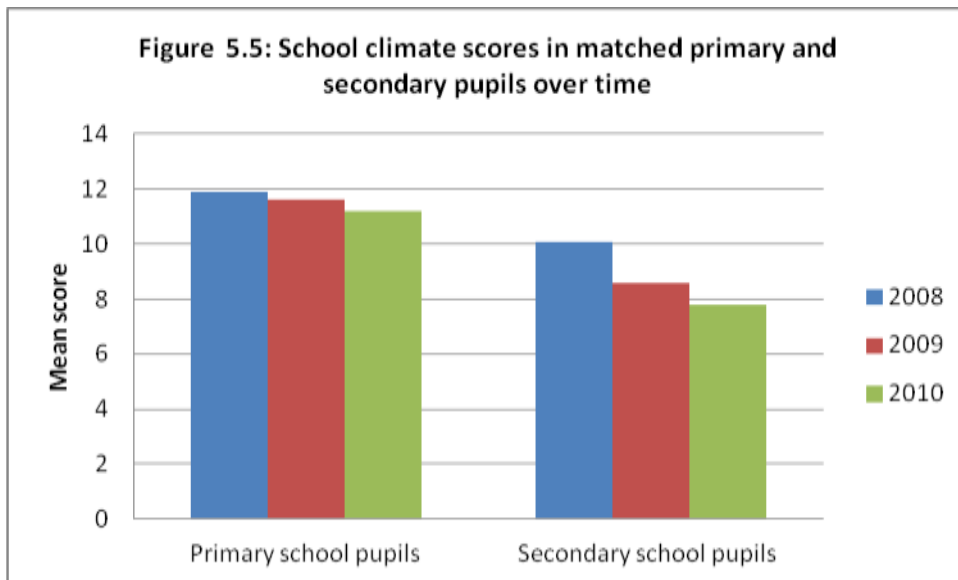


School climate

The mean school climate scores decreased over time in both primary and secondary school pupils (Figure 5.5). As can be seen in Figure 5.5 the decrease in scores is more pronounced year on year in secondary schools than in primary schools. In view of how primary and secondary schools are structured and the nature of the questions that make up the school climate measure the primary pupils scores might reflect 'classroom climate' rather than whole school climate because in primary schools pupils tend to be in one class group.

It is unclear from this trend whether this drop in school climate scores for the secondary school is because of child specific factors such as maturation and pubertal change or whether this represents, as has been noted in previous research, a potential mismatch

between the secondary school environment and the developmental needs of children at this age (Eccles et al, 1993).



Pupil and school factors associated with change in mental health scores

Longitudinal multilevel modelling (MLM) was used to investigate whether pupil and school level characteristics were associated with differential change in behavioural or emotional difficulties, based on children’s self-reports using the M&MS measure.

In terms of school activity the 13 categories of mental health support described in Chapter 4 were further reduced to five factors of school-based mental health support (see Appendix10). These five clusters are shown in table 6.1 against the original 13 categories.

Table 6.1: The initial 13 categories and the associated five factors

13 categories	Associated factor	Description
Social and emotional skills development of pupils	Developmental facilitation	Includes interventions such as SEAL, PATHS, nurture groups, behavioural support, restorative justice, buddy schemes, peer mentoring and activities such as drama, art, music etc.
Creative and physical activity for pupils		
Peer support for pupils		
Behaviour for learning and structural support for pupils		
Information for pupils	Information for pupils	Advice lines, leaflets, internet based information
Individual therapy for pupils	Pupil therapy	Includes counselling, individual and group based therapies such as CBT and psychotherapy
Group therapy for pupils		
Information for parents	Parent focused activities	Includes programmes such as Webster – Stratton and triple P, family therapy and leaflets and advice lines for parents and families of pupils
Training for parents		
Counselling/support for parents		
Training for staff	Staff focused activities	Includes training from mental health professionals, supervision and advice for staff and provisions to help staff deal with stress and difficulties
Supervision and consultation for staff		
Counselling/support for staff		

MLM was first carried out to consider the amount of variation in scores for emotional and behavioural difficulties across pupils and across years of the study that were accounted for by pupils or by schools (see Appendix 11 for details). In both primary and secondary school samples, by far most of the variation in initial emotional and behavioural difficulties scores across pupils was explained by pupils, rather than schools. Pupils also accounted for far

more variation in change in emotional and behavioural difficulties scores over time than schools did. It is likely, therefore, that individual level characteristics make a greater contribution to children's mental health status than school-level factors do. However, given that much of the work carried out in schools worked with target groups of individuals, it is likely that some of the school-level activity is also contributing to individual level variability in mental health scores.

Further models considered school and pupil level factors that might explain variation in children's scores for emotional and behavioural difficulties at the outset only for those children scoring above the clinical threshold for emotional and behavioural difficulties in year 1 (2008) of the study since TaMHS was targeted work, aimed particularly at those experiencing greater levels of difficulties; those above the clinical cut-off were taken as a proxy for the group who would have been worked with most closely.

For primary school pupils, high socio-economic status, high academic attainment and positive perceptions of school climate were all associated with fewer problems overall in terms of both emotional and behavioural difficulties. There were also gender effects such that girls were more likely to have emotional problems and boys were more likely to have behavioural problems; a finding consistent with previous research (Green et al, 2004). These characteristics were not found to be associated with differential rates of change however.

For secondary school pupils, being male and having high academic attainment were associated with fewer emotional difficulties overall, as were schools reporting more use of the CAF, provision of information for pupils and good links with CAMHS. School reports of providing pupils therapy were also associated with greater level of emotional difficulties overall. High socio-economic status, being female and having high academic attainment were all associated with fewer behavioural difficulties. In terms of school level factors, parent-focused mental health support was associated with higher levels of behavioural problems overall.

Finally, models were fitted to consider the association between school and pupil level factors and changes in emotional and behavioural difficulty scores over the three years of the study, again, only for those children scoring above the clinical threshold for emotional and behavioural difficulties in year 1 of the study. Overall, there was a small reduction in both emotional and behavioural difficulties across years of the study for primary school pupils and a small reduction in emotional difficulties but not for behavioural difficulties for secondary school pupils. However, the trajectories of scores over time were quite heterogeneous.

Very few pupil or school level variables were significantly associated with changes in mental health problems over time. For the primary school sample, there was a small but significant association between school reports of information for pupils and less pronounced reductions on emotional difficulties over time. There was also a similar pattern, suggesting that positive school climate was associated with slightly less pronounced decline over time in emotional problems; however, as stated previously, positive school climate scores were associated with fewer emotional difficulties overall. For the secondary school sample information for pupils was very strongly associated with more pronounced reductions in behavioural difficulties over time. Use of CAF and school reports of good links with CAMHS were also associated with more pronounced reductions in behavioural difficulties over time.

Conclusions

The fact that there was a general decrease in emotional problems and behavioural problems in the primary school cohort over the three years of the study on both child and teacher report suggests that there are fewer children who were depressed anxious or unhappy over this period. This could be for a number of reasons.

There has been a great emphasis in recent years on schools providing mental health support to pupils (and indeed on development generally of emotional wellbeing). It is possible that this is having an effect (e.g., 61.4% of primary and 36.8% of secondary pupils reporting receiving some kind of mental health support) and children are feeling generally less sad, anxious or depressed. Another possibility is that it could be that this is a developmental trajectory, whereby as children get older they have fewer emotional problems, though the research evidence on this is mixed.

The picture with secondary school pupils is less clearly positive. Pupil self-report in secondary school indicated a decrease in emotional problems over the three years of the evaluation but teachers reported no change. In terms of behavioural problems, pupil self-report suggested static levels of difficulties across time but teachers responses suggested increase in difficulties over time.

In terms of the findings on behavioural problems the difference between primary and secondary schools may reflect the fact that behavioural difficulties have become more entrenched by the time a child reaches secondary school and, therefore, are harder to influence. It may be, however, that behavioural problems would have been expected to rise

during the transition into teenaged years (Maughan et al, 2004). If so the fact that the self-report suggests stability may be more positive than it at first appears.

Findings from the MLM did indicate some types of school-based mental health support were associated with changes in emotional and behavioural difficulties over time. Both use of CAF and good links with CAMHS were associated with a reduction in behavioural difficulties over time. Both of these factors may reflect the quality of inter-agency working between schools and a range of other services, suggesting that better links and clearer referral pathways lead to fewer behaviour problems over time. However, it is also possible that use of CAF and links with CAMHS could be a proxy for other characteristics of the school, such as general organisation.

Use of information for pupils within schools yielded more mixed findings. While use of information for pupils was associated with improvements in behavioural problems for children in secondary schools, it was associated with less pronounced reduction in emotional difficulties over time for primary school children. However, it is important to note that the effect for behavioural difficulties was much stronger than the effect for emotional difficulties. It is possible that these results suggest information is more appropriate for older children as they have more autonomy to follow guidance independently than younger children. Alternatively, it may be that pupils with emotional difficulties find that information increases their anxiety or worries, or gives them a greater awareness of their difficulties leading them to report higher levels of difficulties.

In all cases associations between school and pupils level predictors and mental health outcomes should be interpreted with caution; because these data are correlational, it is not possible to confidently ascertain the causal direction among types of school-based mental health support and mental health outcomes. For example, it is not clear whether information for pupils leads younger children with emotional problems to improve less or whether an increase in emotional difficulties leads schools to offer information for pupils.

Issues for further consideration

1. The increase of positive ratings of links with CAMHS and increased use of CAF suggests that TaMHS promoted strategies to help integrate disjointed services.
2. The association between giving information to pupils in secondary schools and more pronounced improvements in outcomes for children with behavioural problems may suggest this is a worthwhile activity.
3. The fact that giving information to pupils in primary schools is associated with less positive outcomes for children with emotional problems may suggest this is

something that should not be recommended. However, the magnitude of the effect was small so any interpretation should be treated with caution.

4. The association between CAF and more pronounced improvement over time in secondary school suggests this could be promoted further as an aid inter-agency working and helpful coordination for individuals.
5. Good links with CAMHS being associated with more pronounced improvement over time in mental health status of pupils in secondary school suggests the policy of looking for closer links between specialist CAMHS and schools should continue to be pursued.

CHAPTER 6: RESULTS OF THE RANDOMISED CONTROLLED TRIAL (RCT)

Summary of findings

- Findings from the RCT analysis suggested that TaMHS provision did have a positive impact for children with behavioural difficulties in primary schools. However, no evidence of an impact was found for older age groups or for emotional outcomes.
- Findings for the use of materials designed to enhance TaMHS implementation were mixed. The use of evidence based self-help booklets for pupils in primary school lead to more pronounced reductions in behavioural problems. However evidence based self-help booklets for pupils coupled with Action Learning Sets for staff were associated with less improvement in emotional difficulties for pupils in secondary school.

Background information relevant to this chapter¹³

Whilst there is strong evidence that a number of interventions have shown a positive impact in schools, detecting the impact of a complex intervention such as TaMHS can be difficult. Firstly, identifying the exact children worked with in each school for each intervention across all of those involved – given the range of one-to-one, group and whole school work – was not possible. Secondly, and related to this, individual schools decided to focus on different age groups within the school, these age groups did not always coincide with those being assessed through the national evaluation, which out of necessity focused on only two main cohorts. Finally, it was hard to detect what TaMHS represents that is additional, given that so many other diverse but parallel activities are occurring within schools.

¹³ For literature and further details refer to Chapter 1

Evaluation methodology relevant to this chapter

The RCT was used in this evaluation to complement the longitudinal study because it offers a number of strengths. The random allocation of conditions within an RCT mean that it is possible to disentangle the condition of interest (in this case, the main condition being implementation of TaMHS in 2009 or not) from other characteristics associated with specific LAs. For example, while the longitudinal study allows us to track trends across a longer period of time, because the areas involved in the longitudinal study were specially selected, we are unable to say whether improvements in those children involved over time are due to the introduction of TaMHS or some other confounding event (e.g., a general increase of school-based mental health support outside of the TaMHS project or the positive impact of another parallel intervention, such as SEAL). However, when provision is randomly allocated, systematic differences between groups in characteristics are avoided and it is possible to conclude that any differences between groups are due to the different conditions. This means that we can be more confident about drawing causal inferences from the results.

In this RCT, areas were randomly allocated to either receive the TaMHS programme in 2009 (44 authorities) or not to receive TaMHS until 2010 (30 authorities; see Appendix 2 for response rates).

To explore additional experimental intervention over and above the TaMHS provision would further enhance the mental health outcomes of the children involved, three additional aspects of the random allocation were also included: Action Learning Sets (ALS), booklets for LA leads and booklets for pupils (see Chapter 2 for further details about these conditions of additional support).

1. ALS were randomly allocated to 22 of the 44 areas receiving TaMHS in 2009 and aimed to allow areas to discuss challenges and share learning.
2. Booklets for LA leads were randomly allocated across the 74 areas involved in the RCT. They contained information about project start up and examples from pathfinder areas that had begun the project one year earlier.
3. Evidence based self-help booklets were randomly allocated to half the schools involved in the RCT. They contained self-help information about what children can do if they feel anxious, depressed or angry.

This chapter compares all conditions of the RCT to examine whether any groups had better mental health outcomes than others. Analyses were carried out using MLM (see Chapter 2

for explanation of MLM). Details of the representativeness of this sample can be found in Appendix 2.

Findings

Group comparisons

Models were fitted for emotional and behavioural difficulties separately for primary and secondary school children, focusing on those children who were above clinical cut-off in 2009 (see Appendix 4 for details). A multilevel model (MLM) was used, which took account of variation at school and pupil levels. The latent emotional difficulties and behavioural difficulties scores, based on children's self-reports on the M&MS measure, were used as outcome variables (see Appendices 5 and 12 for details).

Findings suggested that pupils in primary schools who received TaMHS in 2009 showed greater improvements in behavioural difficulties over time than those in schools which did not receive TaMHS in 2009. The same effect was not observed for secondary schools children or for children with emotional difficulties.

In order to further understand the impact of TaMHS, further interactions between TaMHS and non-TaMHS groups and other conditions of the RCT were explored. Two further interactions were observed in the analysis. Pupils in primary schools who received TaMHS in 2009 *and* evidence based self-help booklets showed a greater improvement in behavioural difficulties. However, for children with emotional difficulties in secondary school, those who were in areas that received ALS and also received evidence based self-help booklets showed less improvement in emotional difficulties over time independent of whether they were in an area that received TaMHS or not.

Finally a model was fitted for all the behavioural difficulties data to investigate effect of (a) above/below threshold for behavioural problems (b) primary/secondary school, (c) TaMHS group, and (d) year (see Table 6.1). There was a three-way interaction between threshold, TaMHS group, and year (in bold in Table 6.1; $\chi^2(1) = 5.1$, $p = .02$), meaning that those children with behavioural problems in schools receiving TaMHS showed more pronounced reductions in behavioural problems over time compared to those in schools that did not receive TaMHS. The four-way interaction between all four predictors (bolded final row in Table 6.1) indicated that this effect was predominantly confined to the primary school group, confirming the findings from the preceding models.

Table 6.1: Full model with all interactions for behavioural problems

	Slope	SE	t
(Intercept)	0.28	0.12	2.30
Above threshold at outset	5.73	0.35	16.25
Secondary school	-0.52	0.20	-2.64
TaMHS	-0.12	0.15	-0.77
Year	-0.05	0.01	-3.88
Above threshold × Secondary school	-0.20	0.58	-0.35
Above threshold × TaMHS	1.24	0.43	2.86
Secondary school × TaMHS	0.29	0.23	1.25
Above threshold × Year	-0.45	0.04	-12.17
Secondary school × Year	0.07	0.02	3.39
TaMHS × Year	0.01	0.02	0.76
Above threshold × Secondary school × TaMHS	-1.23	0.69	-1.78
Above threshold × Secondary school × Year	0.01	0.06	0.22
Above threshold × TaMHS × Year	-0.13	0.05	-2.91
Secondary school × TaMHS × Year	-0.04	0.02	-1.56
Above threshold × Secondary school × TaMHS × Year	0.13	0.07	1.85

Conclusions

Findings from the RCT suggested that TaMHS provision did have a positive impact for children with behavioural difficulties in primary schools but no evidence was found for an impact on older age groups or for emotional outcomes. There are a number of possible explanations for this finding. It may be that school-based programmes are best placed to improve behavioural rather than emotional difficulties. Schools are more accustomed to dealing with behavioural problems as part of general classroom management so may also be more able to give support to children with these kinds of problems. Furthermore, teachers are typically more successful at appraising children's behavioural difficulties than their emotional difficulties (Kolko & Kazdin, 1993) so are perhaps better able to identify the group of children with behavioural difficulties requiring additional support. Finally, in terms of making changes to children's behaviour, there are arguments to suggest that younger children are more susceptible to intervention (Webster-Stratton & Taylor, 2001) and also that behavioural problems tend to increase with age with a sharp increase during adolescence (Moffitt, 1993). A combination of these factors perhaps explains why the effects are only observed in the primary school sample.

Findings for the use of information for pupils was mixed, evidence based self-help booklets coupled with additional resources of TaMHS provided more pronounced improvements in behavioural problems for primary school children but evidence based self-help booklets coupled with ALS for staff were associated with less improvement in emotional difficulties. This finding of information giving being effective for children with behavioural difficulties is consistent with findings from the longitudinal study relating to information for pupils (although the age groups in which the effects were observed were not the same). However, the findings relating to the combination of ALS and booklets for pupils are less clear. We have no explanation for how this finding should be interpreted and, therefore, suggest it should be treated with caution.

There may be a number of reasons why effects of TaMHS were not found for other groups of children. First, it is possible that TaMHS was not effective for these groups of children. Second, many of the schools involved in the evaluation who did not receive TaMHS support reported having strategies in place to support children's mental health so were not a 'control' group in this respect. Third, in some cases LAs who were allocated to not receive TaMHS until 2010 decided to begin their project early using additional resources from elsewhere. Fourth, in areas that did receive TaMHS, the approaches taken, the support offered and the age groups worked with varied greatly across areas and schools. Finally, the one-year lag between the RCT group beginning their TaMHS project and the follow-up data being collected may not have been sufficient to allow the project to embed sufficiently to observe strong effects in child mental health outcomes (Groark & McCall, 2009).

Issues for further consideration

1. Provision of school-based mental health support in primary school may be an effective way forward. It is less clear about whether this approach is as relevant for secondary school pupils.
2. Provision of evidence based self-help booklets for pupils seems to be useful for younger children with behavioural problems where additional resources are already being provided to support mental health in the school.
3. Ideally programmes may need more time to embed before the full impact on child outcomes can be detected.

CHAPTER 7: CONCLUSIONS AND COMMENTARY

This research set out to answer 5 key research questions:

- 1) What is the impact of TaMHS provision relative to provision as usual when evaluated using random assignment of areas to TaMHS vs. provision as usual?
- 2) Does the additional provision of support materials when randomly assigned enhance the effect of TaMHS provision on pupil mental health?
- 3) What different approaches and resources are used to provide targeted mental health in schools?
- 4) What factors are associated with changes in pupil mental health for schools implementing targeted mental health during the course of a three year longitudinal study?
- 5) How is targeted mental health provision (and the support materials designed to enhance the impact of such provision) experienced by project workers, school staff, parents and pupils and what lessons are there for future implementation?

Each research question is considered in turn below (overall summary is also provided).

Research Q 1: What was the impact of TaMHS provision relative to provision as usual when evaluated using random assignment of areas to TaMHS vs. provision as usual?

Conclusions:

TaMHS provision resulted in a statistically significant decrease in problems in primary – but not secondary – school pupils who had behavioural problems at the outset, but had no effect on primary or secondary school pupils who had emotional difficulties at outset. These conclusions are based on comparison of children in schools in Local Authorities that, on a randomized basis, did and did not implement TaMHS.

Commentary:

There may be many reasons for the positive effect of TaMHS on change in levels of behaviour problems in primary school pupils (see discussion in Chapter 6). It may be the case that many TaMHS interventions specifically targeted behavioural problems (as suggested by findings in relation to research question 3 below); were especially likely to

involve specialist mental health input (as suggested by findings in relation to research q 3 below); or proved particularly successful in detecting behaviour problems and referring pupils with them for external specialist input (see conclusions in relation to research question 3 below).

The fact that positive effects of TaMHS on children with behaviour problems were restricted to primary and not secondary schools may be due to the fact that it is easier to effect change in primary schools. This may result from the fact that primary school pupils tend to remain throughout the day in a single classroom, exposed for the most part to a single teacher. Also influential may be a greater ability of primary schools to make use of key resources (see conclusions in relation to research question 2 below). A final consideration is that it may simply be more difficult to modify the behaviour of children with behaviour problems when they are older rather than younger (see conclusion in relation to question 4 below).

It is worth noting in this context that it is known that initiatives such as this generally take many years to embed, so to find any impact at this stage in the context of randomisation is positive.

Implications and issues for further consideration:

- 1) It may make sense to prioritise mental health work with primary school pupils in relation to behavioural problems to have maximum impact before problems become too entrenched.
- 2) It is important to note that the evaluation team have still to consider association of TaMHS involvement with later academic attainment levels – this will be reviewed when relevant academic attainment level data is available in 2012.

Research Q 2: Did the additional provision of support materials when randomly assigned enhance the effect of TaMHS provision on pupil mental health?

Conclusions:

- 1) The random allocation of evidence based mental health self-help booklets to pupils in TaMHS schools enhanced the general effect of exposure to TaMHS on primary school pupils with behaviour problems. That is, it resulted in a statistically significant additional decline in their behaviour problems over time. This conclusion is based on

comparison of primary school pupils with behaviour problems at the outset randomly assigned to TaMHS who, on a random basis, did or did not receive evidence based self-help mental health booklets.

- 2) The dual provision of information booklets to students and Action Learning Sets (ALS) for the TaMHS project team resulted in a significantly smaller decline in emotional difficulties for primary school pupils who had emotional difficulties at outset in comparison to the decline experienced by similar children who did not receive these booklets and whose project teams did not take part in ALS. However it is important to note that this effect was much less pronounced than was the effect of the positive impact of the booklets for children with behaviour problems (see conclusion 1 above).
- 3) None of the other support conditions was found to be significantly related to pupil mental health outcomes.

Commentary:

The finding that the provision of information in the form of evidence based mental health self-help booklets was associated with enhanced positive change for primary school pupils with behavioural difficulties, is in line with the finding from the longitudinal (observational) study that increased emphasis on giving information to pupils resulted in greater reductions in behavioural problem for pupils with behavioural problems, albeit in this case for pupils in secondary school (see conclusion to research question 4 below).

The finding that a combination of booklets and project team involvement in ALS was associated with less improvement in outcomes for children with emotional problems is perplexing and more difficult to explain. It may be that the booklets raised anxieties for already anxious children. This is in line with findings in the longitudinal analysis that provision of information was associated with smaller reductions in emotional problems compared to the rest of the sample for pupils in primary schools (see conclusions to research question 4 below). But it is hard to understand why this negative effect should emerge in the RCT only when the project team was also involved in ALS. Moreover the association, whilst statistically significant was weak, and should therefore be treated with particular caution.

Implications and issues for further consideration:

- 1) It may be worth considering further use of self-help materials for primary school pupils at risk of or experiencing behavioural problems.
- 2) Caution should be taken when giving information to pupils with emotional difficulties in primary school to ensure the material does not impact negatively.

Research Q 3: What different approaches and resources are used to provide targeted mental health in schools?

Conclusions:

- 1) Thirteen categories of mental health work in schools were identified: 1) Social and emotional development of pupils, 2) Creative and physical activity for pupils, 3) Information for pupils, 4) Peer support for pupils, 5) Behaviour for learning and structural support for pupils, 6) Individual therapy for pupils, 7) Group therapy for pupils, 8) Information for parents, 9) Training for parents, 10) Counselling for parents 11) Consultation for staff, 12) Counselling for staff and 13) Training for staff.
- 2) The most strongly endorsed category in both primary and secondary schools (apart from promotion of social and emotional development which all schools had to be doing as part of selection criteria for TaMHS implementation) was work on behaviour management in relation to behavioural difficulties.
- 3) There was little change over time in the proportion of schools engaging in the 13 types of mental health work.
- 4) Mental health support was reported to be provided principally by teachers rather than mental health professionals.
- 5) Over time schools reported increasing amounts of specialist mental health input.
- 6) Pupils with behavioural problems were more likely to see a mental health professional than those with emotional problems; and this was true in both primary and secondary schools.

- 7) The majority of both primary and secondary schools reported using approaches developed locally rather than those that had been internationally tested; and no primary or secondary schools reported using approaches that involved following a rigorous protocol or manual.
- 8) Schools indicated high use of educational psychology and other school-based resources for troubled pupils rather than direct referral to specialist CAMHS.
- 9) Use of the CAF increased over time in both primary and secondary schools.
- 10) Though relations with CAMHS were reported to be relatively poor and limited at the start of the evaluation (2008), they improved over the three years of the study.

Commentary

Schools in the TaMHS project reported using a variety of approaches to support children with or at risk of mental health problems. Perhaps, as indicated above, the reason why primary school children with behaviour problems benefited the most from TaMHS was because it was these children who were most likely to receive help from a dedicated mental health worker in school and to be referred for specialist mental health work outside school (as opposed to provision for children with emotional problems).

It is notable that generally schools were using locally developed services and treatments rather than strictly adhering to evidence based and manualised interventions, given that research suggests that the latter should most reliably yield beneficial effects.

In terms of inter-agency working there was evidence that schools were increasingly using the CAF as a way of coordinating across agencies. While school links with specialist CAMHS provision remained limited, there was evidence of significant improvement over the course of the study. It appeared that educational psychologists in particular may be a crucial point of contact in most schools for specialist input for both emotional and behavioural problems.

Implications and issues for further consideration:

- 1) Given independent evidence of their effectiveness from the existing academic literature and the striking absence of use in the schools surveyed there may be an

opportunity to encourage schools to use manualised approaches, based on a set plan of working, to mental health problems with a clear evidence base as these are likely to have greater impact, as long as this can be combined with local ownership to aid uptake.

- 2) Educational psychologists may be a key professional group to work with in relation to mental health provision in schools and their potential role in aiding links between schools and specialist CAMHS.

Research Q 4: What factors were associated with changes in pupil mental health for schools implementing targeted mental health during the course of a three year longitudinal study?

Conclusions:

Change over time:

- 1) Over time and irrespective of whether primary pupils were in TaMHS or other schools, primary school pupils' levels of both emotional and behavioural problems declined significantly across the three years of the study; this was true according to both teacher and pupil reports.
- 2) Secondary school pupils' levels of emotional problems also showed significant reductions across the three years of the study, but this was so only according to pupil self-reports, not teacher reports.
- 3) Secondary school pupils' levels of behavioural problems showed no significant change across the three years of the study based on pupil self-report though teachers reported increased levels of problems.

Factors associated with differential change:

- 1) For secondary school pupils with behavioural problems at the outset, greater reported provision of information to pupils was associated with greater improvements in mental health outcomes over time.

- 2) For primary school pupils with emotional problems, greater provision of information to pupils was associated with less pronounced reductions in emotional problems.
- 3) Greater school reported use of CAF was associated with greater reductions in mental health problems for pupils with behavioural problems over time in secondary school.
- 4) Schools reporting good links with CAMHS experienced greater declines over time in secondary school children's behavioural difficulties.

Commentary:

The fact that pupil and teacher reports revealed pupil mental health status improving over time (with the exception of behavioural difficulties in secondary school) may be testament to the impact of the range of mental health support being developed in schools over this period. It is worth noting that this is consistent with some recent international longitudinal studies (Gutman & Feinstein 2008; Slee et al, 2009; Humphrey, Lendrum, & Wigelsworth, 2010) although the evidence is mixed, and it is not possible to say on the basis of this study whether this is a result of mental health initiative, a developmental trend or a cohort effect.

The fact that change over time in mental health problems was less consistent and less positive in the case of secondary school pupils may be the result of the fact that the older children get, the more entrenched behaviour problems become and thus the more difficult they are to modify. It may also have something to do with children experiencing secondary school less positively – in terms of overall climate – than they do primary schools. Also worthy of consideration is the possibility that secondary schools may be less able to implement effective school-focussed targeted work given how much larger secondary schools are relative to primary schools and how much more complex the education environment is (i.e., changing classrooms, multiple teachers).

The association between school reports of high use of the CAF and reductions in behaviour problems in secondary school pupils suggests that this approach to ensuring joined up working may have beneficial effects. The fact that this was only found in secondary schools (as opposed to primary school) suggests that joined up working may be particularly important for this group perhaps because behavioural problems may be more entrenched by this stage and may be less susceptible to in-school programmes of work than primary school pupils (see conclusions to research question 1 above)

The association between schools' reporting of good links with specialist CAMHS and improvement in behavioural difficulties in secondary school pupils suggests that access to specialist help may be particularly important for pupils in secondary school (as opposed to primary school) again given the fact that their behavioural problems may be more entrenched and may be less susceptible to in-school programmes of work than primary school pupils (see conclusions to research question 1 above).

The finding that greater reported provision of information to pupils in secondary schools was associated with greater reduction in mental health problems for children with behavioural problems may suggest that the provision of this information might have helped direct them to relevant services or even more directly provided them with guidance on how to cope. Given the absence of any significant effect of the self-help booklets in the RCT on behavioural problems in this group (see conclusions for research question 1 above) and the positive effect of greater inter-agency working and specialist links discussed above, it seems likely that the former speculation might be more valid than the latter.

The finding that provision of information to children resulted in less reduction in emotional problems for primary school pupils may be due to such materials raising anxieties for already anxious children. This inference would seem consistent with the RCT findings indicating that provision of leaflets resulted in smaller reductions of difficulties for children with emotional problems in school (see conclusions to research question 2 above).

Implications and issues for further consideration:

- 1) It may make sense to prioritise improved inter-agency working (such as by use of systems such as the CAF), improved referral routes between schools and specialist CAMHS as ways to help address behavioural problems in pupils in secondary schools rather than focus on school based programmes. This could include the provision of materials to help young people find and access support.
- 2) Caution should be taken when giving information to pupils in primary school with emotional difficulties to ensure the material does not impact negatively.

Research Q 5: How was targeted mental health provision (and the support materials designed to enhance the impact of such provision) experienced by project workers, school staff, parents and pupils and what lessons are there for future implementation?

Conclusions:

- 1) TaMHS workers were extremely positive about the initiative and felt it worked best when TaMHS was fully integrated into schools. They highlighted challenges to finding a common language to use between mental health providers and schools. They also expressed concern about ensuring long-term funding and the embedding of the effort in the school over the longer term.
- 2) School staff were positive and enthusiastic about TaMHS. They identified a number of examples of positive change which they ascribed to the project. In particular they valued having TaMHS workers based in the school, people who they could consult regularly regarding children they had concerns about.
- 3) Parents tended to identify schools as the key point of contact for concerns about mental health issues. In particular they identified teachers as the key group they turned to if worried about their child's mental health. Teachers were also regarded as the ones who provided the most help in these situations in comparison with other groups such as family doctor and family friends.
- 4) Parents were generally positive about TaMHS and stressed the importance of good communication in working with schools on mental health issues for their children.
- 5) Pupils were not asked specifically about the TaMHS project but were generally aware and positive about support available from counsellors and peers mentors and others within the school.
- 6) Pupils reported high levels of contact with sources of mental health support in schools and those with the greatest difficulties reported the greatest contact.
- 7) Primary school children showed slightly more positive ratings of this kind of support than secondary schools pupils.
- 8) Pupils with greatest difficulties tended to rate their experience of support less positively than those with lower level of difficulties.

- 9) Pupils who saw the evidence based mental health self-help booklets rated them positively, with the primary school booklet being rated more positively than the secondary school booklet.
- 10) A particular challenge identified by some TaMHS workers, school staff and parents was the danger of new TaMHS provision substituting rather than supplementing existing provision within schools.

Commentary

TaMHS was experienced as a valued initiative by all groups including staff, parents and pupils.

Support from school staff is highly valued by parents especially for children in primary school where it may be particularly important that schools continue to remain an accessible point of support and advice for parents and pupils. This is in line with previous research on who parents turn to for help when they are worried about their child's mental health.

The fact that such large numbers of children reported accessing a variety of forms of mental health support in school led the evaluation team to question whether the question raising this issue in the student survey was fully understood. On the other hand, the fact that pupils with problems reported the greatest level of contact suggests that possibly resources are being appropriately targeted, though it should be noted those with significant problems reported less positive ratings of the help received.

The issue of possible substitution of existing services by a new initiative is something that has been identified in other projects. Such substitution has been referred to as 'displacement', where allocation of existing capacity to implement the new programme or initiative at the detriment of capacity elsewhere (HM Treasury, 2003).

Implications and issues for further consideration

- 1) It may be important to ensure that schools retain a role in being able to refer their pupils for appropriate help given the fact that parents identify them as the key point of contact and source of good advice for their concerns about their children.

- 2) It may be helpful to ensure that in any future roll out of mental health provision in schools attention is paid to ensuring a common language and as full integration as possible of services in schools.
- 3) When implementing interventions such as this one on a large scale, it may be of benefit to determine beforehand how best to avoid displacing existing support and to how such support can be sustained, for example by not requiring that provision be “innovative” or “new” and rather allowing areas to draw on existing good practice.

Summary of findings

TaMHS was a large scale government policy initiative that aimed to promote mental health support in schools. It was well received by workers, teachers, parents and pupils.

The RCT found that the implementation of TaMHS led to a significant reduction in problems for pupils in primary school with behavioural problems, but not for pupils with emotional problems or for secondary school pupils with either emotional or behavioural problems. Reduction in problems for pupils in primary school with behavioural problems was greater when pupils were also given evidence based self-help leaflets.

The Longitudinal Study revealed that overall the self-reported mental health of children taking part in the study improved (except for behaviour problems in secondary school pupils).

In secondary school greater inter-agency working (measured by use of CAF) and more positive links with specialist CAMHS and provision of information to pupils were all independently associated with reduction in behaviour problems.

There was some evidence that giving information to pupils in primary school with emotional problems may be associated with less reduction in emotional problems.

The association with academic attainment for all groups is to be assessed in 2012 when academic records for the pupils involved in this study will be available.

Summary of implications and issues for further consideration

Targeting Mental Health in Primary schools

It may make sense to prioritise mental health work with primary school pupils in relation to behavioural problems to have maximum impact before problems become too entrenched.

It may be worth considering further use of evidence based self-help materials for primary school pupils at risk of or with behavioural difficulties.

Caution should be taken when giving information to pupils in primary school with emotional problems to ensure the material does not impact negatively.

Primary schools may like to consider how best to ensure they do not overlook children with emotional problems in terms of accessing specialist mental health help.

Targeting Mental Health in Secondary schools

It may make sense to prioritise improved inter-agency working (such as by use of systems such as the CAF) as ways to help address behavioural problems in pupils in secondary school.

It may be beneficial to prioritise improved relationships and referral routes between schools and specialist CAMHS as ways to help address behavioural problems in pupils in secondary school.

It may make sense to prioritise the provision of materials to help young people find and access such support help address behavioural problems in pupils in secondary school.

Secondary schools may like to consider how best to ensure they do not overlook children with emotional problems in terms of accessing specialist help.

Evidence based practice

It may be helpful for schools to be encouraged to consider using more manualised approaches with a clear evidence base as these have been found in the literature to have the greatest impact, though this needs to be combined with need for local ownership to aid uptake.

Inter-agency working

It may be important to ensure that schools retain a role in being able to refer their pupils for appropriate help given the fact that parents identify them as the key point of contact and good advice for their concerns about their children.

Educational psychologists appear to be a key group to work with in relation to mental health provision in schools and their potential role in aiding links between schools and specialist CAMHS.

Strong links with specialist CAMHS and good use of inter-agency working (as demonstrated by high use of the CAF) should be encouraged, especially in secondary schools where they are associated with reduction in behavioural problems for pupils with problems.

Future implementation of policy

It may be helpful to ensure that in any future roll out of mental health provision in schools attention is paid to ensuring a common language and as full integration as possible of services in schools.

When implementing interventions such as this one on a large scale, it may be of benefit to determine beforehand how best to avoid displacing existing support and to how such support can be sustained, for example by not requiring that provision be “innovative” or “new” and rather allowing areas to draw on existing good practice.

Future research

It is important to note the evaluation team have still to consider association of TaMHS involvement with later academic attainment levels – this will be reviewed when relevant academic attainment level data is available in 2012.

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APPENDICES

APPENDIX 1: Supporting material for LA's and pupils



Figure 1a: Get up and Go (primary school booklet)

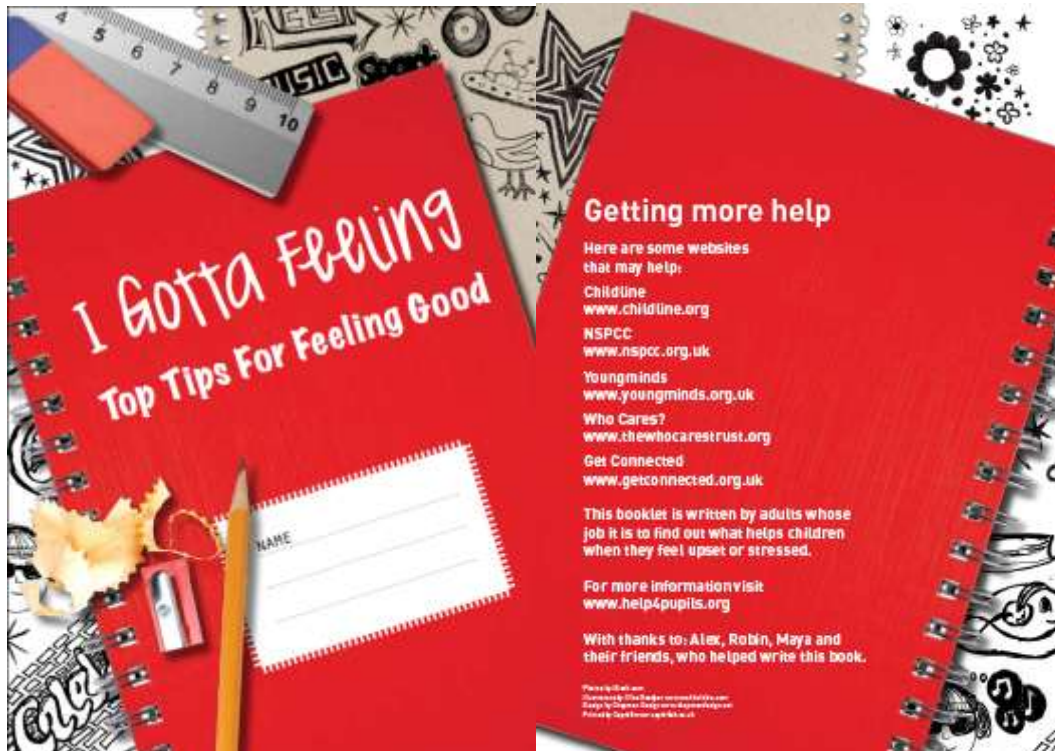


Figure 1b: I've gotta feeling (secondary school booklet)



How to... engage schools parents and pupils

DCSF guidance states that TdMHS needs to be run across at least 2 secondary schools and their feeder primary schools in each area.

Even if the schools are not to implement TdMHS until 2010 they have to be signed up in 2009 as they will be part of the national evaluation 2009.

The selected schools must already be implementing SEAL and have national healthy school status.

In addition it is worth considering the following in selecting schools:

- Allowing schools to opt in once they have been provided with information on the project.
- Considering each school's level of need versus their capacity to engage (it may not be advisable to pick very needy schools if they cannot engage).
- It may be helpful to cluster schools according to some criteria (e.g. geographical areas or 1 secondary school and its associated primaries) but clusters to allow them to share learning/resources or to deliver training.
- It may be helpful to invite school representatives to stakeholder days or a search day for the project. At these events schools only be provided with information regarding the project and what would be involved in their participation as well as raising awareness of the issues addressed by the project.
- It may be helpful to set up stakeholder or advisory groups to monitor the project and provide ongoing input.

Below are examples of search events from two phase 1 areas:

Example Phase 1 area – Pathfinder D

Set up

- Participating schools were invited to attend a stakeholder day to introduce the TdMHS project.

Who was involved?

- Led by 4 members of the TdMHS team
- 25 people attended – approximately 2 per school (2 senior leadership, 1 school project lead)

What did it cover?

- Focused on the following themes:
 - What is mental health?
 - How CAMHS is arranged
 - Early intervention
 - Impacts of keeping children in systems other than excluding them
 - Asked school staff to discuss what they felt were the major challenges in their clusters

How was it successful?

- Schools discussing challenges allowed the TdMHS team to pick up lessons and come back with solutions.
- Found that some schools had a lot going on already that they didn't realise was health and well-being (e.g. parenting programmes, SEAL).

What else was used?

- 3 x 1.5 day stakeholder days
- Visits from PM and SD psych to each school to establish if services already in place, 2) what needs to be put in place
- Newsletter

Figure 1c: LA booklet

APPENDIX 2: Sample response rates and representativeness

Participation Figures

Table 2a: Participation figures in the longitudinal study and RCT

	2008		2009		2010	
<u>Longitudinal study</u>	N of pupils	N of schools	N of pupils	N of schools	N of pupils	N of schools
Pupil surveys: mental health (SDQ & M&MS) & school climate	19695	391	1673 2	298	11533	231
Parent surveys: child mental health (SDQ) & help seeking	1842	372	1061	268	780	215
Teacher surveys: child mental health (short response)	3671	283	6973	159	5223	124
Teacher Surveys: child mental health (SDQ)	1622	262	1148	157	833	121
School Coordinator surveys: school-based mental health support & links with other agencies	282		164		109	
LA surveys: project start-up, school-based mental health support & links with other agencies	N/A		18		21	
<u>RCT</u>	N of pupils	N of schools	N of pupils	N of schools	N of pupils	N of schools
Pupil surveys: mental health (SDQ & M&MS) & school climate	RCT allocation		307 96	559	19418	373
Parent surveys: child mental health (SDQ) & help seeking			285 7	522	1606	337
Teacher surveys: child mental health (short response)			159 80	356	9322	208
Teacher Surveys: child mental health (SDQ)			284 3	347	1482	201
School Coordinator surveys: school-based mental health support & links with other agencies			387		214	
LA surveys: project start-up, school-based mental health support & links with other agencies			2		56	

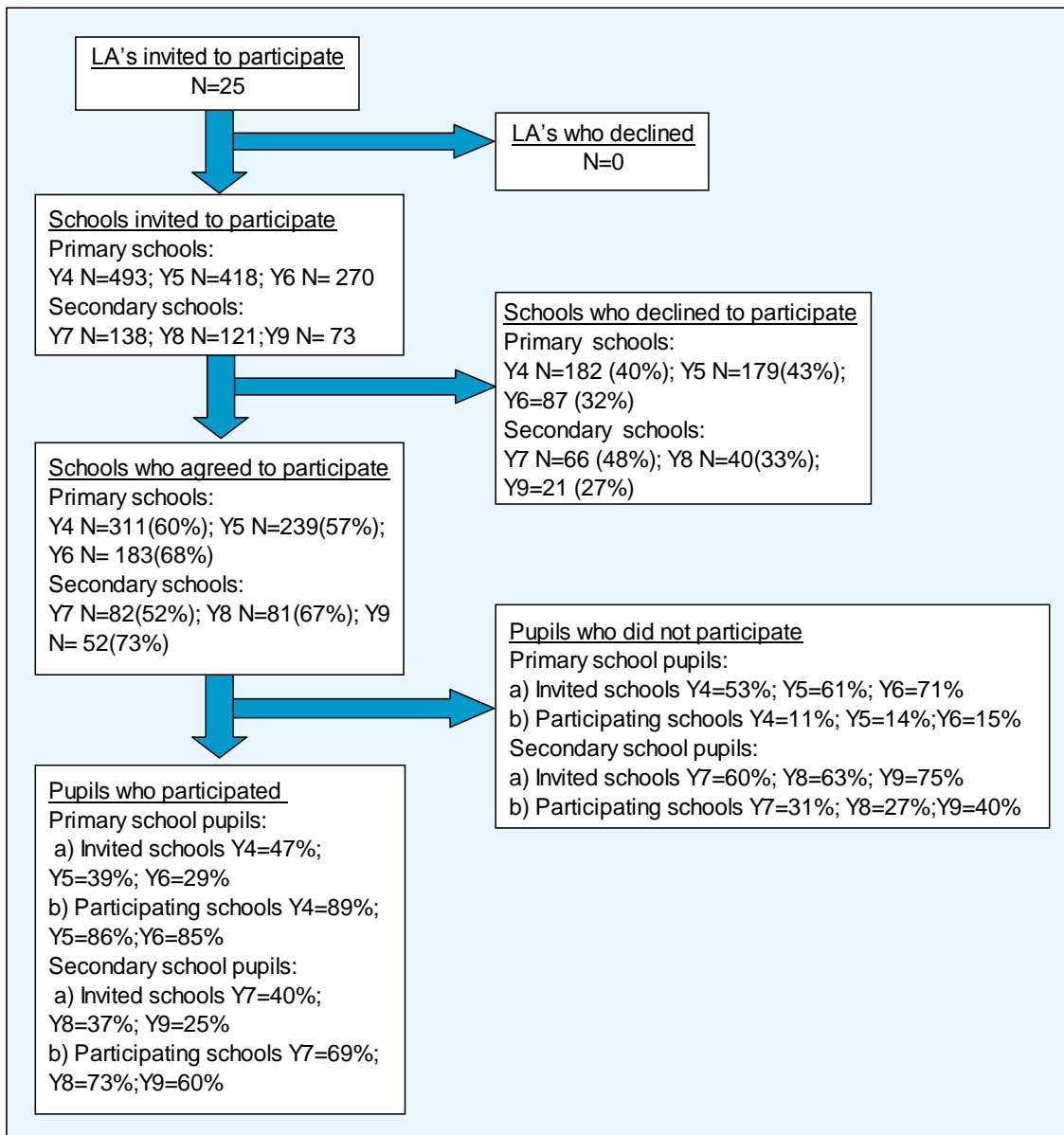


Figure 2a: Response rates at LA, schools and pupil level for the longitudinal study¹⁴.

¹⁴ NB Figures describe those who were 'invited to participate'. However, as the inclusion of schools within TaMHS and within the national evaluation often involved complex negotiations between schools and LAs, there are no exact figures about those invited. Instead we have taken those schools who logged on to the Me and My School website at least once as those who were invited, and those schools where at least one pupils survey completed as those who had participated

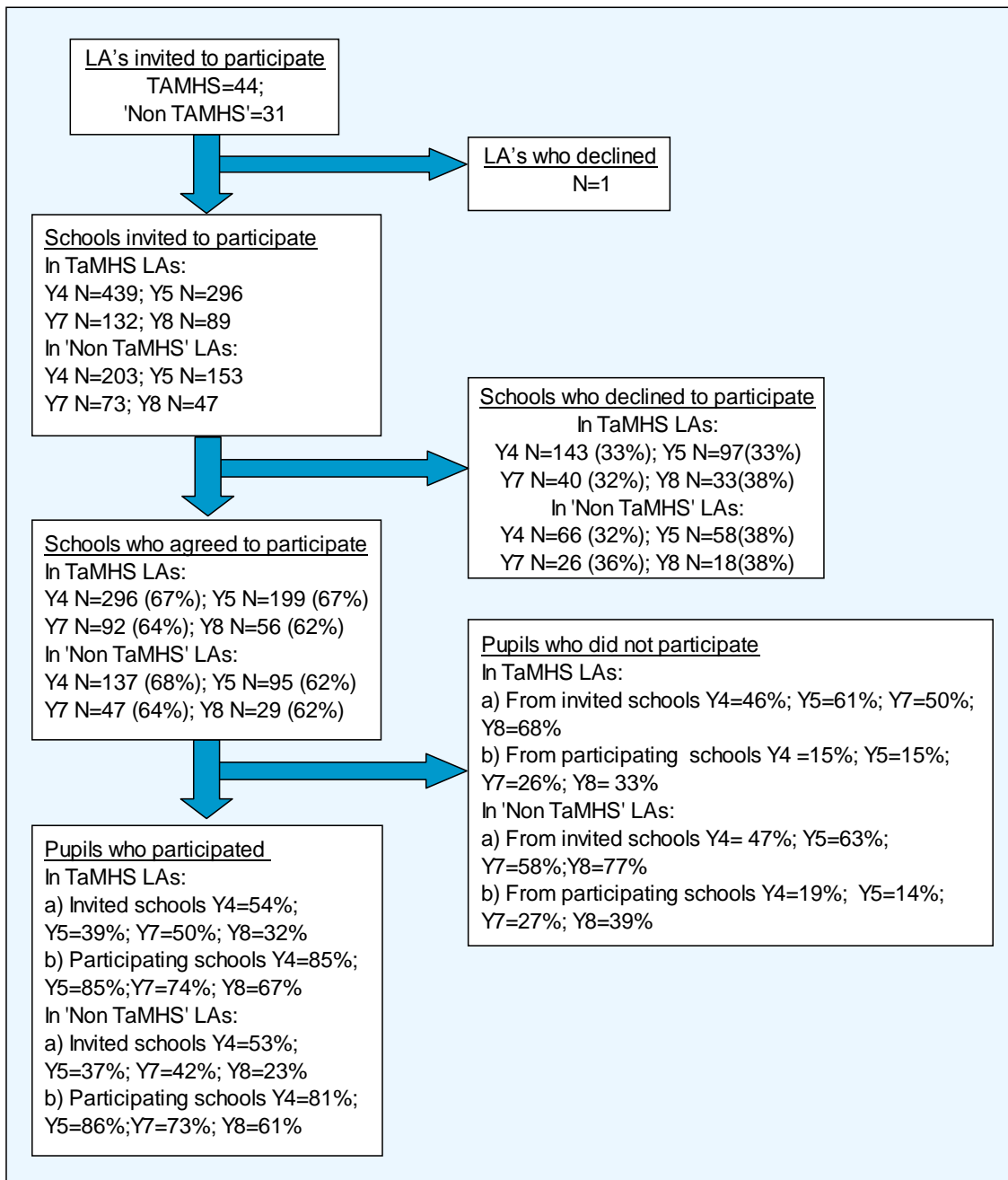


Figure 2b: Response rates for the RCT

Representativeness

National figures

Some of the National figures quoted below and used for comparison, refer to greater age ranges than the single year samples in the questionnaire samples. The National figures for SDQ refer to the age range 11-15 and come from a national survey conducted by National

Statistics (for details see Meltzer et al., 2000¹⁵). The National figure of 0.5% in care refers to children of all ages. The national figures for ethnicity, SEN statements were obtained from the DfE Statistical first release (SFR), 2010¹⁶. Key stage results are from earlier Statistical releases from the DCSF (Key Stage 1 from SFR 2007 & Key Stage 2 from SFR 2008).

Longitudinal Study: primary schools

Compared to national figures higher proportions of participating primary school pupils were from a more deprived socio-economic background as indicated by the proportion eligible for free school meals (FSM) (20-23% across years compared to national average of 14%) and the mean IDACI (Income Deprivation Affecting Children Index) score (0.28-0.29 across years compared to national average value of 0.24). Participating pupils had higher proportions of pupils statemented with Special Educational Needs (SEN) (1.4-1.8 compared to national 1.4), similar proportions in care and had Key Stage 1 scores slightly below the national average (14.8-15 compared to 15.3 nationally).

Longitudinal Study: primary school pupils who participated all 3 years

Pupils who had data matched across all 3 years had higher proportion of FSM eligible pupils (19%) compared to 14% nationally and mean IDACI score of 0.27 compared to 0.24 nationally. Proportion of pupils with SEN statements was slightly higher (1.5%) than national figures (1.4%). Proportion of pupils in care was slightly lower in participating pupils (0.4%) than nationally (0.5%). Key Stage 1 mean score was 15.06 in matched participating pupils which is slightly below the 15.3 national average. The proportion of pupils classified as White British was slightly higher than primary schools nationally (77.3% versus 74.5% nationally).

Longitudinal Study: secondary schools

Like in primary schools, participating secondary school pupils had higher proportions of pupils with FSM eligibility (15-20% across years compared to national average of 11.9%) and lower IDACI scores (0.27-0.28 across years compared to 0.22 nationally) which indicates that on average participating pupils had higher proportions of deprivation compared

¹⁵ Meltzer, H., Gatward, R., Goodman, R., & Ford, F. (2000). *Mental health of children and adolescents in Great Britain*. London: The Stationery Office

¹⁶ DfE: Schools, pupils and their characteristics, Jan 2010. Data from this report is from the school census 2010

to the national average. Participating pupils also had similar proportion of SEN statemented pupils (1.9 -2.1% across years compared to 2% nationally), almost the same proportion of pupils in care (0.5%) and similar mean Key stage 2 scores to national figures (range of 27.3-28 across years compared to 27.7 national average).

Longitudinal Study: secondary school pupils who participated in all 3 years

Pupils who had data matched across all 3 years had higher proportion of FSM eligible pupils (17.7%) compared to 11.9% nationally and mean IDACI score of 0.27 compared to 0.22 nationally. Proportion of pupils with SEN statements was lower (1.4%) than national figures (2%). Key Stage 2 mean score was 27.69 in matched participating pupils which almost the same as the 27.7 national average. The proportion of pupils classified as White British was slightly lower than national figures for secondary schools (72.7% versus 78.6% nationally).

Scores on SDQ emotional, conduct and total difficulties scales compared to national SDQ figures suggest that participating pupils had similar emotional (TaMHS=2.79, SDQ value=2.81) and total difficulties scores (TaMHS=10.35, SDQ value=10.3), but lower scores on the conduct scale (TaMHS=1.96, SDQ value=2.24).

RCT: primary schools

Participating pupils from both the RCT branches were included only if they had data both years as only these data were used in all analyses. For the responding pupils on each branch of the RCT, TaMHS and non-TaMHS, the proportion of pupils eligible for FSM is very similar in both branches of the RCT (23% non-TaMHS, 24% in TaMHS) and much higher than the national proportion of 14%. Both groups had mean IDACI values of approximately 0.30 (TaMHS =0.31, No-TaMHS=0.29) which is higher than the national value of 0.24. This suggests that both branches of the RCT have similar rates of deprivation and this is higher than the national average.

The proportion of statemented pupils was different in the 2 branches of the RCT (TaMHS=1.8%, Non TaMHS=1.3%). The proportion in the Non TaMHS group is similar to national value (1.4%) but the proportion in the TaMHS group is greater than the national value. Mean Key Stage 1 scores were very similar in both branches of the RCT (TaMHS=15.02, No-TaMHS=14.96) and lower than national average score of 15.3. The proportion of pupils classified as White British was 74.4% which is very similar to the 74.5% in primary schools nationally.

RCT: secondary schools

In secondary schools for the responding pupils on each branch of the RCT, TaMHS and non-TaMHS, the mean values for the IDACI scores were very close (TaMHS=0.26, non-TaMHS 0.25) but higher than the national value of 0.22. The proportion of pupils eligible for free school meals are very similar in the 2 groups and very similar to the national value (TaMHS=21.2%, non-TaMHS=22.1%, National= 21.6%). This suggests that both branches of the RCT have similar rates of deprivation and this is slightly higher than the national average.

The proportion of pupils with SEN statements was very similar in the 2 branches of the RCT and almost the same as national proportions (TaMHS=2.8%, non-TaMHS=2.7%, National=2.8%). Average Key Stage 2 scores in the TaMHS and non-TaMHS groups were similar (TaMHS=27.95, non-TaMHS=27.93) and slightly higher than the national average of 27.7. The proportion of pupils classified as White British was 80.3% which is higher than the 78.6% across secondary schools nationally.

Scores on SDQ emotional, conduct and total difficulties scales compared to national SDQ figures suggest that pupils in the TaMHS group had lower scores on the emotional, conduct and total difficulties scales compared to the non-TaMHS group. Pupils in the no-TaMHS group had an average emotional problems score of 2.80 which is similar to the national SDQ score of 2.81 and higher than the TaMHS group score of 2.68. For the conduct problem scale both the TaMHS and non-TaMHS groups had lower scores (TaMHS=1.97, non-TaMHS=2.05) than the 2.24 national SDQ score. The total difficulties score was higher in the non-TaMHS group (10.56) than in the TaMHS group (10.21) and the national score (10.3).

Representativeness of the sample used in Chapter 3

Compared to primary schools nationally, primary schools included in this chapter have a higher proportion of pupils eligible for free school meals (19% vs. 14% nationally) and slightly higher than average IDACI score (0.26 vs. 0.24 nationally). Similarly, compared to secondary schools nationally, secondary schools included in this chapter have higher proportion of pupils eligible for free school meals (14.5% vs. 11.9% nationally) and slightly higher average IDACI score (0.26 versus 0.22 nationally).

When compared to schools that participated in this study but are not included in this chapter (for not having complete school co-ordinator data at all three time points) primary schools used in analyses had slightly lower school IDACI scores (analyses schools, M=0.26, other

schools, M=0.29) and almost the same proportion of pupils receiving free school meals (around 19%). 71% of analyses schools were community schools compared to 78% of participating schools not included in this chapter.

Schools included in this section did not include any PRU's, academies and community special schools.

Secondary schools included in analyses had almost the same mean school IDACI scores and a slightly higher proportion (M=14.5%) of pupils receiving free school meals when compared to the rest of the participating schools (M=13.8%). 69% of schools included in this chapter are Community schools which is the same proportion of community schools in participating schools excluded from school co-ordinator survey analyses.

Representativeness of the sample used in Chapter 4

Compared to a national sample this sample is more deprived (higher proportion with Free School Meals and higher IDACI score), a lower proportion of responding pupils have SEN statements and responding pupils have slightly higher Key Stage scores than the national average.

Parents of primary pupils who completed the parent survey in 2008 had a lower proportion receiving Free School Meals than the proportion in primary schools nationally (10.6% vs. 14% nationally). The proportion with Special Educational Needs statements was the same as the national proportion. Mean IDACI score of parents who completed survey was the same as the national average. Parents who completed surveys had on average children with higher Key Stage 1 scores (16.2) than the national average (15.3).

The trends for parents of secondary school pupils who completed parent surveys was similar. Parents of secondary pupils who completed the parent survey in 2008 had less proportion receiving Free School Meals (9.2% vs. 11.9% nationally). The proportion with Special Educational Needs statements was lower (1.5%) than the national proportion (2%). Mean IDACI score of parents who completed survey was the same as the national average. Parents who completed surveys had on average children with higher Key Stage 1 scores (16.48) than the national average (15.3).

APPENDIX 3: Measures

Me and My School

This measure consists of 3 scales: Emotional difficulties scale, behavioural difficulties scale and school climate scale. The children respond “always”, “sometimes” or “never” depending on their level of agreement with each statement (refer to appendix 4 for details of measure development and psychometric properties).

Emotional difficulties

I feel happy
I feel lonely
I am unhappy
I like the way I look
Nobody likes me
I enjoy break times
I enjoy playing with friends
I cry a lot
Other children tease me
I worry when I am at
I worry a lot
I have problems sleeping
I have lots of friends
I wake up in the night
I am shy
I feel scared
I enjoy being with other

Behavioural difficulties

I get very angry
I lose my temper
I bully others
I do things to hurt people
I am calm
I hit out when I am angry
I break things on purpose

School climate

At this school we care
At this school we like
We can talk to
Teachers try hard to
We feel safe in school
Our Teachers are fair
There is an adult in my

The measure was subject to a range of psychometric analysis (see Appendix 4 for details) and based on these analyses, a subset of items were finally selected for inclusion in the emotional difficulties and behavioural difficulties subscales. These items are highlighted in bold in the list above.

SDQ- Pupil self-report

The items can be summed up into 5 subscales: Hyperactivity, Emotional symptoms, Behavioural problems, Peer problems and Prosocial and a Total difficulties score. This measure can be completed by children aged 11-18 years and was therefore only completed by secondary school pupils. Responses are on a 3 point scale: Not true, Somewhat true and Certainly true.

- I try to be nice to other people. I care about their feelings
- I am restless, I cannot stay still for long
- I get a lot of headaches, stomach-aches or sickness
- I usually share with others (food, games, pens etc.)
- I get very angry and often lose my temper
- I am usually on my own. I generally play alone or keep to myself
- I usually do as I am told
- I worry a lot
- I am helpful if someone is hurt, upset or feeling ill
- I am constantly fidgeting or squirming
- I have one good friend or more
- I fight a lot. I can make other people do what I want
- I am often unhappy, down-hearted or
- Other people my age generally like me
- I am easily distracted, I find it difficult to concentrate
- I am nervous in new situations. I easily lose confidence
- I am kind to younger children
- I am often accused of lying or cheating
- Other children or young people pick on me or bully me
- I often volunteer to help others (parents, teachers, children)
- I think before I do things
- I take things that are not mine from home, school or elsewhere
- I get on better with adults than with people my own age
- I have many fears, I am easily scared
- I finish the work I'm doing. My attention is good

If child answers positively to:

“Overall, do you think that you have difficulties in one or more of the following areas: emotions,

concentration, behaviour or being able to get on with other people?”

They are asked some additional questions:

- How long have these difficulties been present?
- Do the difficulties upset or distress you?
- Do the difficulties interfere with your everyday life in the following areas: (Home life, friendships, classroom learning, leisure activities)
- Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Help and Booklet Questions

These questions were only asked in 2010 (final year of survey).

Pupils respond to the three questions regarding help received in by selecting one of the following options: Never, Once, A few times or More than five times. If they answer anything other than 'never' they are then asked to indicate how helpful they found it : Not helpful, quite helpful or very helpful.

- Over the last year I have talked to a counsellor in school because I have been stressed, sad or angry
- Over the last year I have talked to a peer mentor in school because I have been stressed, sad or angry
- I have had other help in school because I have been stressed, sad or angry

Pupils were also asked whether they had seen certain booklets and if they responded yes they were asked how helpful they had found the booklets.

Teacher Short Questions

Teachers were asked to rate all pupils as either having No problems, minor problems, some problems or sever problems for emotional and behavioural difficulties.

Teacher SDQ

The items can be summed up into 5 subscales: Hyperactivity, Emotional symptoms, Behavioural problems, Peer problems and Prosocial and a Total difficulties score. Responses are on a 3 point scale: Not true, Somewhat true and Certainly true.

- | | |
|---|---|
| • Considerate of other people's feelings | • Generally liked by other children |
| • Restless, overactive, cannot stay still for long | • Easily distracted, concentration wanders |
| • Often complains of headaches, stomach-aches or sickness | • Nervous or clingy in new situations, easily loses confidence |
| • Shares readily with other children (treats, toys, pencils etc.) | • Kind to younger children |
| • Often has temper tantrums or hot tempers | • Often lies or cheats |
| • Rather solitary, tends to play alone | • Picked on or bullied by other children |
| • Generally obedient, usually does what adults request | • Often volunteers to help others (parents, teachers, other children) |
| • Many worries, often seems worried | • Thinks things out before acting |
| • Helpful if someone is hurt, upset or feeling ill | • Steals from home, school or elsewhere |
| • Constantly fidgeting or squirming | • Gets on better with adults than with other children |
| • Has at least one good friend | • Many fears, easily scared |
| • Often fights with other children or bullies them | • Sees tasks through to the end, good attention span |
| • Often unhappy, down-hearted or tearful | |

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

If the answer is Yes they go to answer the following items:

- How long have these difficulties been present?
- Do the difficulties upset or distress the child?
- Do the difficulties interfere with the child's everyday life in the following areas? = PEER RELATIONS
- Do the difficulties interfere with the child's everyday life in the following areas? = CLASSROOM LEARNING
- Do the difficulties put a burden on the class as a whole?

Parent SDQ

Responses are on a 3 point scale: Not true, Somewhat true and Certainly true.

The items can be summed up into 5 subscales: Hyperactivity, Emotional symptoms, Behavioural problems, Peer problems and Prosocial and a Total difficulties score.

- Considerate of other people's feelings
- Restless, overactive, cannot stay still for long
- Often complains of headaches, stomach-aches or sickness
- Shares readily with other children (treats, toys, pencils etc.)
- Often has temper tantrums or hot tempers
- Rather solitary, tends to play alone
- Generally obedient, usually does what adults request
- Many worries, often seems worried
- Helpful if someone is hurt, upset or feeling ill
- Constantly fidgeting or squirming
- Has at least one good friend
- Often fights with other children or bullies them
- Often unhappy, down-hearted or tearful
- Generally liked by other children
- Easily distracted, concentration wanders
- Nervous or clingy in new situations, easily loses confidence
- Kind to younger children
- Often lies or cheats
- Picked on or bullied by other children
- Often volunteers to help others (parents, teachers, other children)
- Thinks things out before acting
- Steals from home, school or elsewhere
- Gets on better with adults than with other children
- Many fears, easily scared
- Sees tasks through to the end, good attention span

The parent is asked the following question: Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

If the answer is positive they are then asked the following questions:

- How long have these difficulties been present?
- Do the difficulties upset or distress your child?
- Do the difficulties interfere with your child's everyday life in the following areas? HOME LIFE
- Do the difficulties interfere with your child's everyday life in the following areas? FRIENDSHIPS
- Do the difficulties interfere with your child's everyday life in the following areas? CLASSROOM LEARNING
- Do the difficulties interfere with your child's everyday life in the following areas? LEISURE ACTIVITIES
- Do the difficulties put a burden on you or the family as a whole?

School Co-ordinator survey

CHILD A. Imagine an 11 year old pupil with **disruptive** behaviour who is abusive to teachers and other adults, who often fights with other children or bullies them, lies, and is generally aggressive and difficult to manage. This has been going on for over half a term. Teachers have tried to talk to this pupil but it doesn't seem to have helped. Parents have also been contacted but are unsure what to do.

A.1 If this were a child in your school, would they be able to see someone in your school for help with their difficulties? (answer Yes / No). *If the answer is **Yes**, the following two questions will be asked:*

A.2 They are: Choose as many as appropriate

- Class teacher
- Another teacher e.g. special needs teacher
- Teaching assistant e.g. special needs assistant
- Health professional e.g. school nurse, school doctor
- Mental health professional e.g. psychologist, psychiatrist, counsellor
- Other _____

A.3 They would help by: Choose as many as appropriate

- Listening to their problems and offering understanding and general support
- Teaching them how to behave and think differently in situations they find difficult
- Exploring with them the root of their difficulties in their family or their past
- Teaching them new skills to solve problems and get on with other children
- Discussing providing medicine to help them control their feelings or behaviour
- Other _____
- Don't know

A.4 If **CHILD A** were a child in your school would the child be encouraged to join a support group?

(answer Yes/No). *If the answer is **Yes**, the following two questions will be asked:*

A.5 Who runs this group? Please select all that apply

- Class teacher
- Another teacher e.g. special needs teacher
- Teaching assistant e.g. special needs assistant
- Health professional e.g. school nurse, school doctor
- Mental health professional e.g. psychologist, psychiatrist, counsellor
- Other _____

A.6 This group might help the child to: Please select all that apply

- Discuss any problems and share ideas and support
- Behave and think differently in situations they find difficult
- Gain skills to get on better with other children
- Explore the root of their difficulties in their family or the past
- Develop appropriately through involvement in a nurture group
- Learn emotional skills through involvement in small group SEAL
- Other _____
- Don't know

A.7 If **CHILD A** were a child in your school, would the family be offered any help or support by the school?

*(answer Yes/No). If the answer is **Yes**, the following two questions will be asked:*

A.8 Who would offer this support? Please select all that apply

- Class teacher
- Another teacher e.g. special needs teacher
- Teaching assistant e.g. special needs assistant
- Health professional e.g. school nurse, school doctor
- Mental health professional e.g. psychologist, psychiatrist, counsellor
- Other _____

A.9 What would family/carers be offered? Please select all that apply:

- Techniques to help them deal with their own anxieties
- Meetings with other families to share thoughts and support
- Training to manage their child's behaviour e.g. Triple P, Webster Stratton
- Meetings as a family to help them find solutions that work for them
- Other _____
- Don't know

A.10 Who else might the school refer this child to? Please select all that apply

- No one
- Local Authority Behaviour Support Team
- Pupil Referral Unit
- Educational Psychology Service
- General Practitioner
- Child and Adolescent Mental Health Service
- Voluntary service _____
- Private service _____

A.11 What other help might a pupil with **disruptive** behaviour (abusive, fights, bullies, lies, aggressive, difficult) be offered? Please enter your response in the box below (free text box given)

A.12 For a child with **disruptive** behaviour (abusive, fights, bullies, lies, aggressive, difficult) in your school, would a CAF be completed on this child? Y/N

A.13 How do you assess if the support you offered to a child with **disruptive** behaviour (abusive, fights, bullies, lies, aggressive, difficult) has helped? *Please select all that apply*

- Feedback from child to a teacher www.tmhse.org enquiry@tmhse.org
- Behaviour report completed by teachers
- Report from the person who tried to help the child
- Observe the child in the playground or classroom
- Use of a self-report questionnaire completed by the child
- Use of a questionnaire completed by parents
- Use of a questionnaire completed by teachers
- Look at exam results
- other _____

Note: *exactly the same questions are then asked for a child who appears unhappy as described below:*

Child B: Imagine an 11 year old pupil who appears **unhappy** and who appears to be quite isolated from other children and often seems quite low in confidence and mood. They are very clingy and fearful in new situations and can become very tearful and appear worried. This has been going on for over half a term.

Teachers have tried to talk to this pupil but this does not seem to have helped. The parents have also been contacted but are unsure what to do.

Some general questions are then asked:

C1. Please indicate how often the Common Assessment Framework was used for a pupil in your school over the last year.

- Never
- 1-5
- 6-10
- 11-15
- 16-20
- More than 20

C2. Over the last year (September 07 – September 08), have there been any activities for staff at your school that are to do with helping children who are unhappy or disruptive?

Text boxes are provided to describe the activity or training material and who provided it- you can add as many text boxes as required

C3. Do you feel you have good links with local child mental health services?

- Yes, very much
- yes, some
- yes, a little
- no, not much
- No, not at all

C4. Please list below your local child mental health services (can be statutory, private or voluntary) and indicate how much contact you have had with them in the past

Never on one occasion 2-5 times more than 5 times (*You can add as many text boxes as required*)

Please indicate job role(s) of anyone involved in answering these questions. Choose as many as appropriate

- Head teacher
- Teacher
- Special needs co-ordinator
- Administrator
- Business manager
- Other

C5. How sure do you feel about the answers you have given?

- Very sure
- Sure
- Quite sure
- Not very sure
- Not at all sure

C6. Please rate how far the things your school is doing to help pupils with emotional and behavioural problems fall into each of the following categories (Not at all, A little, Somewhat, Quite a lot, Very much):

1. Social and emotional skills development of pupils

e.g. SEAL, Silver SEAL, nurture groups, circle time, PATHS

2. Creative and physical activity for pupils

e.g. drama, music, art, cookery, circus skills, outward bounds, breath-works, mindful movement, yoga

3. Information for pupils

e.g. advice lines, leaflets, texting services, internet based information

4. Peer support for pupils

e.g. buddy schemes, peer mentoring, peer massage

5. Behaviour for learning and structural support for pupils

e.g. behaviour support, restorative justice, sanctions, celebrating success, lunchtime clubs, calm rooms

6. Individual therapy for pupils

e.g. counselling, cognitive and/or behavioural therapy, psychotherapy

7. Group therapy for pupils

e.g. group therapy, cognitive and/or behavioural therapy groups

8. Information for parents

e.g. Leaflets, advice lines, texting services, internet based information

9. Training for parents

e.g. parenting programmes such as Webster Stratton and Triple P

10. Counselling/support for parents

e.g. individual work for parents, family therapy, family SEAL

11. *Training for staff*

e.g. specific training from a mental health professional, training in inter-agency working

12. *Supervision and consultation for staff*

e.g. on-going supervision or advice from a mental health professional

13. *Counselling/support for staff*

e.g. provision to help staff deal with stress and any emotional difficulties

C7. Please select the statement that is most true for your school as a whole:

Our school aims to help pupils with emotional and behavioural difficulties by focusing mainly on:

- specific individual pupils
- small groups of pupils
- all pupils in the school

The person or people in our school(s) who help pupils with emotional and behavioural difficulties are in the main:

- members of school staff with no specialist mental health training
- member of school staff with some specialist mental health training
- mental health specialists

The ways of helping pupils with emotional and behavioural difficulties are in the main:

- new and have not been tried before
- tried before locally and seem to help
- tried before nationally or internationally and found to help

The ways of helping pupils with emotional and behavioural difficulties in our school(s) were chosen in the main:

- by the school
- by the local authority
- by the school and local authority jointly

The ways of helping pupils with emotional and behavioural difficulties are in the main:

- based on a set plan of working that has to be strictly adhered to
- based on a plan but open to adaptation
- not based on any set plan: up to the person leading what they do

The ways of helping pupils with emotional and behavioural difficulties are in the main focused on

- preventing problems arising
- helping children who are starting to develop problems
- helping children who already have problems

APPENDIX 4: Me and my school (M&MS) clinical cut-offs and initial validation

Clinical cut offs were established for the M&MS measure against the already established cut offs for the SDQ using equipercentile equating (Kolen & Brennan, 2004). Cut off scores for the M&MS subscales are reported in Table 4a; they are 14 for the emotional scale (with a borderline cut off of 12); 7 for the behavioural subscale (with a borderline cut off of 6).

Table 4a: Cut-offs for the M&MS measure

	Normal	Borderline	Clinical
Emotional	0-11	12-13	14
Behavioural	0-5	6	7-12

Item selection from the original set of items was done based on exploratory factor analysis (EFA) and Differential item functioning (DIF) that was carried out on data collected in the first year (2008). Based on the analyses the items in bold from the list of all items were used in all the analyses¹⁷.

Emotional difficulties

I feel happy
I feel lonely
I am unhappy
 I like the way I look
Nobody likes me
 I enjoy break times
 I enjoy playing with friends
I cry a lot
Other children tease me
I worry when I am at
I worry a lot
I have problems sleeping
I have lots of friends
I wake up in the night
I am shy
I feel scared
 I enjoy being with other

Behavioural difficulties

I get very angry
I lose my temper
I bully others
I do things to hurt people
 I am calm
I hit out when I am angry
I break things on purpose

School climate

At this school we care
At this school we like
We can talk to
Teachers try hard to
We feel safe in school
Our Teachers are fair
There is an adult in my

¹⁷ The items selected and the scales are based analyses carried out so far. It must be noted that measures require extensive psychometric analysis to validate robustly and the specific items making up the scales may change slightly in future with further analyses.

In order to establish the validity of the scales created, correlations between these scales and the relevant SDQ subscales were calculated. Table 4b shows that the correlation between the M&MS emotional scale and the corresponding SDQ subscale is high ($r = .67, p < .01$), as is the correlation between the M&MS behavioural scale and the corresponding SDQ scale ($r = .71, p < .01$). As expected, the correlations with the opposite subscales (e.g., M&MS emotional with SDQ conduct) are much lower, suggesting good construct validity. A similar pattern of findings is observed with the teacher and parent report SDQ (see Table 4c).

Table 4b: Correlations between the M&MS scales and the SDQ scales (pupil self-report).

2008 Secondary school pupils, N=7673	SDQ emotional	SDQ conduct	M&MS emotional difficulties	M&MS behavioural difficulties
SDQ Emotional	-			
SDQ Conduct	.255(**)	-		
M&MS emotional difficulties	.671(**)	.236(**)	-	
M&MS behavioural difficulties	.224(**)	.706(**)	.298(**)	-

Correlation is significant at the 0.01 level (2-tailed).

Table 4c: Correlations between M&MS scales and Teacher and parent report SDQ scales in Primary school pupils

2008 Primary school pupils	Teacher SDQ Emotional	Teacher SDQ Conduct	Parent SDQ Emotional	Parent SDQ Conduct
M&MS emotional difficulties	.206(**)	.109(**)	.166(**)	.065
N	762	765	597	598
M&MS behavioural difficulties	.120(**)	.397(**)	.090(*)	.338(**)
N	792	795	646	647

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table 4d: Correlations between the M&MS and SDQ (pupil) with parent and teacher SDQ in secondary pupils

2008 Secondary school pupils	Teacher SDQ Emotional	Teacher SDQ Conduct	Parent SDQ Emotional	Parent SDQ Conduct
M&MS emotional difficulties	.349(**)	.075	.331(**)	.169(**)
N	518	519	580	580
M&MS behavioural difficulties	.001	.418(**)	.078	.303(**)
N	541	541	626	626
Pupil SDQ Emotional	.348(**)	.057	.378(**)	.151(**)
N	520	522	595	595
Pupil SDQ Conduct	.051	.491(**)	.093(*)	.366(**)
N	520	522	594	594

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

APPENDIX 5: Latent scores

Latent scores are an attempt to get at essence of what the scale attempts to measure (e.g., emotional difficulties), whilst taking out some of the measurement error. Latent scores were used to extract what was common between items in an attempt to reduce measurement error. Confirmatory Factor Analysis (CFA) was used to generate these scores based on how the individual questionnaire item responses (manifest scores) relate to each other. This approach is common in social science where many of the phenomena of interest are difficult to measure directly or exactly (latent). This is particularly important in the case of child self-report measures, as reading age and understanding of specific concepts is likely to have some effect on children's responses to individual questionnaire items. Since latent variables reflect what is common between items, they reduce error associated with individual items. In the analysis presented in chapter 6, latent scores were generated for children's self-reports of emotional and behavioural difficulties (based on M&MS).

APPENDIX 6: Tables to support figures in Chapter 3

Table 6a: Professional group that would help a pupil with behavioural problems in primary schools.

		2008		2009		2010	
		No	Yes	No	Yes	No	Yes
Class teacher	N	9	32	4	37	9	32
	%	21.95	78.05	9.76	90.24	21.95	78.05
Another teacher e.g. special needs teacher	N	5	36	8	33	4	37
	%	12.20	87.80	19.51	80.49	9.76	90.24
Teaching assistant e.g. special needs assistant	N	14	27	10	31	10	31
	%	34.15	65.85	24.39	75.61	24.39	75.61
Health professional e.g. school nurse, school doctor	N	26	15	23	18	26	15
	%	63.41	36.59	56.10	43.90	63.41	36.59
Mental health professional e.g. psychologist, psychiatrist, counsellor	N	18	23	6	35	10	31
	%	43.90	56.10	14.63	85.37	24.39	75.61
Other	N	29	12	24	17	29	12
	%	70.73	29.27	58.54	41.46	70.73	29.27

Table 6b: Professional group that would help a pupil with emotional problems in primary schools

Primary		2008		2009		2010	
		No	Yes	No	Yes	No	Yes
Class teacher	N	4	37	3	38	10	31
	%	9.76	90.24	7.32	92.68	24.39	75.61
Another teacher e.g. special needs teacher	N	9	32	8	33	7	34
	%	21.95	78.05	19.51	80.49	17.07	82.93
Teaching assistant e.g. special needs assistant	N	11	30	9	32	9	32
	%	26.83	73.17	21.95	78.05	21.95	78.05
Health professional e.g. school nurse, school doctor	N	26	15	25	16	26	15
	%	63.41	36.59	60.98	39.02	63.41	36.59

Mental health professional e.g. psychologist, psychiatrist, counsellor	N	23	18	13	28	16	25
	%	56.10	43.90	31.71	68.29	39.02	60.98
Other	N	25	16	25	16	29	12
	%	60.98	39.02	60.98	39.02	70.73	29.27

Table 6c: Professional group that would help a pupil with behavioural problems in secondary schools

Secondary		2008		2009		2010	
		No	Yes	No	Yes	No	Yes
Class teacher	N	5	8	4	9	4	9
	%	38.46	61.54	30.77	69.23	30.77	69.23
Another teacher e.g. special needs teacher	N	3	10	4	9	2	11
	%	23.08	76.92	30.77	69.23	15.38	84.62
Teaching assistant e.g. special needs assistant	N	4	9	3	10	3	10
	%	30.77	69.23	23.08	76.92	23.08	76.92
Health professional e.g. school nurse, school doctor	N	4	9	3	10	3	10
	%	30.77	69.23	23.08	76.92	23.08	76.92
Mental health professional e.g. psychologist, psychiatrist, counsellor	N	5	8	1	12	1	12
	%	38.46	61.54	7.69	92.31	7.69	92.31
Other	N	7	6	5	8	7	6
	%	53.85	46.15	38.46	61.54	53.85	46.15

Table 6d: Professional group that would help a pupil with emotional problems in secondary schools

		2008		2009		2010	
		No	Yes	No	Yes	No	Yes
Class teacher	N	1	12	1	12	4	9

	%	7.69	92.31	7.69	92.31	30.77	69.23
Another teacher e.g. special needs teacher	N	6	7	2	11	1	12
	%	46.15	53.85	15.38	84.62	7.69	92.31
Teaching assistant e.g. special needs assistant	N	6	7	3	10	3	10
	%	46.15	53.85	23.08	76.92	23.08	76.92
Health professional e.g. school nurse, school doctor	N	5	8	2	11	3	10
	%	38.46	61.54	15.38	84.62	23.08	76.92
Mental health professional e.g. psychologist, psychiatrist, counsellor	N	8	5	2	11	2	11
	%	61.54	38.46	15.38	84.62	15.38	84.62
Other	N	5	8	8	5	9	4
	%	38.46	61.54	61.54	38.46	69.23	30.77

Table 6e: Extent to which different interventions were used in primary schools in 2009 and 2010

TYPE OF INTERVENTION	Not at all				A little				Somewhat				Quite a lot				Very much				Total	Total
	2009		2010		2009		2010		2009		2010		2009		2010		2009		2010		2009	2010
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	N
Social and emotional development of pupils					1	2.44	4	9.76	4	9.76	3	7.32	13	31.71	20	48.78	23	56.10	14	34.15	41	41
Creative and physical activity for pupils			1	2.44	5	12.20	3	7.32	9	21.95	12	29.27	17	41.46	14	34.15	10	24.39	11	26.83	41	41
Information for pupils	4	10.00	3	7.32	13	32.50	17	41.46	14	35.00	10	24.39	7	17.50	8	19.51	2	5.00	3	7.32	40	41
Peer support for pupils	2	4.88	1	2.44	6	14.63	7	17.07	11	26.83	12	29.27	14	34.15	12	29.27	8	19.51	9	21.95	41	41
Behaviour for learning and structural support for pupils					4	9.76	1	2.50	3	7.32	6	15.00	18	43.90	16	40.00	16	39.02	17	42.50	41	40
Individual therapy for pupils	2	4.88	3	7.50	7	17.07	9	22.50	11	26.83	6	15.00	9	21.95	13	32.50	12	29.27	9	22.50	41	40

Group therapy for pupils	3	7.32	2	5.13	11	26.83	8	20.51	11	26.83	14	35.90	10	24.39	9	23.08	6	14.63	6	15.38	41	39
Information for parents	1	2.44	3	7.32	10	24.39	5	12.20	18	43.90	14	34.15	7	17.07	14	34.15	5	12.20	5	12.20	41	41
Training for parents	8	19.51	9	21.95	14	34.15	11	26.83	10	24.39	6	14.63	7	17.07	10	24.39	2	4.88	5	12.20	41	41
Counselling for parents	10	24.39	10	25.00	9	21.95	10	25.00	14	34.15	9	22.50	4	9.76	7	17.50	4	9.76	4	10.00	41	40
Consultation for staff	4	9.76	4	10.26	10	24.39	10	25.64	11	26.83	9	23.08	7	17.07	10	25.64	9	21.95	6	15.38	41	39
Counselling for staff	18	43.90	12	30.00	13	31.71	11	27.50	7	17.07	9	22.50	1	2.44	5	12.50	2	4.88	3	7.50	40	41
Training for staff	4	9.76	7	17.50	11	26.83	12	30.00	18	43.90	8	20.00	4	9.76	9	22.50	4	9.76	4	10.00	41	40

Table 6f: Extent to which different interventions were used in secondary schools in 2009 and 2010

TYPE OF INTERVENTION	Not at all				A little				Somewhat				Quite a lot				Very much				Total	Total
	2009		2010		2009		2010		2009		2009		2010		2010		2009		2010		2009	2010
	N	%	N	%	N	N	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	N
Social and emotional development of pupils					1	7.69	1	7.69	3	23.08	2	15.38	6	46.15	6	46.15	3	23.08	4	30.77	13	13
Creative and physical activity for pupils	1	7.69			1	7.69			3	23.08	5	38.46	7	53.85	5	38.46	1	7.69	3	23.08	13	13
Information for pupils					2	15.38	1	7.69	3	23.08	6	46.15	8	61.54	4	30.77			2	15.38	13	13
Peer support for pupils							1	7.69	4	30.77	3	23.08	5	38.46	4	30.77	4	30.77	5	38.46	13	13
Behaviour for learning and structural support for pupils					1	7.69			1	7.69			3	23.08	8	61.54	8	61.54	5	38.46	13	13
Individual therapy for pupils	1	7.69			2	15.38	2	15.38	2	15.38	3	23.08	6	46.15	4	30.77	2	15.38	4	30.77	13	13

Group therapy for pupils					3	23.08	4	30.77	6	46.15	3	23.08	4	30.77	3	23.08			3	23.08	13	13
Information for parents	7	7.69	1	7.69	3	23.08	3	23.08	5	38.46	4	30.77	2	15.38	2	15.38	2	15.38	3	23.08	13	13
Training for parents	5	38.46	3	23.08	3	23.08	3	23.08	5	38.46	5	38.46			2	15.38					13	13
Counselling for parents	6	46.15	4	30.77	1	7.69	5	38.46	4	30.77	4	30.77	2	15.38							13	13
Consultation for staff	3	23.08	1	9.09	4	30.77	6	54.55	4	30.77					3	27.27	2	15.38	1	9.09	13	11
Counselling for staff	3	23.08	2	15.38	4	30.77	6	46.15	6	46.15	2	15.38			2	15.38			1	7.69	13	13
Training for staff	1	7.69			4	30.77	6	46.15	7	53.85	3	23.08	1	7.69	3	23.08			1	7.69	13	13

Table 6g: Primary school responses to 'The ways of helping pupils with emotional and behavioural difficulties are in the main:'

	2009		2010	
	N	%	N	%
New and not tried before	3	7.69		
Tried before locally and seem to help	21	53.85	19	50.00
Tried before nationally or internationally and found to help	15	38.46	19	50.00
Total	39	100.00	38	100.00

Table 6h: Secondary school responses to 'The ways of helping pupils with emotional and behavioural difficulties are in the main:'

	2009		2010	
	N	%	N	%
New and not tried before	1	7.69		
Tried before locally and seem to help	7	53.85	9	69.23
Tried before nationally or internationally and found to help	5	38.46	4	30.77
Total	13	100.00	13	100.00

Table 6i: Primary school responses to 'The ways of helping pupils with emotional and behavioural difficulties are in the main:'

	2009		2010	
	N	%	N	%
Based on a set plan of working that has to be strictly adhered to	0	0	0	0
Based on a plan but open to adaptation	39	95.12	34	87.18
Not based on any set plan	2	4.88	5	12.82
Total	41	100.00	39	100.00

Table 6j: Secondary school responses to 'The ways of helping pupils with emotional and behavioural difficulties are in the main:'

	2009		2010	
	N	%	N	%
Based on a set plan of working that has to be strictly adhered to	0	0	0	0
Based on a plan but open to adaptation	10	76.92	12	92.31
Not based on any set plan	3	23.08	1	7.69
Total	13	100.00	13	100.00

Table 6k: Primary school responses to 'The person or people in our school(s) who help pupils with emotional and behavioural difficulties are in the main:'

	2009		2010	
	N	%	N	%
Staff with no specialist mental health training	21	51.22	12	30.77
Staff with some specialist mental health training	18	43.90	24	61.54
Mental health specialists	2	4.88	3	7.69
Total	41	100.00	39	100.00

Table 6l: Secondary school responses to 'The person or people in our school(s) who help pupils with emotional and behavioural difficulties are in the main:'

	2009		2010	
	N	%	N	%
Staff with no specialist mental health training	4	30.77	2	16.67
Staff with some specialist mental health training	8	61.54	10	83.33
Mental health specialists	1	7.69		
Total	13	100.00	12	100.00

Table 6m: Who do primary schools refer pupils with behavioural problems to?

		2008		2009		2010	
Primary		No	Yes	No	Yes	No	Yes
LA Behaviour Support Service	N	3	38	1	40	5	36
	%	7.32	92.68	2.44	97.56	12.20	87.80
Pupil Referral Unit	N	22	19	23	18	24	17
	%	53.66	46.34	56.10	43.90	58.54	41.46
Educational Psychology Service	N	0	41	0	41	4	37
	%	0	100.00	0	100.00	9.76	90.24
General Practitioner	N	29	12	28	13	26	15
	%	70.73	29.27	68.29	31.71	63.41	36.59
Child and Adolescent Mental Health Service	N	41	0	41	0	40	1
	%	100.00	0	100.00	0	97.56	2.44
Voluntary service	N	34	7	33	8	32	9
	%	82.93	17.07	80.49	19.51	78.05	21.95
Private service	N	39	2	40	1	37	4
	%	95.12	4.88	97.56	2.44	90.24	9.76

Table 6n: Who do primary schools refer pupils with emotional problems to?

		2008		2009		2010	
		No	Yes	No	Yes	No	Yes
LA Behaviour Support Service	N	22	19	25	16	24	17
	%	53.66	46.34	60.98	39.02	58.54	41.46
Pupil Referral Unit	N	37	4	38	3	37	4
	%	90.24	9.76	92.68	7.32	90.24	9.76
Educational Psychology Service	N	5	36	9	32	9	32
	%	12.20	87.80	21.95	78.05	21.95	78.05
General Practitioner	N	29	12	29	12	26	15
	%	70.73	29.27	70.73	29.27	63.41	36.59
Child and	N	40	1	38	3	37	4

Adolescent Mental Health Service	%	97.56	2.44	92.68	7.32	90.24	9.76
Voluntary service	N	38	3	36	5	33	8
	%	92.68	7.32	87.80	12.20	80.49	19.51
Private service	N	40	1	39	2	36	5
	%	97.56	2.44	95.12	4.88	87.80	12.20

Table 6o: Who do secondary schools refer pupils with behavioural problems to?

		2008		2009		2010	
		No	Yes	No	Yes	No	Yes
LA Behaviour Support Service	N	1	12	1	12	2	11
	%	7.69	92.31	7.69	92.31	15.38	84.62
Pupil Referral Unit	N	7	6	6	7	6	7
	%	53.85	46.15	46.15	53.85	46.15	53.85
Educational Psychology Service	N	1	12	0	13	1	12
	%	7.69	92.31	0	100.00	7.69	92.31
General Practitioner	N	6	7	3	10	6	7
	%	46.15	53.85	23.08	76.92	46.15	53.85
Child and Adolescent Mental Health Service	N	13	0	13	0	13	0
	%	100.00	0	100.00	0	100.00	0
Voluntary service	N	9	4	10	3	9	4
	%	69.23	30.77	76.92	23.08	69.23	30.77
Private service	N	13	0	11	2	11	2
	%	100.00	0	84.62	15.38	84.62	15.38

Table 6p: Who do secondary schools refer pupils with emotional problems to?

		2008		2009		2010	
		No	Yes	No	Yes	No	Yes
LA Behaviour Support Service	N	11	2	9	4	11	2
	%	84.62	15.38	69.23	30.77	84.62	15.38

Pupil Referral Unit	N	13		13		12	1
	%	100.00		100.00		92.31	7.69
Educational Psychology Service	N	4	9	4	9	3	10
	%	30.77	69.23	30.77	69.23	23.08	76.92
General Practitioner	N	4	9	5	8	5	8
	%	30.77	69.23	38.46	61.54	38.46	61.54
Child and Adolescent Mental Health Service	N	12	1	12	1	12	1
	%	92.31	7.69	92.31	7.69	92.31	7.69
Voluntary service	N	11	2	10	3	6	7
	%	84.62	15.38	76.92	23.08	46.15	53.85
Private service	N	13		10	3	11	2
	%	100.00		76.92	23.08	84.62	15.38

Table 6q: Primary schools rating of good links with CAMHS

	2008		2009		2010	
	N	%	N	%	N	%
No, Not at all	2	4.88				
No, Not much	8	19.51	2	4.88		
Yes, a little	10	24.39	5	12.20	8	19.51
Yes, some	11	26.83	19	46.34	15	36.59
Yes, very much	10	24.39	15	36.59	18	43.90
Total	41	100.00	41	100.00	41	100.00

Table 6r: Secondary schools rating of good links with CAMHS

	2008		2009		2010	
	N	%	N	%	N	%
No, Not much	2	15.38	1	7.69		
Yes, a little	4	30.77	1	7.69	1	7.69

Yes, some	7	53.85	7	53.85	6	46.15
Yes, very much			4	30.77	6	46.15
Total	13	100.00	13	100.00	13	100.00

Table 6s: Extent of CAF use in primary schools

	2008		2009		2010	
	N	%	N	%	N	%
Never	11	26.83	5	12.20	4	9.76
1-5	22	53.66	22	53.66	26	63.41
6-10	6	14.63	11	26.83	5	12.20
11-15	2	4.88	2	4.88		
16-20					4	9.76
more than 20			1	2.44	2	4.88
Total	41	100.00	41	100.00	41	100.00

Table 6t: Extent of CAF use in secondary schools

	2008		2009		2010	
	N	%	N	%	N	%
Never	3	23.08	1	7.69		
1-5	7	53.85	4	30.77	6	46.15
6-10	1	7.69	2	15.38	4	30.77
11-15			3	23.08	1	7.69
16-20	1	7.69	2	15.38	1	7.69
more than 20	1	7.69	1	7.69	1	7.69
Total	13	100.00	13	100.00	13	100.00

APPENDIX 7: Summary of range of interventions from case studies

Table 7a: A summary of interventions aimed at pupils across 4 case study schools

Type of Intervention	Description
<i>Social and Emotional Skills Development</i>	
SEAL	Social and Emotional Aspects of Learning (SEAL) is an intervention for both primary and secondary schools aimed at enhancing student's emotional and social skills. SEAL adopts a whole-school approach so that it can be incorporated into the curriculum.
Circle Time	Circle Time is a type of group intervention which involves the whole class. It is more commonly used with primary schools in the UK and involves students sitting together in a circle to discuss any issues that might be troubling them. Such an integrative approach helps to promote active listening skills and empathy as well as boost confidence and self-esteem.
Pyramid Club	The Pyramid Club was designed to aid in the development of social and emotional skills in primary school-aged children. It consists of 10 week sessions run after school and focuses on building student's self-esteem, confidence, friendship skills, and overall sense of well-being (National Pyramid Trust, 2005)
Pyramid Transition Club	The Pyramid Transition Club is based on the same model as the Pyramid Club but targets students who are anxious about the move to the next phase in their education and focuses on issues such as bullying, managing more work load etc.
[electronic resource]	[Electronic resource] is an electronic intervention which aims at helping students to cope with their social and emotional needs.
Nurture Groups	Nurture groups provide a safe environment where children who find it difficult to feel safe and secure are provided with planned learning opportunities.
[Computer package]	A computer package that aims to help children and vulnerable adults disclose and communicate a distressful experience or relationship. Through a series of modules, children are encouraged to share this information on their experiences and emotions with their family or educational staff. A trained adult must sit alongside the child assist, guide and interact with them through a structured interview process (Calam, Cox,

<p>FRIENDS</p> <p>[Support for children who have a family member with a mental health problem]</p>	<p>Glasgow, Jimmieson, & Larsen, 2000).</p> <p>'FRIENDS' is an intervention for children with anxiety disorders and consists of 10-sessions of Cognitive-Behavioural Intervention (CBT). The sessions are normally conducted with small groups of students and aim to build positive relationships with peers and adults enhance student's confidence and ability to self-express in a manageable way (Lowry-Webster, Barrett & Lock, 2003).</p> <p>Programme to help children adapt to a close (parent, sibling, care-giver etc.) family member's mental health problem. The main focus of the program is to deliver age-appropriate education about mental illness. Other aims are to increase resilience, aid children in coping more effectively, increasing self-esteem and improving creativity and self-expression.</p>
<p><i>Creative and Physical Activity for pupils</i></p> <p>Art Therapy</p> <p>Creative Therapy</p>	<p>Art-related activities designed to offer the child freedom and spontaneity to express themselves in an unrestrictive manner.</p> <p>Creative Therapy can take the form of play activities, art, dance, story-telling etc.</p>
<p><i>Peer Support for pupils</i></p> <p>Peer Mentors</p> <p>[Specialist mentors]</p> <p>Peer Massage</p>	<p>Peer mentoring schemes involve training certain pupils as 'buddies', "peer mentors' or 'befrienders'. Based on the assumption that young people prefer talking difficulties with others their own age.</p> <p>[Specialist mentors] refer to students who are specifically trained to help peers who are being bullied on the internet.</p> <p>Peer massage is an intervention which aims to promote social inclusion, concentration, relaxation and improve student's motor skills.</p>
<p><i>Behaviour for learning and structural support</i></p> <p>Restorative Justice</p> <p>Inclusion Units</p>	<p>Restorative Justice is based on the premise that re-integrative shaming can lead to less crime, delinquent behaviour and violence. It involves an informal meeting with the victim, offender, families of both parties involved and school staff members in which they discuss the offender's actions and the impact this had on the victim.</p> <p>Inclusion units refer to rooms that are used for 'time out' or they can also serve as place for reflection, an area for recuperation, and a space for those students who are</p>

	stressed.
<i>Individual Therapy</i>	
Cognitive Behavioural Therapy (CBT)	CBT emphasises the process of learning in improving and maintaining behaviour. The child is encouraged to identify connections between thoughts and their responses to social situations.
Narrative Therapy	Narrative therapy is based on the idea that stories give cognitive and emotional significance to experience; they are a means of constructing and negotiating a social identity, and give moral weight and existential significance to actions and events.
<i>Group Therapy</i>	
Art Therapy	<i>See above</i>
FRIENDS	<i>See above</i>

NB terms appearing in square brackets have been made generic to avoid identifying individual areas

Table 7b: A summary of interventions aimed at families across 4 case study schools

Type of Intervention	Description
<i>Information for parents</i>	
Parentline Plus	Parentline plus is a national freephone helpline for parents who have concerns about their children and is funded by DfE.* The helpline offers information, support and where appropriate, information for pupils and referrals to other sources of help.
[Voluntary sector support package]	[Voluntary sector support package] providing a range of services from supporting families at their homes, one-to-one support for children and advice and information regarding budgeting, housing benefits etc.
<i>Training for parents</i>	
[Family support package]	[Family support package] targeting families with young people in early teenage years to help them prepare for the teenage years. It consists of several sessions of family skills training and aims to increase resilience and reduce risk factors for a range of mental health problems.
Parent mentoring	Parent mentoring involves training parents to become mentors for other parents. Generally training is provided to the volunteer parents and then they are matched to callers requesting help with challenges similar to those the volunteer has experienced.

<i>Counselling & Support for parents</i>	
CBT	CBT can also help parents to cope and manage their child's behaviour as well as maintain their own mental well-being.
Parentline Plus	<i>See above</i>

Table 7c: A summary of interventions aimed at Staff across 4 case study schools

Type of Intervention	Description
<i>Training for staff</i>	
Reflective Practice training	Reflective Practice Training aims to teach school staff strategies to support student's behaviours by critically examining the student's personal values and decisions behind their actions (Osterman, 1990).
Child Protection training	Every school is required to provide training in safe-guarding and child protection issues. School staff are taught how to identify signs and symptoms of abuse, know to whom and how to report allegations, and monitor and report as required on the welfare of students on the Child Protection Register.
Every Child Matters training	Every Child Matters is a set of reforms supported by the Children Act 2004. Courses are run on a wide range of areas from working with families and communities to sports and exercise psychology.
Attachment Training	School staff are given an overview of attachment theory and how negative early relationships can affect the emotional, social, and educational well-being of children. They are taught how to strengthen the parent/carer child relationship.
Everybody's Business	Mental health awareness training
SEAL Workshop	SEAL workshops aim to aid school staff in identifying student's emotional concerns and to create the most suitable condition to facilitate

	learning. School staff will be able to help student's to recognize and manage their feelings, enhance their self-awareness and improve their social skills.
<i>Supervision and Consultation for staff</i>	
CAF Meetings	CAF meetings enabled all the professionals to work together and aid the school staff in completing the CAF form.
Therapist Training	In order to facilitate the sustainability of the TaMHS project, a TaMHS worker trained and supervised several teaching assistants in the delivery of various interventions.
<i>Counselling/support for staff</i>	
Staff well-being course	Staff well-being courses refer to programmes which aim to support school staff members own emotional health and well-being.
Staff interventions/drop in sessions	

APPENDIX 8: Tables to support figures in Chapter 4

Tables 8a to 8j below details where parents and pupils reported going to for help with emotional or behavioural difficulties

Table 8a: Where do parents of primary pupils seek help? How useful do they find it?

		2008				2009				2010			
		No	Yes but not helpful	Yes, a little helpful	Yes, helped a lot	No	Yes but not helpful	Yes, a little helpful	Yes, helped a lot	No	Yes but not helpful	Yes, a little helpful	Yes, helped a lot
Family Member	N	101	29	112	56	48	14	76	27	35	18	39	22
	%	33.9	9.7	37.6	18.8	29.1	8.5	46.1	16.4	30.7	15.8	34.2	19.3
Friend	N	143	26	102	27	91	10	47	17	57	11	38	8
	%	48.0	8.7	34.2	9.1	55.2	6.1	28.5	10.3	50.0	9.6	33.3	7.0
Teacher	N	88	42	102	67	51	20	59	36	32	20	43	19
	%	29.4	14.0	34.1	22.4	30.7	12.0	35.5	21.7	28.1	17.5	37.7	16.7
Family Doctor	N	218	27	39	13	126	10	20	9	84	9	18	3
	%	73.4	9.1	13.1	4.4	76.4	6.1	12.1	5.5	73.7	7.9	15.8	2.6

Table 8b: Where do parents of secondary pupils seek help? How useful do they find it?

		2008				2009				2010			
		No	Yes but not helpful	Yes, a little helpful	Yes, helped a lot	No	Yes but not helpful	Yes, a little helpful	Yes, helped a lot	No	Yes but not helpful	Yes, a little helpful	Yes, helped a lot
Family Member	N	70	22	100	48	27	9	51	22	16	9	32	7
	%	29.2	9.2	41.7	20.0	24.8	8.3	46.8	20.2	25.0	14.1	50.0	10.9
Friend	N	123	19	75	22	54	7	35	13	30	5	23	5
	%	51.5	7.9	31.4	9.2	49.5	6.4	32.1	11.9	47.6	7.9	36.5	7.9
Teacher	N	84	36	75	43	35	20	38	16	15	15	18	15
	%	35.3	15.1	31.5	18.1	32.1	18.3	34.9	14.7	23.8	23.8	28.6	23.8
Family Doctor	N	173	19	30	16	81	9	11	8	41	4	10	8
	%	72.7	8.0	12.6	6.7	74.3	8.3	10.1	7.3	65.1	6.3	15.9	12.7

Table 8c: Primary school pupils report of receiving mental health support in schools

	Counsellor		Peer Mentor		Other Help	
	N	%	N	%	N	%
never	3834	65.88	4133	69.39	3110	51.84
once	707	12.15	753	12.64	1076	17.94
a few times	806	13.85	724	12.16	1224	20.4
more than 5 times	473	8.13	346	5.81	589	9.82
Total	5820	100	5956	100	5999	100

Table 8d: Secondary school pupils report of receiving mental health support in schools

	Counsellor		Peer Mentor		Other Help	
	N	%	N	%	N	%
never	4222	79.98	4251	81.19	3944	75.22
once	382	7.24	426	8.14	545	10.39
a few times	410	7.77	416	7.94	569	10.85
more than 5 times	265	5.02	143	2.73	185	3.53
Total	5279	100	5236	100	5243	100

Table 8e: Primary school pupils who stated that they received help in schools and score on the M&MS emotional difficulties scale

Emotional difficulties score		Counsellor		Peer Mentor		Other Help	
		No	Yes	No	Yes	No	Yes
.00	N	165	35	175	29	158	48
	%	82.5%	17.5%	85.8%	14.2%	76.7%	23.3%
1.00	N	247	66	275	43	244	82
	%	78.9%	21.1%	86.5%	13.5%	74.8%	25.2%
2.00	N	303	102	344	71	297	120
	%	74.8%	25.2%	82.9%	17.1%	71.2%	28.8%
3.00	N	309	102	337	87	289	139
	%	75.2%	24.8%	79.5%	20.5%	67.5%	32.5%
4.00	N	320	120	345	105	272	185
	%	72.7%	27.3%	76.7%	23.3%	59.5%	40.5%
5.00	N	289	142	319	131	232	223
	%	67.1%	32.9%	70.9%	29.1%	51.0%	49.0%
6.00	N	287	167	319	145	262	206
	%	63.2%	36.8%	68.8%	31.3%	56.0%	44.0%
7.00	N	304	132	323	128	236	214
	%	69.7%	30.3%	71.6%	28.4%	52.4%	47.6%
8.00	N	242	160	254	153	169	237
	%	60.2%	39.8%	62.4%	37.6%	41.6%	58.4%
9.00	N	202	164	215	162	139	234
	%	55.2%	44.8%	57.0%	43.0%	37.3%	62.7%
10.00	N	184	132	190	131	111	213
	%	58.2%	41.8%	59.2%	40.8%	34.3%	65.7%
11.00	N	134	124	148	114	89	175
	%	51.9%	48.1%	56.5%	43.5%	33.7%	66.3%
12.00	N	106	101	118	87	73	138
	%	51.2%	48.8%	57.6%	42.4%	34.6%	65.4%

13.00	N	74	68	85	60	47	101
	%	52.1%	47.9%	58.6%	41.4%	31.8%	68.2%
14.00	N	47	50	43	56	23	75
	%	48.5%	51.5%	43.4%	56.6%	23.5%	76.5%
15.00	N	31	33	33	32	13	53
	%	48.4%	51.6%	50.8%	49.2%	19.7%	80.3%
16.00	N	25	28	27	26	9	44
	%	47.2%	52.8%	50.9%	49.1%	17.0%	83.0%
17.00	N	7	15	12	11	7	15
	%	31.8%	68.2%	52.2%	47.8%	31.8%	68.2%
18.00	N	6	7	5	8	4	9
	%	46.2%	53.8%	38.5%	61.5%	30.8%	69.2%
19.00	N	1	4	2	3	0	5
	%	20.0%	80.0%	40.0%	60.0%	.0%	100.0%
20.00	N	4	2	5	1	4	2
	%	66.7%	33.3%	83.3%	16.7%	66.7%	33.3%
21.00	N	2	3	4	2	3	3
	%	40.0%	60.0%	66.7%	33.3%	50.0%	50.0%
22.00	N	2	4	3	4	1	5
	%	33.3%	66.7%	42.9%	57.1%	16.7%	83.3%
23.00	N	0	2	2	1	2	1
	%	.0%	100.0%	66.7%	33.3%	66.7%	33.3%
24.00	N	2	0	1	1	1	1
	%	100.0%	.0%	50.0%	50.0%	50.0%	50.0%

Table 8f: Primary school pupils who stated that they received help in schools and score on the M&MS behavioural difficulties scale

Behavioural difficulties score		Counsellor		Peer Mentor		Other Help	
		No	Yes	No	Yes	No	Yes
.00	N	1200	332	1262	291	1115	459
	%	78.3%	21.7%	81.3%	18.7%	70.8%	29.2%
1.00	N	619	273	665	261	537	393
	%	69.4%	30.6%	71.8%	28.2%	57.7%	42.3%
2.00	N	529	284	576	261	429	408
	%	65.1%	34.9%	68.8%	31.2%	51.3%	48.7%
3.00	N	480	316	532	269	343	467
	%	60.3%	39.7%	66.4%	33.6%	42.3%	57.7%
4.00	N	316	210	328	216	191	355
	%	60.1%	39.9%	60.3%	39.7%	35.0%	65.0%
5.00	N	172	159	201	137	109	231

	%	52.0%	48.0%	59.5%	40.5%	32.1%	67.9%
6.00	N	109	118	132	106	70	169
	%	48.0%	52.0%	55.5%	44.5%	29.3%	70.7%
7.00	N	56	80	71	72	44	101
	%	41.2%	58.8%	49.7%	50.3%	30.3%	69.7%
8.00	N	34	52	39	47	18	69
	%	39.5%	60.5%	45.3%	54.7%	20.7%	79.3%
9.00	N	28	19	23	26	16	33
	%	59.6%	40.4%	46.9%	53.1%	32.7%	67.3%
10.00	N	10	6	10	9	6	11
	%	62.5%	37.5%	52.6%	47.4%	35.3%	64.7%
11.00	N	6	13	8	12	6	14
	%	31.6%	68.4%	40.0%	60.0%	30.0%	70.0%
12.00	N	4	9	5	6	3	8
	%	30.8%	69.2%	45.5%	54.5%	27.3%	72.7%

Table 8g: Secondary school pupils who stated that they received help in schools and score on the M&MS emotional difficulties scale

Emotional difficulties score		Counsellor		Peer Mentor		Other Help	
		No	Yes	No	Yes	No	Yes
.00	N	247	19	248	17	241	23
	%	92.9%	7.1%	93.6%	6.4%	91.3%	8.7%
1.00	N	357	36	361	32	355	39
	%	90.8%	9.2%	91.9%	8.1%	90.1%	9.9%
2.00	N	436	55	445	45	427	64
	%	88.8%	11.2%	90.8%	9.2%	87.0%	13.0%
3.00	N	448	74	448	70	442	78
	%	85.8%	14.2%	86.5%	13.5%	85.0%	15.0%
4.00	N	389	102	400	86	380	103
	%	79.2%	20.8%	82.3%	17.7%	78.7%	21.3%
5.00	N	377	94	384	85	358	112
	%	80.0%	20.0%	81.9%	18.1%	76.2%	23.8%
6.00	N	337	78	333	77	294	115
	%	81.2%	18.8%	81.2%	18.8%	71.9%	28.1%
7.00	N	292	79	299	73	257	114
	%	78.7%	21.3%	80.4%	19.6%	69.3%	30.7%
8.00	N	236	66	221	81	208	96
	%	78.1%	21.9%	73.2%	26.8%	68.4%	31.6%
9.00	N	230	86	228	86	196	117
	%	72.8%	27.2%	72.6%	27.4%	62.6%	37.4%

10.00	N	171	75	161	79	147	96
	%	69.5%	30.5%	67.1%	32.9%	60.5%	39.5%
11.00	N	134	61	136	58	116	75
	%	68.7%	31.3%	70.1%	29.9%	60.7%	39.3%
12.00	N	110	49	101	55	93	63
	%	69.2%	30.8%	64.7%	35.3%	59.6%	40.4%
13.00	N	64	31	71	23	63	31
	%	67.4%	32.6%	75.5%	24.5%	67.0%	33.0%
14.00	N	30	37	40	26	28	37
	%	44.8%	55.2%	60.6%	39.4%	43.1%	56.9%
15.00	N	29	13	29	13	24	18
	%	69.0%	31.0%	69.0%	31.0%	57.1%	42.9%
16.00	N	12	13	17	7	14	9
	%	48.0%	52.0%	70.8%	29.2%	60.9%	39.1%
17.00	N	10	11	11	9	9	12
	%	47.6%	52.4%	55.0%	45.0%	42.9%	57.1%
18.00	N	9	5	10	4	8	6
	%	64.3%	35.7%	71.4%	28.6%	57.1%	42.9%
19.00	N	4	3	3	4	3	4
	%	57.1%	42.9%	42.9%	57.1%	42.9%	57.1%
20.00	N	7	0	3	4	5	2
	%	100.0%	.0%	42.9%	57.1%	71.4%	28.6%
21.00	N	3	1	2	2	3	1
	%	75.0%	25.0%	50.0%	50.0%	75.0%	25.0%
22.00	N	3	2	3	2	3	2
	%	60.0%	40.0%	60.0%	40.0%	60.0%	40.0%
23.00	N	2	1	2	1	3	0
	%	66.7%	33.3%	66.7%	33.3%	100.0%	.0%
24.00	N	8	1	8	1	7	2
	%	88.9%	11.1%	88.9%	11.1%	77.8%	22.2%

Table 8h: Secondary school pupils who stated that they received help in schools and score on the M&MS behavioural difficulties scale

Behavioural difficulties score		Counsellor		Peer Mentor		Other Help	
		No	Yes	No	Yes	No	Yes
.00	N	1090	122	1082	120	1082	120
	%	89.9%	10.1%	90.0%	10.0%	90.0%	10.0%
1.00	N	734	98	724	105	724	105
	%	88.2%	11.8%	87.3%	12.7%	87.3%	12.7%
2.00	N	716	170	740	143	740	143

	%	80.8%	19.2%	83.8%	16.2%	83.8%	16.2%
3.00	N	574	165	572	161	572	161
	%	77.7%	22.3%	78.0%	22.0%	78.0%	22.0%
4.00	N	403	141	412	123	412	123
	%	74.1%	25.9%	77.0%	23.0%	77.0%	23.0%
5.00	N	250	117	252	110	252	110
	%	68.1%	31.9%	69.6%	30.4%	69.6%	30.4%
6.00	N	155	91	170	70	170	70
	%	63.0%	37.0%	70.8%	29.2%	70.8%	29.2%
7.00	N	83	57	80	60	80	60
	%	59.3%	40.7%	57.1%	42.9%	57.1%	42.9%
8.00	N	63	32	57	40	57	40
	%	66.3%	33.7%	58.8%	41.2%	58.8%	41.2%
9.00	N	26	19	29	16	29	16
	%	57.8%	42.2%	64.4%	35.6%	64.4%	35.6%
10.00	N	19	16	22	13	22	13
	%	54.3%	45.7%	62.9%	37.1%	62.9%	37.1%
11.00	N	9	7	8	8	8	8
	%	56.3%	43.8%	50.0%	50.0%	50.0%	50.0%
12.00	N	9	7	9	7	9	7
	%	56.3%	43.8%	56.3%	43.8%	56.3%	43.8%

Table 8i: Primary school pupils rating of mental health support received in school

	Counsellor		Peer mentor		Other help	
	N	%	N	%	N	%
Not helpful	222	11.65%	207	11.35%	247	8.64%
Quite helpful	976	51.21%	974	53.40%	1525	53.36%
Very helpful	708	37.15%	643	35.25%	1086	38.00%
Total	1906	100.00%	1824	100.00%	2858	100.00%

Table 8j: Secondary school pupils rating of mental health support received in school

	Counsellor		Peer mentor		Other help	
	N	%	N	%	N	%
Not helpful	219	21.30%	196	19.66%	198	15.21%
Quite helpful	574	55.84%	578	57.97%	817	62.75%
Very helpful	235	22.86%	223	22.37%	287	22.04%
Total	1028	100.00%	997	100.00%	1302	100.00%

Table 8k: How helpful did primary pupils below and above the clinical cut-off for emotional problems find help received in schools.

		N	Mean	Std. Deviation	T-value
Counsellor	Below cut-off	1545	2.28	.637	5.54**
	Above cut-off	141	1.97	.707	
Peer mentor	Below cut-off	1442	2.25	.634	3.78**
	Above cut-off	144	2.04	.728	
Other help	Below cut-off	2284	2.31	.611	4.48**
	Above cut-off	210	2.11	.636	

** p<0.001, *p<0.01

Table 8l: How helpful did primary pupils below and above the clinical cut-off for behavioural problems find help received in schools.

		N	Mean	Std. Deviation	T-value
Counsellor	Below cut-off	1623	2.27	.637	4.1**
	Above cut-off	169	2.06	.754	
Peer mentor	Below cut-off	1538	2.26	.626	4.33**
	Above cut-off	171	2.04	.743	
Other help	Below cut-off	2448	2.31	.607	5.58**
	Above cut-off	230	2.08	.676	

** p<0.001, *p<0.01

Table 8m: How helpful did secondary pupils below and above the clinical cut-off for emotional problems find help received in schools.

		N	Mean	Std. Deviation	T-value
Counsellor	Below cut-off	864	2.04	.669	2.88*
	Above cut-off	87	1.82	.708	
Peer mentor	Below cut-off	866	2.06	.649	3.34**
	Above cut-off	73	1.79	.666	
Other help	Below cut-off	1115	2.10	.603	3.09*
	Above cut-off	95	1.89	.676	

** p<0.001, *p<0.01

Table 8n: How helpful did secondary pupils below and above the clinical cut-off for behavioural problems find help received in schools.

		N	Mean	Std. Deviation	T-value
Counsellor	Below cut-off	867	2.04	.656	3.39**
	Above cut-off	135	1.83	.686	
Peer mentor	Below cut-off	833	2.06	.638	3.2*
	Above cut-off	143	1.86	.698	
Other help	Below cut-off	1113	2.08	.595	2.84*
	Above cut-off	159	1.92	.671	

** p<0.001, *p<0.01

Interventions trialled in the RCT alongside TaMHS as additional support

In order to explore whether additional support in addition to TaMHS would provide an enhanced support package for schools and LAs, a number of conditions were included as per of the RCT. Detailed below is the range of support developed and respondents view of this support

LA booklets

Booklets were developed for LA leads involved in the RCT based on learning derived from information gathered from the first year of the longitudinal study. They included information about setting up steering groups and working teams, and advice about engaging with schools and formulating project plans as well as example of good practice. Booklets were randomly allocated to half of the LAs involved in the RCT. 274 schools (52.7%) were in LA's that received the LA pack and 246 (47.3%) in LA's that did not receive LA packs.

LA views on LA booklets

LA booklets were circulated early in the second year of the TaMHS project and covered examples from pathfinders who began their project one year earlier about setting up different aspects of the project and what to expect.

LAs were not formally asked to provide feedback about the LA booklets; however, they were able to leave responses to small number of questions on the Help4pupils website. Those that did respond (five LAs) were positive about the booklet (see Figure 7.3). In particular, LAs were felt that the layout was good and indicated that they would be likely to use the booklet in developing their TaMHS provision.

Table 80: Reponses regarding the LA booklets

		Quite useful	Very Useful	Extremely useful	Total
Please rate how useful you think you will find the Help4Pupils resources when developing targeted mental health provision in schools in your local authority.	N	2	1	2	5
	%	40.00	20.00	40.00	100.00
Please rate how likely you think you are to use this resource when developing targeted mental health provision in schools?	N	1	2	2	5
	%	20.00	40.00	40.00	100.00
Please rate the layout of the resource.	N		2	3	5
	%		40.00	60.00	100.00
Please rate the content of the resource.	N	1	1	1	3
	%	33.33	33.33	33.33	100.00

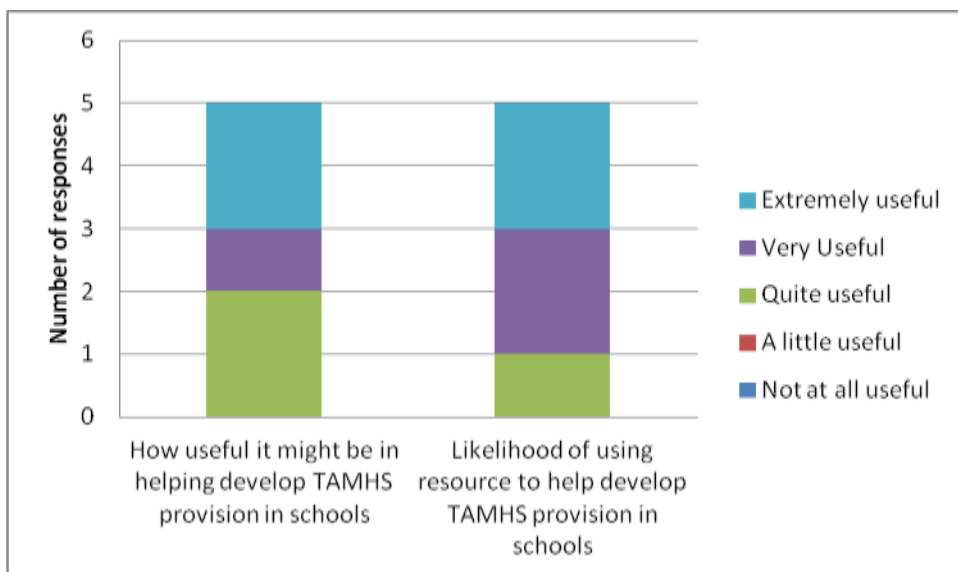


Figure 8a: Graph showing feedback on how useful LA's thought the booklets would be

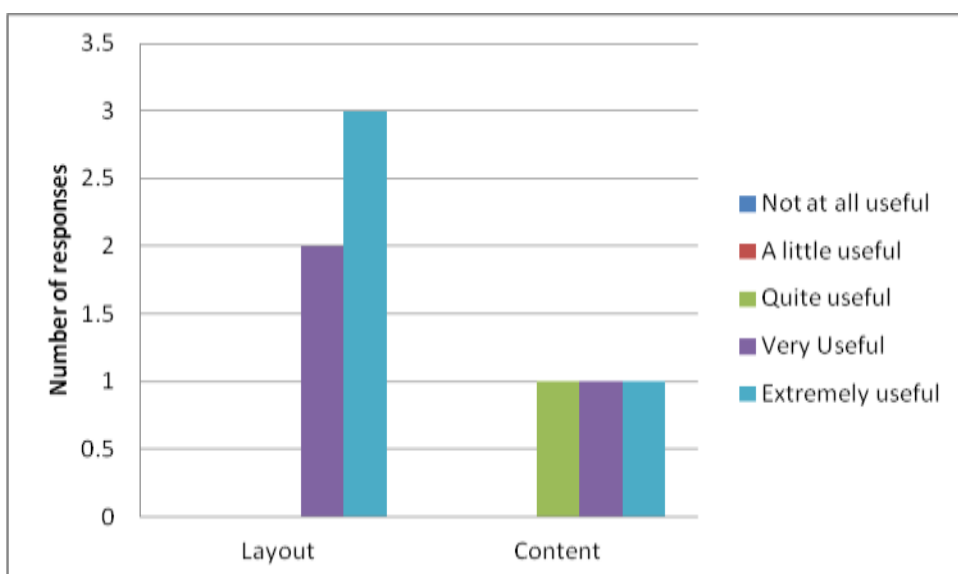


Figure 8b: Graph showing LA's feedback on content and layout of booklets

Other comments about the booklet included that it was “easy to access and comprehensive” and “timely and very valuable”. However, some LAs noted that it would have been useful to have received the booklet earlier to help with initial planning.

Action Learning Sets

Action Learning Sets were group meetings provided regionally to LA leads, TaMHS workers and school staff in order for them to share learning, and discuss challenges and solutions. Action Learning Sets were trialled because they were initially offered to pathfinders involved

in the first wave of TaMHS (those in the longitudinal study) who reported finding them useful. Learning Sets were randomly allocated to half of those taking part in the RCT who were in the condition allocated to begin TaMHS in 2009. Out of schools who received TaMHS in 2009, 171 schools received Action Learning Sets and 180 schools did not receive them.

Views on Action Learning Sets (ALS)

Action Learning Sets (ALS), were one of the additional support conditions provided as part of the RCT. They were regular regional meetings for LA TaMHS teams and school staff to attend and share learning, challenges and successes with other areas.

Those from LAs who attended ALS were asked to complete questionnaires about the extent to which attending these sessions had helped them to engage with stakeholders and develop their local projects. Those that responded (half of the areas involved) were generally positive about the support that was provided (see Figures 8c and 8d).

Respondents were particularly positive about the support the ALS had given them to consult with other TaMHS staff, to develop their ideas on where their TaMHS project was going and to provide consultation to schools.

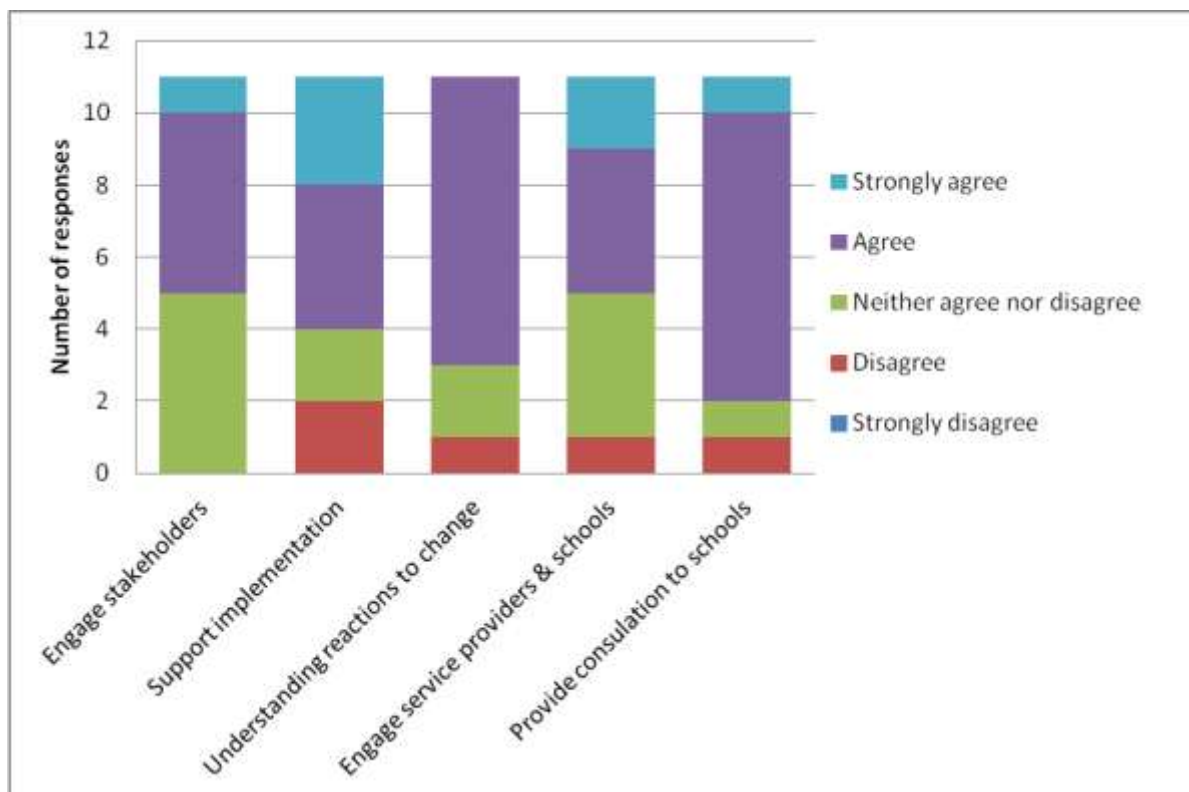


Figure 8c: Responses to how the TAMHS Action learning sets helped in various aspects of TAMHS

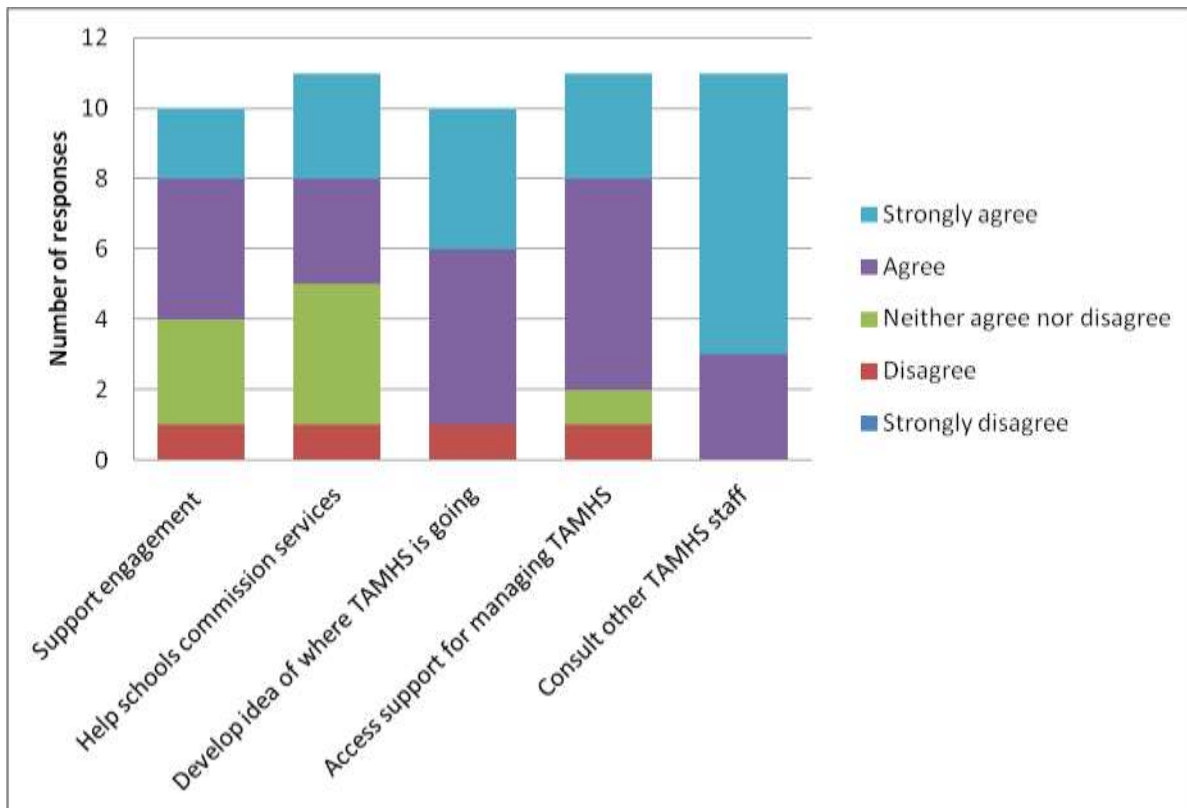


Figure 8d: Responses to how the TAMHS Action learning sets helped in various aspects of TAMHS

LA booklets

LA booklets were a second type of additional support provided as part of the RCT (see Chapter 2 for further details). LAs were not required to complete surveys rating LA booklets but a small amount of areas did provide feedback this is summarised below

Table 8p: Responses to questions relating to if the TaMHS action learning sets supported ability in the various areas

		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Total
Actively engage different stakeholders in thinking about how to implement TaMHS	N			5	5	1	11
	%			45.5	45.5	9.1	100
Support different stakeholders in implementing TaMHS	N		2	2	4	3	11
	%		18.2	18.2	36.4	27.3	100

Understand different stakeholders' reactions to the changes required to implement TaMHS	N		1	2	8		11
	%		9.1	18.2	72.7		100
Engage different service providers and schools	N		1	4	4	2	11
	%		9.1	36.4	36.4	18.2	100
Provide consultation to schools about how to implement TaMHS	N		1	1	8	1	11
	%		9.1	9.1	72.7	9.1	100
Support schools to engage with children and families	N		1	3	4	2	10
	%		10	30	40	20	100
Help schools in commissioning services that promote mental health and well being	N		1	4	3	3	11
	%		9.1	36.4	27.3	27.3	100
Develop a clear idea of where my TaMHS project is going	N		1		5	4	10
	%		10		50	40	100
Access support in managing the TaMHS implementation	N		1	1	6	3	11
	%		9.1	9.1	54.5	27.3	100
Meet with/consult other TaMHS project staff	N				3	8	11
	%				27.3	72.7	100

Pupil Booklets

Pupil booklets were self-help materials developed to give children strategies to feel better if they were experiencing emotional or behavioural difficulties. The booklets include advice based on evidence-based principals (e.g., CBT strategies) and were developed in collaboration with children and young people. Different booklets were developed for primary and secondary aged pupils. These booklets were randomly allocated to half of the schools involved in the RCT. 259 schools (49.8%) of the schools were allocated the pupils booklets and 261 schools (50.2%) did not receive them.

Pupil booklet responses are shown in the main report. Below are additional tables in relation to this

Table 8q: Pupil booklet. Who saw the booklets: by RCT condition

		Booklet RCT				Non Booklet RCT			
		Primary		Secondary		Primary		Secondary	
		N	%	N	%	N	%	N	%
Get up and Go	No	2610	59.3	3767	93.5	3916	88.5	3448	93.1
	Yes	1790	40.7	263	6.5	511	11.5	256	6.9
I gotta feeling	No	4073	92.4	3230	80.1	4071	92	3522	95
	Yes	335	7.6	802	19.9	355	8	184	5

Table 8r: How helpful did pupils in the RCT booklet condition find the booklets

	Get up and go (Primary)		I gotta feeling (secondary)	
	N	%	N	%
Yes, Not helpful	226	12.6	207	25.8
Yes, Quite Helpful	822	45.9	465	58
Yes, Very helpful	742	41.5	130	16.2
Total	1790	100	802	100

APPENDIX 9: Pupil outcomes: Change in emotional and behavioural difficulties and school climate over time

Table 9a: Mean M&MS emotional and behavioural difficulty scores in primary and secondary pupils across 3 years

	N	2008		2009		2010	
Primary Schools		Mean	SD	Mean	SD	Mean	SD
Emotional difficulties	2205	7.87	4.04	7.19	4.22	6.25	4.11
Behavioural difficulties	2687	2.62	2.45	2.38	2.30	2.2	2.26
Secondary schools							
Emotional difficulties	1995	6.22	3.88	5.46	3.82	5.42	3.97
Behavioural difficulties	2311	2.46	2.24	2.34	2.19	2.38	2.29

Table 9b: Proportions above the clinical cut-off for emotional and behavioural difficulties in primary schools across 3 years

	2008		2009		2010	
Emotional difficulties	Count	%	Count	%	Count	%
Normal	1829	82.95	1861	84.40	1970	89.34
Borderline	184	8.34	191	8.66	119	5.40
Clinical	192	8.71	153	6.94	116	5.26
Behavioural difficulties						
Normal	2343	87.20	2418	89.99	2448	91.11
Borderline	129	4.80	107	3.98	93	3.46
Clinical	215	8.00	162	6.03	146	5.43

Table 9c: Proportions above the clinical cut-off emotional and behavioural difficulties in secondary schools across 3 years

	2008		2009		2010	
Emotional difficulties	Count	%	Count	%	Count	%
Normal	1800	90.23	1855	92.98	1836	92.03
Borderline	100	5.01	74	3.71	91	4.56
Clinical	95	4.76	66	3.31	68	3.41

Behavioural difficulties						
Normal	2083	90.13	2114	91.48	2074	89.74
Borderline	83	3.59	83	3.59	108	4.67
Clinical	145	6.27	114	4.93	129	5.58

Table 9d: Teacher report on the short questionnaire of pupil emotional and behavioural difficulties

	N	2009		2010	
		Mean	SD	Mean	SD
Primary Schools					
Emotional difficulties	1477	.32	.703	.29	.680
Behavioural difficulties	1477	.26	.653	.22	.612
Secondary schools					
Emotional difficulties	699	.27	.672	.27	.666
Behavioural difficulties	699	.30	.707	.36	.761

Table 9e: Average pupil school climate scores across 3 years

	N	2008		2009		2010	
		Mean	SD	Mean	SD	Mean	SD
Primary Schools							
School climate	3339	11.9	2.32	11.63	2.46	11.20	2.79
Secondary schools							
School climate	2642	10.07	2.77	8.59	3.2	7.78	3.32

APPENDIX 10: Exploratory factor analysis of interventions in schools

Factor analysis is a method to explore the variability within the data in order to consider whether a smaller number of underlying constructs (or factors) can be extracted from a greater number of questionnaire items. This approach was used with the 13 categories of school-based mental health support, which identified five underlying factors.

Table 10a: Results of the factor analyses. Only factor loadings above 0.4 are presented.

Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
Social and emotional skills development of pupils		0.65			
Creative and physical activities for pupils		0.52			
Information for pupils					0.91
Peer support for pupils		0.46			
Behaviour for learning and structural support for pupils		0.58			
Individual therapy for pupils				0.92	
Group therapy for pupils				0.45	
Information for parents			0.46		
Training for parents			0.74		
Counselling for parents			0.52		
Consultation for staff	0.65				
Counselling for staff	0.69				
Training for staff	0.69				

Table 10b: Five groupings derived based on factor analysis

<i>Grouping</i>	<i>Categories that make up grouping</i>
Developmental facilitation	<ul style="list-style-type: none"> 1. Social and emotional development of pupils 2. Creative and physical activity for pupils 4. Peer support for pupils 5. Behaviour for learning and structural support for pupils
Information for pupils	<ul style="list-style-type: none"> 3. Information for pupils
Pupil therapy	<ul style="list-style-type: none"> 6. Individual therapy for pupils 7. Group therapy for pupils
Parent focus	<ul style="list-style-type: none"> 8. Information for parents 9. Training for parents 10. Counselling for parents
Staff focus	<ul style="list-style-type: none"> 11. Consultation for staff 12. Counselling for staff 13. Training for staff

APPENDIX 11: Multilevel modelling

Exploratory trajectory clustering

Exploratory trajectory clustering was used to attempt to identify patterns (or cluster) or trajectories of change in emotional and behavioural difficulties across years of the longitudinal study.

A non-parametric k-means algorithm for longitudinal data (Genolini & Falissard, 2010), implemented in R (R Development Core Team, 2011), was used to explore the data. Manhattan distance, rather than Euclidean distance, was used as it is less adversely affected by outliers. Let y_{it} and y_{jt} denote the values of y , e.g., M&MS score, for

participants i and j at time t . Manhattan distance is defined $\sum_{t=1}^N |y_{it} - y_{jt}|$. In words, the distance is the sum of absolute differences in scores at each time point. Each clustering run was repeated twenty times with different random starting positions to avoid local maxima, and solutions with two to six clusters were explored.

The Calinski-Harabasz criterion was used to try to select the number of clusters. In most cases this criterion suggested only two clusters, which was insufficient given visual inspection of trajectories within the clusters. Five clusters were chosen for each of the analyses as the solutions were stable across the twenty reruns, and visual inspection indicated the clusters adequately characterised similar patterns of trajectory. We should emphasise that this is an exploratory technique to gain intuitions about the patterns of change and does not indicate that there are only five patterns of change.

Data were analysed separately for pupils above and below clinical threshold (for emotional problems (internalizing) a value ≥ 12 was considered above threshold and for behavioural problems ≥ 6) and for primary (see 6a) and secondary schools (see 7b).

This approach identified a number of different trajectories for those above and below clinical thresholds. For example, trajectory D for emotional problems (internalizing) above the clinical threshold (Figure 11a) characterises those children's whose scores began very high in 2008, then dropped dramatically in 2009 and then remained fairly stable from 2009 to 2010.

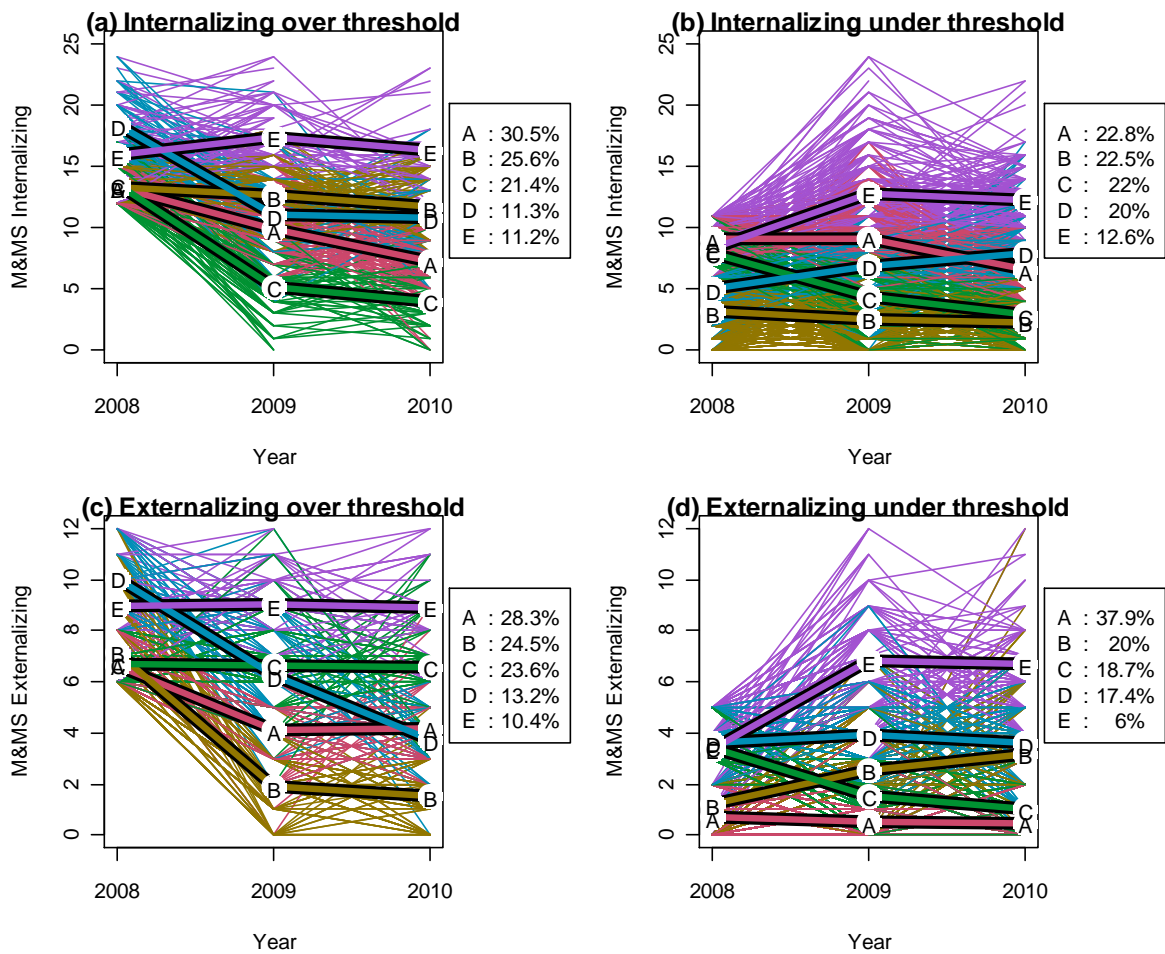


Figure 11a: Trajectories for primary school pupils for (a,b) emotional difficulties and (c,d) behavioural for pupils who are (a,c) above and (b,d) below the clinical threshold. Thick lines denote the means of each cluster; thin lines are individual pupil trajectories.

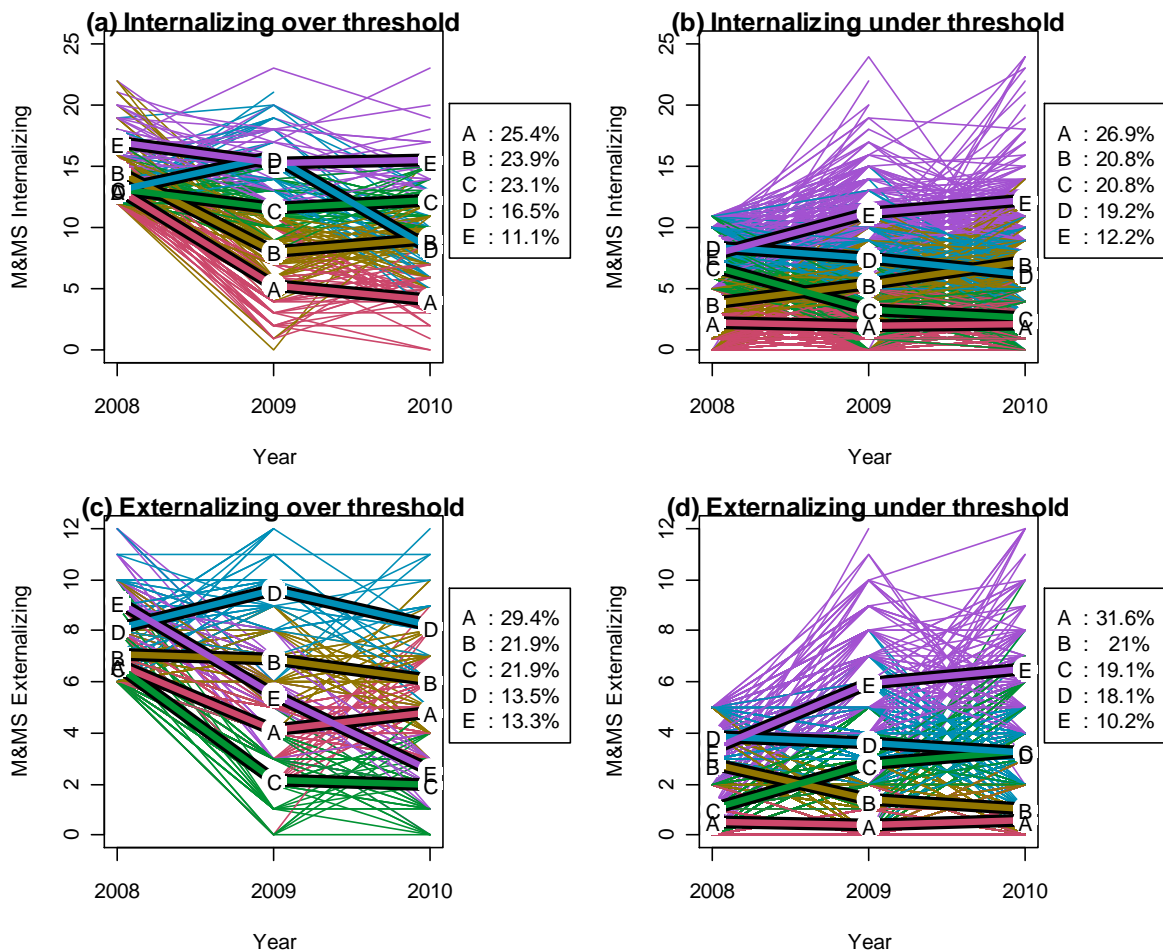


Figure 11b: Trajectories for secondary school pupils for (a,b) emotional difficulties and (c,d) behavioural for pupils who are (a,c) above and (b,d) below the clinical threshold. Thick lines denote the means of each cluster; thin lines are individual pupil trajectories.

Variance accounted for by pupils and schools

Multilevel models (MLMs) were fitted by maximum likelihood estimation using the lme4 package (Bates, Maechler, & Bolker, 2011) in R.

Firstly, we fitted models predicting emotional difficulties and behavioural scores as a function of year, allowing the slope for year and the intercept to vary by pupil and by school (see Table 11a and 11b). As may be seen, by far most of the variation in both outset (i.e., intercept) score and change is explained by pupils, rather than schools.

Table 11a: Random effects estimates for the primary school sample¹⁸

		<i>Emotional problems</i>			<i>Behavioural problems</i>		
		<i>Var</i>	<i>SD</i>	<i>Cor</i>	<i>Var</i>	<i>SD</i>	<i>Cor</i>
Pupil	(Intercept)	12.24	3.50		5.38	2.32	
	Year	1.04	1.02	-0.54	0.44	0.66	-0.66
School	(Intercept)	0.00	0.00		0.39	0.63	
	Year	0.07	0.27	0.00	0.04	0.20	-0.64
Residual		7.10	2.66		2.06	1.44	

Table 11b: Random effects estimates for the secondary school sample

		<i>Emotional problems</i>			<i>Behavioural problems</i>		
		<i>Var</i>	<i>SD</i>	<i>Cor</i>	<i>Var</i>	<i>SD</i>	<i>Cor</i>
Pupil	(Intercept)	10.72	3.27		2.79	1.67	
	Year	0.71	0.84	-0.47	0.07	0.26	-0.14
School	(Intercept)	0.79	0.89		0.19	0.43	
	Year	0.08	0.28	-0.67	0.04	0.21	-0.51
Residual		6.65	2.58		2.31	1.52	

Tests of explanatory variables

All predictors were modelled in their original units. The pupil-rated school climate variable was highly correlated with individual pupil ratings of emotional difficulties and behavioural. A MLM was used to derive a school-level estimate of climate, partitioning variance due to pupils and due to schools. The fitted formula was

$$\text{climate}_{psy} = \alpha + \gamma_p + \gamma_s + \varepsilon_{psy},$$

where climate_{psy} is pupil p 's rating of school s at year y ; α is the estimate of the population mean climate; γ_p is the random effect for pupil p ; γ_s is the random effect for school s ; and ε_{psy} is the observation-level residual. Estimates were then computed for γ_s for each school. The other school-level predictors were only available for the third year, but were assumed to be constant across all three years.

¹⁸ Var = variance; SD = standard deviation; Cor = correlation

Predictors of mental health difficulties

Table 11c: Main effects for primary school pupils¹⁹

	<i>Df</i>	<i>Emotional problems</i>		<i>Behavioural problems</i>	
		<i>LRT</i>	<i>p</i>	<i>LRT</i>	<i>p</i>
Ethnicity	6	11.8	0.07	4.1	0.66
IDACI	1	5.2	0.02	11.8	< 0.001
FSM	1	2.5	0.11	9.4	< 0.01
Gender	1	61.8	< 0.001	269.5	< 0.001
KS1	1	81.9	< 0.001	100.7	< 0.001
School climate	1	17.8	< 0.001	22.8	< 0.001
School developmental facilitation	1	0.1	0.72	1.5	0.21
School information for pupils	1	0.2	0.62	1.0	0.32
School based pupil therapy	1	0.2	0.62	1.5	0.21
School based staff focused support	1	1.7	0.20	0.5	0.49
School based parent focused support	1	0.5	0.48	0.0	0.91
Use of CAF	1	3.0	0.09	0.3	0.56
Links with CAMHS	1	0.1	0.82	3.6	0.06
Year	1	135.0	< 0.001	29.0	< 0.001

More emotional difficulties are predicted by a higher IDACI score (mean slope = 1.03, *SE* = 0.45, *t* = 2.27), being female (mean slope = 1.02, *SE* = 0.13, *t* = 7.91), having a lower Key Stage (KS1) scores (mean slope = -0.17, *SE* = 0.02, *t* = -9.14), and worse school climate (mean slope = -0.55, *SE* = 0.13, *t* = -4.40). On average, emotional difficulties improved each year (mean slope = -0.76, *SE* = 0.05, *t* = -14.14), though note the heterogeneity of trajectories highlighted previously.

More behavioural difficulties are predicted by a higher IDACI score (mean slope = 0.92, *SE* = 0.26, *t* = 3.59), free school means (mean slope = 0.29, *SE* = 0.09, *t* = 3.07), being male (mean slope = -1.19, *SE* = 0.07, *t* = -16.83), having a lower KS1 scores (mean slope = -0.11, *SE* = 0.01, *t* = -10.13), worse school climate (mean slope = -0.39, *SE* = 0.08, *t* = -5.14), and there was a trend of an effect for a poorer links with CAMHS (mean slope = -0.12, *SE* = 0.06, *t* = -1.96). On average, behavioural difficulties improved each year (mean slope = -0.20, *SE* = 0.04, *t* = -5.75), though again note the heterogeneity of trajectories highlighted previously.

¹⁹ *Df* = degrees of freedom; *LRT* = log-likelihood ratio test; *p* = probability level, when *p* < .05 is statistically significant; *SE* = standard error *t* = *t* statistic

Table 11d: Main effects for secondary school pupils

	<i>Df</i>	<i>Emotional problems</i>		<i>Behavioural problems</i>	
		<i>LRT</i>	<i>p</i>	<i>LRT</i>	<i>p</i>
Ethnicity	6	6.4	0.38	9.0	0.17
IDACI	1	1.2	0.27	18.5	< 0.001
FSM	1	2.7	0.10	14.5	< 0.001
Gender	1	33.6	< 0.001	126.8	< 0.001
KS1	1	1.8	0.18	0.0	0.97
KS2	1	7.3	0.01	26.6	< 0.001
School climate	1	3.4	0.06	0.2	0.66
School developmental facilitation	1	1.3	0.26	0.8	0.36
School information for pupils	1	3.7	0.05	0.4	0.51
School based pupil therapy	1	4.7	0.03	2.7	0.10
School based staff focused support	1	0.6	0.43	3.4	0.06
School based parent focused support	1	1.7	0.19	4.3	0.04
Use of CAF	1	8.2	< 0.01	0.5	0.48
Links with CAMHS	1	5.6	0.02	0.2	0.65
Year	1	8.3	< 0.01	1.1	0.30

More emotional difficulties are predicted by being female (mean slope = 0.89, $SE = 0.15$, $t = 5.83$), a lower Key Stage (KS2) scores (mean slope = -0.06 , $SE = 0.02$, $t = -2.71$), lower use of CAF (mean slope = -0.37 , $SE = 0.12$, $t = -3.24$), and poorer links with CAHMS (mean slope = -0.67 , $SE = 0.27$, $t = -2.54$). Information for pupils, on average, was also associated with fewer emotional difficulties (mean slope = -0.34 , $SE = 0.16$, $t = -2.11$), however school based pupil therapy was associated with more emotional difficulties (mean slope = 0.21, $SE = 0.09$, $t = 2.22$; again note the caveat concerning causal direction). On average, symptoms improved each year (mean slope = -0.33 , $SE = 0.10$, $t = -3.49$).

More behavioural difficulties are predicted by being male (mean slope = -0.98 , $SE = 0.08$, $t = -11.64$), a lower KS2 grade (mean slope = -0.06 , $SE = 0.01$, $t = -5.17$), and school based parent focused support (mean slope = -0.05 , $SE = 0.03$, $t = -2.06$). There was also a trend for school based staff focused support to be associated with more behavioural difficulties (mean slope = 0.05, $SE = 0.03$, $t = 1.91$). For behavioural difficulties, no average change was detected between years.

Explanations of change

To investigate change, MLMs were fitted to data from pupils who were above the clinical thresholds. Models were first fitted allowing slopes for year and intercepts to vary by pupil and school, but these showed signs of over-fitting. The final models chosen had only random intercepts for pupils. Table 11e shows results for primary school pupils. Only the interaction between year and information for pupils for emotional difficulties was statistically significant. Examining the slope, information for pupils predicts a slight reduction in the improvement of emotional problems (mean slope = 0.36, $SE = 0.16$, $t = 2.26$). Since information for pupils was not randomly assigned to different schools, this could indicate that schools where pupils tend to show a worsening of symptoms are also those where information for pupils was more likely to be used. The effect size is small. Also given the number of statistical tests used, this could be due to chance.

Table 11e: Interactions between year and explanatory variables in primary school pupils

	<i>Emotional problems</i>			<i>Behavioural problems</i>		
	<i>Df</i>	<i>LRT</i>	<i>p</i>	<i>Df</i>	<i>LRT</i>	<i>p</i>
Year × Ethnicity	6	5.0	0.54	6	3.9	0.69
Year × IDACI	1	0.2	0.64	1	0.5	0.48
Year × FSM	1	0.8	0.37	1	0.0	0.92
Year × Gender	1	0.5	0.49	1	1.6	0.20
Year × KS1	1	0.1	0.78	1	0.3	0.60
Year × School climate	1	2.4	0.12	1	4.3	0.04
Year × School Developmental Facilitation	1	0.2	0.62	1	0.1	0.81
Year × School Information for pupils	1	5.1	0.02	1	0.9	0.35
Year × School based pupil therapy	1	0.3	0.58	1	0.2	0.67
Year × School based staff focused activity	1	0.2	0.64	1	2.2	0.13
Year × School based parent focused activity	1	1.7	0.19	1	0.8	0.37
Year × Use of CAF	1	0.4	0.53	1	0.6	0.44
Year × Links with CAMHS	1	0.1	0.77	1	0.2	0.70

Table 11f shows results for secondary schools. The most striking finding is that information for pupils is associated with an improvement of behavioural difficulties over time (mean slope = -0.97 , $SE = 0.21$, $t = -4.63$). There were also effects of improvement the greater CAF (mean slope = -0.23 , $SE = 0.12$, $t = -2.01$) and CAMHS (mean slope = -0.73 , $SE = 0.35$, $t = -2.12$) scores.

Table 11f: Interactions between year and explanatory variables in secondary school pupils

	<i>Emotional problems</i>			<i>Behavioural problems</i>		
	<i>Df</i>	<i>LRT</i>	<i>p</i>	<i>Df</i>	<i>LRT</i>	<i>p</i>
Year x Ethnicity	6	1.1	0.98	5	1.1	0.96
Year x IDACI	1	1.3	0.26	1	0.0	0.95
Year x FSM	1	2.6	0.11	1	2.8	0.10
Year x Gender	1	0.5	0.47	1	0.3	0.62
Year x KS1	1	1.3	0.25	1	0.6	0.43
Year x KS2	1	0.2	0.65	1	0.2	0.65
Year x School climate	1	1.2	0.28	1	1.0	0.32
Year x School Developmental Facilitation	1	3.5	0.06	1	0.2	0.68
Year x School Information for pupils	1	0.3	0.57	1	20.6	< 0.001
Year x School based pupil therapy	1	1.5	0.23	1	3.0	0.08
Year x School based staff focused activity	1	0.4	0.52	1	0.2	0.62
Year x School based parent focused activity	1	1.0	0.31	1	0.9	0.34
Year x Use of CAF	1	0.3	0.58	1	4.0	0.04
Year x Links with CAMHS	1	0.9	0.34	1	4.4	0.04

APPENDIX 12: RCT analysis

Multilevel models (MLMs) were fitted separately for emotional and behavioural difficulties scores and for primary and secondary school children. Random intercepts were used for pupils and schools. The latent emotional and behavioural scores were used as outcome variables. Initial models only included those above the clinical cut off for emotional or behavioural problems.

The main model coefficients of interest are interactions with year as these represent change in symptoms from 2009 to 2010.

Models were fitted for emotional and behavioural difficulties separately, for primary and secondary school children, focusing on those children who were above clinical cut-off in 2009. A MLM was used with random intercepts for pupils and schools. The latent emotional and behavioural difficulties scores were used as outcome variables.

Firstly, there was an interaction between year and whether schools received TaMHS support on behavioural scores in primary school pupils ($\chi^2(1) = 4.7$, $p = .03$), however no effect was found in secondary school pupils. Pupils in primary schools in the TaMHS group showed a greater decrease in behavioural than those in schools which did not (slope = -0.13 , SE = 0.06 , $t = -2.17$). There were no other two-way interactions between year and the intervention variables (p 's between $.14$ and $.99$).

There were no four-way interactions between year and the intervention variables (p 's between $.28$ and $.89$). There were, however, three-way interactions for behavioural difficulties in primary school pupils between year and whether TaMHS funded and whether evidence based self-help materials were received ($\chi^2(1) = 4.9$, $p = .03$). Pupils in schools who were both TaMHS funded and received evidence based self-help materials showed a greater decrease in behavioural difficulties (slope = -0.26 , SE = 0.12 , $t = -2.21$). There was also an effect for emotional difficulties in secondary school pupils: an interaction between year, action learning and pupil pack – independent of whether TaMHS funding was received ($\chi^2(1) = 4.0$, $p = .04$), however this was less improvement over time (slope = 0.28 , SE = 0.14 , $t = 2.01$). There was a trend of an interaction between TaMHS, pupil pack and year ($\chi^2(1) = 3.5$, $p = .06$) – more improvement in symptoms (slope = -0.28 , SE = 0.15 , $t = -1.89$).

Finally a model was fitted for all the behavioural difficulties data to investigate effect of (a) above/below threshold for behavioural problems (b) primary/secondary school, (c) TaMHS group, and (d) year. The four-way interaction between these four predictors was marginally

significant ($\chi^2(1) = 3.4, p = .06$). Focusing on RCT-relevant interactions, there was a three-way interaction between threshold, TaMHS group, and year (in bold; $\chi^2(1) = 5.1, p = .02$). Table 12a shows the model coefficients.

Table 12a: Full model with all interactions for behavioural problems

	<i>Slope</i>	<i>SE</i>	<i>t</i>
(Intercept)	0.28	0.12	2.30
Above threshold at outset	5.73	0.35	16.25
Secondary school	-0.52	0.20	-2.64
TaMHS	-0.12	0.15	-0.77
Year	-0.05	0.01	-3.88
Above threshold × Secondary school	-0.20	0.58	-0.35
Above threshold × TaMHS	1.24	0.43	2.86
Secondary school × TaMHS	0.29	0.23	1.25
Above threshold × Year	-0.45	0.04	-12.17
Secondary school × Year	0.07	0.02	3.39
TaMHS × Year	0.01	0.02	0.76
Above threshold × Secondary school × TaMHS	-1.23	0.69	-1.78
Above threshold × Secondary school × Year	0.01	0.06	0.22
Above threshold × TaMHS × Year	-0.13	0.05	-2.91
Secondary school × TaMHS × Year	-0.04	0.02	-1.56
Above threshold × Secondary school × TaMHS × Year	0.13	0.07	1.85

The results for this model are consistent with those from the models separately looking at primary/secondary for those above the clinical cut off. Above threshold and receiving TaMHS implies more reduction in problems (mean slope = -0.13 , $SE = 0.05$, $t = -2.91$). The reduction cancels out for secondary school ($-0.13 + 0.13$), though we can't be confident of the mean estimate for the four-way interaction. This is again consistent with separate models which uncovered a statistically significant effect for behavioural difficulties in primary but not secondary schools.

There are other effects observable in the coefficients which are worth commenting on. Reduction across years, independent of intervention, is less for secondary than primary schools. However secondary pupils showed fewer behavioural problems at outset, indicating that these coefficients model regression to the mean effects. Similarly for the above threshold coefficients, those with more problems at outset showed a greater reduction in difficulties.

Figures 12a and b show the mean estimates of latent scores as a function of TaMHS group and year, in primary and secondary schools for pupils above the clinical cut-off

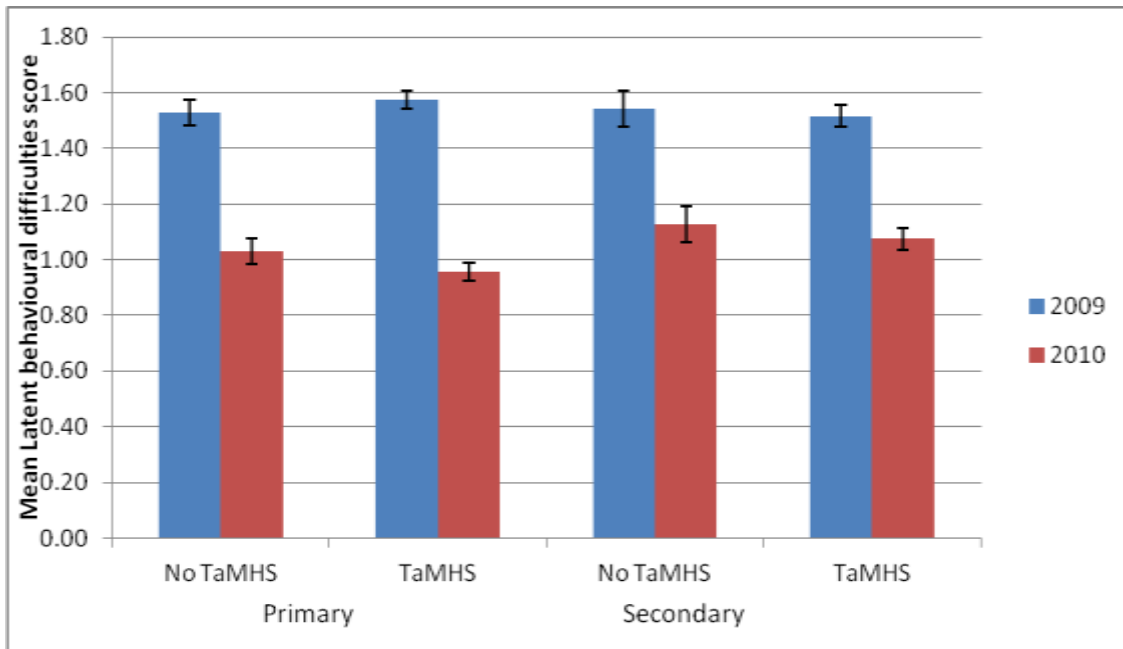


Figure 12a: Mean behavioural difficulties latent score and standard errors

As can be seen from Figure 12a the change in mean scores from 2009 to 2010 is more in the TaMHS group than the No-TaMHS group, illustrating the statistically significant difference between these groups identified through the MLMs.

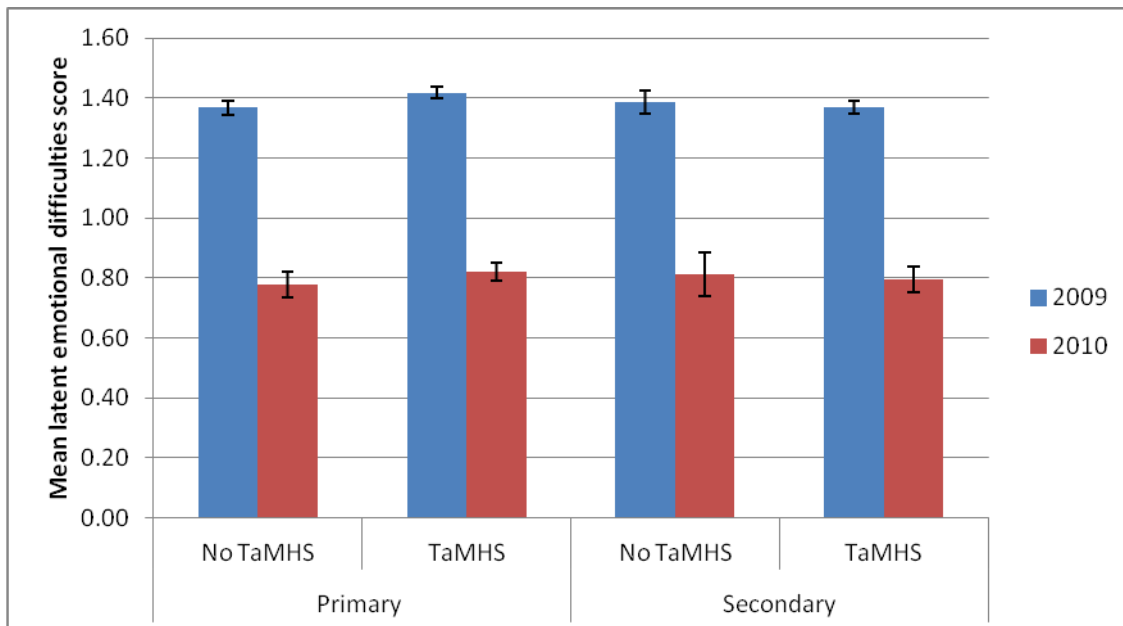


Figure 12b: Mean emotional difficulties latent score and standard errors

Ref: DFE-RR177

ISBN: 978-1-78105-039-2

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November 2011