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Mental health provision in schools: priority, facilitators and barriers in 10 European countries

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Background: Although schools are a key setting for the provision of mental health support for young people, little is known about the facilitators and barriers for providing such support. This study aimed to collect information from schools in 10 European countries regarding the priority given to mental health support for students, existence of a mental health-related school policy, links with relevant external agencies, schools' perceptions on whether they are providing sufficient mental health support and the barriers to provision of mental health support. **Methods:** Data from 1346 schools were collected in France, Germany, Ireland, the Netherlands, Poland, Serbia, Spain, Sweden, United Kingdom and Ukraine through an online survey. **Results:** Around 3% of the surveyed schools indicated that mental health provision was not a priority, compared to 47% indicating that it was a high/essential priority. More than half the surveyed schools did not implement a school policy regarding mental health. Half the surveyed schools reported not providing sufficient support with the key barriers identified including limited staff capacity, funding, access to specialists and lack of national policy and less than a third of schools reported good or excellent links with local mental health services. However, the responses varied by country with 8–19% between-country variation across the study outcomes. Secondary schools reported significantly better links with agencies, were more likely to have a school policy and were less likely to indicate having sufficient existing support compared to primary schools. Privately funded schools reported that mental health support was a higher priority and identified less barriers to provision compared to publicly funded schools. **Conclusion:** This study provides an up-to-date and cross-country insight into schools' perceptions regarding priority given to mental health support and the barriers they face in providing sufficient mental health and wellbeing support for their students. The cross-country comparisons allow for a better understanding of the relationships between policy, practice and implementation and provide a platform for shared experiences and learning.

Key Practitioner Message

- Schools are considered a key community setting for mental health support for young people and in many cases the first point of access for screening and intervention. However, little is known about the level of priority schools place on mental health support and their perceived facilitators and barriers to provision.
- Responses from schools in 10 European countries indicate that many schools report not doing enough to support their students' mental health. The majority of schools do not report good links with external agencies relevant for mental health, although this varies by type of external agency and country.
- Key barriers identified include limited staff capacity, funding and access to specialists. Lack of national policy was also identified as a key barrier in countries where these do not already exist, suggesting that national policy and guidance around school mental health provision may promote higher activity in schools.
- The findings suggest that improving schools' links with agencies and access to specialists might be one route to facilitate the capacity of schools to effectively support their students' wellbeing.

Keywords: Mental health; wellbeing; intervention; schools; barriers; policy; Europe

Introduction

The estimated prevalence of mental health disorders among young people varies across European countries from 10% to 22% (Green, McGinnity, Meltzer, Ford, & Goodman, 2005; Pez, Boyd, Christophe, & Kovess-Masfety, 2013; Ravens-Sieberer et al., 2008; World Health Organization, 2005). Longitudinal research indicates that symptoms in youth are predictive of disorders in adulthood (Roza, Hofstra, van der Ende, & Verhulst, 2003) – a leading cause of global health burden (Murray et al., 2012). This highlights the importance of adequate community-based support and prevention/promotion efforts in school years for children's mental health (Allen, Balfour, Bell, & Marmot, 2014). This study examines the role of schools in mental health provision in Europe by investigating their views on the priority given, potential facilitators and perceived barriers to providing school-based mental health support. The following paragraphs outline the background and rationale for the key components examined in the study.

Given the amount of time young people spend in school, the existence of structures within schools that allow planned provision and interventions to be implemented effectively (e.g. curricula, behaviour monitoring, staff-parent communication), and their role as a key referral source to specialist services, schools represent an ideal setting for supporting mental health difficulties and promoting wellbeing (Caan et al., 2014; Greenberg, 2010; Jané-Llopis & Braddick, 2008; Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). In addition, the key barriers to receiving support, including stigma and difficulty accessing services are reduced in schools (Stephan et al., 2007; Weist, 1999). Although schools are a key setting in which mental health interventions can be implemented, they often fail to be prioritized within schools (Burke & Stephan, 2008; Greenberg, 2010; Shoshani & Steinmetz, 2013). Hence, one of the key aspects of this study will be to investigate the priority given to mental health support in schools.

Country-level investigations in 36 European countries have highlighted that mental health support and services for young people are generally worse than for adults and that there is a lack of specialized training and resources (Levav, Jacobsson, Tsiantis, Kolaitis, & Ponizovsky, 2004). More specifically at the school level, European initiatives such as the Health Promoting Schools Framework (HPSF) in the 1980s encouraged schools to develop and implement health-promoting initiatives, enhance links between schools and community and focus on the development and implementation of policies (Clarke & Barry, 2015). In recent years, children's mental health problems have been increasingly recognized as a large public health challenge (Patel, Flisher, Hetrick, & McGorry, 2007). This has been reflected in initiatives by the European Commission such as the Child and Adolescent Mental Health in Enlarged European Union project, which aimed to provide opportunities for knowledge exchange and learning between European states to support greater evidence-based practice. Within this initiative, experts from different European countries have gathered information on available policies, existing programmes, workforce and infrastructures for mental health treatment and promotion in each country (Braddick, Carral, Jenkins, & Jané-Llopis, 2009; Puras & Sumskiene, 2009). However, data directly from schools are not available on their priorities, school-level policies and existing provision for mental health. The important role that can be played by schools for screening, intervention and promotion is highlighted in recent European level policies, of note, the current European Joint Action on Mental Health and Wellbeing (2013–2016). Its main aims include building a framework for action in mental health policy at the European level and one of the key issues it addresses is promotion of mental health in schools. In the light of these European-level initiatives and the increasing emphasis on the role of schools in providing support, we examine the presence of school-level policies as a potential facilitator of school-based provision of mental health support.

The relevance of schools as a setting for mental health support and promotion is widely accepted (Burke & Stephan, 2008). In addition, they are a key referral source to specialist services (Pettitt, 2003). In this regard, the links schools have with local services become relevant. This aspect of a school's role in intervention and treatment has been a key element of focus for initiatives such as HPSF. In addition, there is some evidence, although not extensive, which suggests that good links with relevant external agencies and specialists can facilitate a school's ability to provide suitable support to children with mental health difficulties (Wolpert et al., 2011). Hence, in this study, we investigate schools' links with relevant local services and external agencies as another potential facilitator of provision in schools.

Less than a third of children who need mental health support receive help, and usually only after problems have reached a certain level of severity (Angold et al., 2002). It is noteworthy that of the small proportion of children who receive support, schools are one of the key settings in which services are accessed (Burns et al., 1995). Given that most children who might need mental health support do not receive sufficient help, there clearly remain barriers for sufficient provision in schools. Hence, understanding the barriers schools in Europe face is essential and provides insight into resources and support required by schools in order to effectively help students with mental health difficulties and promote student wellbeing. Teich, Robinson and Weist (2008) investigated the perceived barriers to mental health provision in schools in the United States. Among potential barriers included in this study such as financial constraints and available resources, schools in the United States most commonly identified inadequate school and community mental health resources as being a serious barrier to providing appropriate support. In another US-based study, Langley, Nadeem, Kataoka, Stein, and Jaycox (2010) conducted interviews with school staff regarding barriers to providing evidence-based treatments in schools. Key barriers identified included competing responsibilities, parent engagement and logistics. Studies have also focussed on specific barriers to young people receiving mental health support in school such as parents' or students' attitudes (Ohan, Seward, Stallman, Bayliss, & Sanders, 2015; Rickwood, Deane, Wilson, & Ciarrochi, 2005). In comparison to the United States, there is a dearth of studies that have investigated factors that schools in European countries perceive as being barriers to providing school-based

mental health support, which is one of the main aims of this study.

Investigations that span multiple countries are not only useful in terms of providing relevant information to stakeholders in the participating countries, but also allow for comparisons based on country characteristics (such as economic and cultural, Levav et al., 2004), existing policies (Braddick et al., 2009) and contextual factors (Burke & Stephan, 2008). Such studies also promote knowledge exchange and learning. Hence, this study includes data from 10 European countries, of varying geographical location, economic development and cultural characteristics, aiming to provide an overview of the priority, facilitators and barriers for school mental health provision across diverse European countries.

In summary, this study aims to investigate (a) the priority given to mental health support in schools across a number of European countries, (b) the existence of school policy regarding student mental health support, (c) the quality of links with relevant external agencies in providing support for mental health difficulties and (d) whether schools perceive they are doing enough to support their students and (e) the perceived barriers to mental health provision. For each of these elements, we evaluate overall levels, between-country differences and school characteristics that predict variation in these outcomes. This study is unique in terms of encompassing cross-national data from schools in 10 European countries, thus allowing between-country comparisons and the identification of recommendations that could be made to enhance current mental health provision in schools across Europe.

Methods

Sampling

The aim of the research group was to obtain data from a diverse range of European countries that covered a geographical and economic spread. Consistent with this target, selected countries belong to different geographical parts of Europe (e.g. Sweden from Scandinavia, Spain from the South-West, Germany and Poland from Central Europe and Ukraine from Eastern Europe). Not all participating countries are EU members (e.g. Ukraine and Serbia) and the countries represent diverse political and economic systems. The final countries included in the study were also selected based on convenience in terms of access to the research group and presence of collaborators, hence resulting in the 10 countries present in this study.

Participants

Participants were 1346 schools from 10 European countries [France: $n = 73$ (5.4%), Germany: $n = 182$ (13.5%), Ireland: $n = 171$ (12.7%), the Netherlands: $n = 140$ (10.4%), Poland: $n = 195$ (14.5%), Serbia: $n = 207$ (15.4%), Spain: $n = 80$ (5.9%), Sweden: $n = 40$ (3.0%), United Kingdom: $n = 174$ (12.9%), Ukraine: $n = 84$ (6.2%)]. Across all participating countries the sampling strategy was the same – all schools with email contact details were invited to take part in the study. Access to this information (email addresses) varied by country – in some, they were available publicly and in other countries, the information was obtained with the support from relevant local agencies. Of the schools that completed the survey, 52.5% were primary schools, 35.3% were secondary schools, 10.2% were combined primary and secondary schools and 1.9% were classified as other (e.g. preschools); 92.3% of schools were state funded and 7.7% were privately funded. In addition, 57.7% of schools stated their location as being urban. Average school size was 445.24 students ($SD = 469.28$). The majority of school staff that answered the survey were headteachers ($n = 673$), followed by teachers ($n = 311$), school psychologists ($n = 185$) and deputy headteachers ($n = 183$).

Procedure

The project was reviewed by the institutional ethics committee and given the project does not include individual participants or their personal information, full research committee review was advised to be unnecessary. All participating schools (individuals on their behalf) provided informed consent before completing the survey.

The survey was distributed to schools via email. School email addresses were obtained through engaging with educational departments and through online databases. All schools that we obtained email contact information for were sent invitations to participate in the study and were provided with a link to the survey. The email also instructed schools to identify school staff (one or more) best suited to answer the questions regarding mental health provision in their organization ('We request you to identify person(s) best suited to answer questions regarding current provisions and interventions to support mental health and well-being in your school to complete the survey'). Having accessed the survey, schools were given information about the study and the confidentiality of individual school responses was explained. Schools were then requested to proceed to the survey if they consented to participate. All data were collected in the school year between September 2013 and June 2014.

Measures

The measure was developed based on existing research (Teich et al., 2008; Wolpert et al., 2011) and through liaising with researchers and school staff (greater details of the measure development and content are available- Patalay et al., 2014). Initially, based on the existing literature and the aims of the study, the research group, with input from advisors (which included researchers, school staff and clinical and educational psychologists), determined the key areas of focus for the survey and drafted the questions with appropriate response options. The measure was developed in a constant cycle of question development, translation, focus groups/interviews in different countries, which fed back into question development. Hence, although the master version of the questionnaire was maintained in English, feedback from teachers/psychologists from the different countries shaped the content and language of the survey. Focus groups, interviews and pilot surveys were carried out with teachers and psychologists to ensure appropriate interpretation, coherence and optimal understanding of the questions translated into different languages in the online surveys. The survey content, order, formatting and presentation was consistent across translations. Once schools were invited and consented to participate, school representatives responded to questions relating to the schools characteristics followed by the specific sections as outlined in the following paragraph. See Appendix S1 for the survey items and response options in the English version of the online questionnaire. For versions in the other languages (German, Dutch, Spanish, French, Polish, Ukranian, Serbian), please contact the corresponding author.

First, schools were asked regarding the priority given to mental health and wellbeing provision in their school ('not a priority/low priority/medium priority/high priority/essential'). They were then asked whether they were implementing any policy within the school regarding mental health and wellbeing provision. Next, the extent and quality of schools' links with relevant local external agencies such as mental health services, health services, social services, juvenile justice, charities, societies and nongovernmental organizations was indicated on a 5-point scale ('no links' to 'strong links'). Following this, schools were asked whether they think enough is being done in their institution to support student mental health and wellbeing. Finally, schools indicated the extent (ranging from 'not at all' to 'very much') to which they perceive a range of factors (e.g. school funding, availability of specialists in the local area) as being

barriers to mental health provision in their school. We also included an 'other' open-ended option for agencies and barriers to allow schools to include factors that were not considered by the research team, so these could inform the results and future research.

Analysis

In accordance with the aims of this study, for the five elements of interest (priority, school policy, links, sufficient support and barriers) we present (a) overall descriptive statistics indicating response levels for each question, (b) between country-level variation, and (c) predictive school characteristics. To do this, we first present descriptive statistics for each of the responses for the overall sample, followed by an intraclass correlation coefficient estimate of the between country-level variation in each outcome. This is followed by a description and graphical presentation of data for the 10 participating countries. Finally, to investigate the school characteristics (type, funding, location) that predict variation in the study outcomes, we conducted multilevel (to account for schools being nested within countries) regression analysis predicting overall levels of priority, extent, policy, links and barriers to provision.

Results

Priority

When asked about the level of priority given to mental health provision in their school, 3.3% of schools reported that it was not a priority, for 13.4% it had low priority, 36.0% indicated medium priority, 38.4% high priority and 9.0% reported such provision as essential. Multilevel analysis demonstrated that 14% of variation in extent of priority was explained by between country-level variation. The percentage of schools indicating high or essential priority differed between participating countries (Figure 1) with values from 17.8% in France to 72.8% in Poland (France: 17.8%, Germany: 47.8%, Ireland: 50.0%, the Netherlands: 52.9%, Poland: 72.8%, Serbia: 25.7%, Spain: 31.2%, Sweden: 38.5%, United Kingdom: 59.8%, Ukraine: 45.2%).

In terms of school-level predictors of these factors (regression results in Table 1), private schools overall indicated that mental health and wellbeing of students was a higher priority (compared to state funded schools).

School policy

The overall percentage of schools implementing a policy related to mental health provision was 41.8%. Nineteen percent of between country-level variation in existence of a school policy regarding mental health support was estimated with values ranging from 15.7% of schools in France to 78.3% in the Netherlands (France: 15.7%, Germany: 20.6%, Ireland: 51.5%, the Netherlands: 78.3%, Poland: 28.7%, Serbia: 55.3%, Spain: 22.8%, Sweden: 65.0%, United Kingdom: 43.6%, Ukraine: 29.8%; Figure 1).

Compared to primary schools, secondary schools were significantly more likely to have a school policy regarding mental health provision in their schools (Table 1). There were no significant differences based on location or funding source of schools.

Links with external agencies

Schools reported better links with social and health services, followed by mental health services and third sector or voluntary/nongovernment organizations (Table 2). Overall, less than a third of schools reported good or excellent links with local mental health services, which had the second lowest average links after juvenile justice system. The highest percentage of between country-level variance was found for links with mental health services (16.1%) and the lowest was found for links with local health services (8.8%). Figure 2 demonstrates the links with agencies by the participating countries. Certain countries reported good links overall, with other countries varying more depending on the agency in question. For instance, French schools reported good links in the least proportions (<10%, except health services 22.3%), whereas more than two-thirds (67.9%) of Dutch schools reported good links with mental health services. Most third sector involvement was reported by Serbia, Poland and Germany, whereas the Netherlands and Sweden reported poor links with third sector agencies. In the open response other agencies schools commonly mentioned included external school psychologists, the police, city councils, youth organizations, churches and

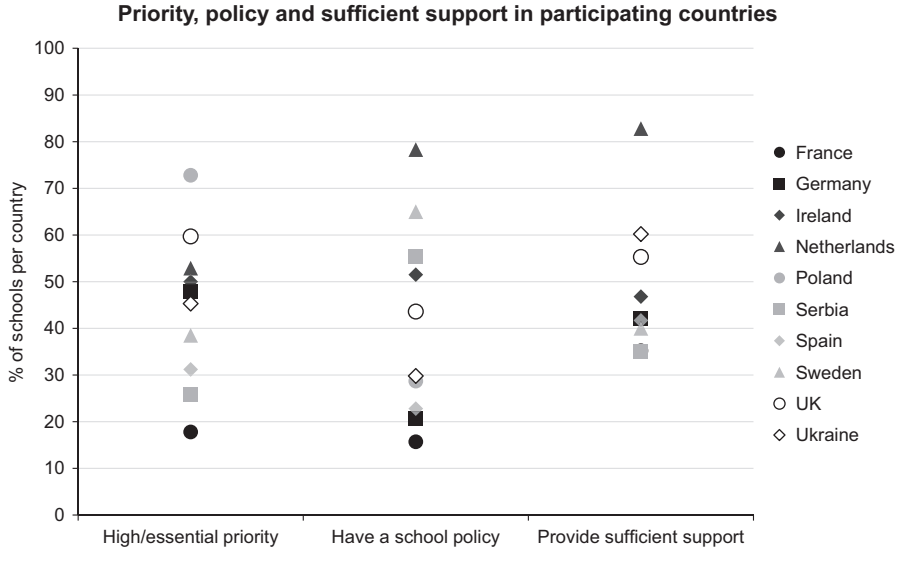

Figure 1. Demonstrates the country-level variation in priority of mental health support, existence of a school policy related to mental health and whether schools perceive themselves to be providing sufficient support across the 10 participating European countries

Table 1. School characteristics predicting responses to key study variables across the sample

	Priority *B*(*SE*)	Sufficient support *B*(*SE*)	School policy *B*(*SE*)	Average links with agencies *B*(*SE*)	Average perceived barriers *B*(*SE*)
School type[a] (secondary)	−.06 (.05)	−.35** (.13)	.36** (.13)	.14** (.05)	−.01 (.04)
School type[a] (primary and secondary)	.10 (.12)	.05 (.27)	.40 (.31)	.21 (.11)	−.09 (.10)
School type[a] (other)	.01 (.18)	.39 (.43)	−.29 (.58)	.09 (.17)	−.11 (.15)
School funding[b] (private)	.21* (.10)	.23 (.24)	.04 (.25)	−.12 (.09)	−.26** (.09)
School location[c] (rural)	−.07 (.05)	.09 (.12)	−.11 (.13)	−.08 (.05)	−.001 (.04)
Country-level variation (ICC)	.14	.10	.19	.15	.12

ICC, intraclass correlation coefficient.
Reference group: [a]primary schools, [b]state funded schools, [c]urban location.
*$p < .05$; **$p < .01$.

Table 2. Extent and quality of links with relevant local agencies for mental health support in schools

	No links %	Poor links %	Fair links %	Good links %	Excellent links %	Average response[a] *M* (*SD*)	Percentage of country variance
Mental health services	19.1	20.8	27.4	27.2	5.5	2.79 (1.19)	16.1
Health services	6.7	18.5	29.8	35.5	9.5	3.22 (1.07)	8.8
Social services	4.3	17.2	29.0	38.1	11.5	3.35 (1.03)	12.1
Juvenile justice system	40.8	19.2	20.4	16.5	3.1	2.22 (1.23)	10.8
Charities, NGOs	24.4	19.8	25.3	23.9	6.5	2.68 (1.23)	13.7

[a]Average from a possible score ranging from 1 to 5, score of 5 indicating excellent links.

country-specific organizations, for instance, the National Educational Psychological Services in Ireland.

Secondary schools reported better links with local agencies compared to primary schools. School location and type of funding did not predict extent/quality of links with agencies (Table 1).

Sufficient support

Overall, 50% of participating schools reported that they are doing enough to support student mental health, with 10% of between country-level variation. Figure 1 demonstrates proportions of schools within each of the countries indicating that they had sufficient support already in their schools. Serbian and French schools were least likely to indicate having sufficient support compared to Dutch schools where more than four–fifth of schools indicated doing enough (France: 35.2%, Germany: 42.1%, Ireland: 46.8%, the Netherlands: 82.8%, Poland: 55.4%, Serbia: 35.0%, Spain: 41.7%, Sweden: 40.0%, United Kingdom: 55.3%, Ukraine: 60.2%).

Barriers

As can be seen in Table 3, overall, the biggest barrier to the provision of mental health support was staff capacity followed by school funding and availability of specialists in the local area. The highest between-country variation was observed for links with agencies (17.2%) and the lowest for general attitude towards mental health (9.9%) and parent attitudes (9.0%). Other barriers mentioned by schools included lack of physical space or facilities for activities, long waiting lists for psychological services, student attitudes, rural location of the school leading to lack of external services nearby, and also that too many interventions to choose from can overwhelm and confuse teachers.

Figure 3 demonstrates the between country-level variation in perception of the various factors as barriers to provision in schools. Overall, Dutch schools did not report many barriers to providing support in schools. France, Spain and Ireland had the highest proportions of schools indicating that availability of specialists, links with relevant agencies, lack of national policy and staff capacity were barriers to provision.

Multilevel regressions indicated a 12% between-country variation in average extent of barriers reported. The only significant predictor of perceived barriers was type of school funding with private schools reporting significantly less barriers to provision of support in schools (Table 1).

Discussion

As outlined in the introduction, schools play a key role in delivering provision to support and promote children's mental health and are uniquely placed to provide support and refer individuals experiencing difficulties to specialist services. With the increasing drive to improve school-based provision and support for students, it becomes essential to consult schools in order to understand the challenges they face when providing support. This study surveyed schools across 10 countries in Europe with the aim of documenting their perceptions regarding the priority given to mental health support, the existence of a school policy or guidance regarding student mental health, the extent of links with relevant local agencies, whether they perceive themselves as providing sufficient support and perceived barriers to support. We also examined school factors (e.g. primary/secondary, funding) that might predict the extent of links with agencies and perceived barriers to providing support in schools. Data were collected from a range of countries across Europe – spanning different geographical, cultural and economic characteristics – with the hope that country-based differences might lead to a

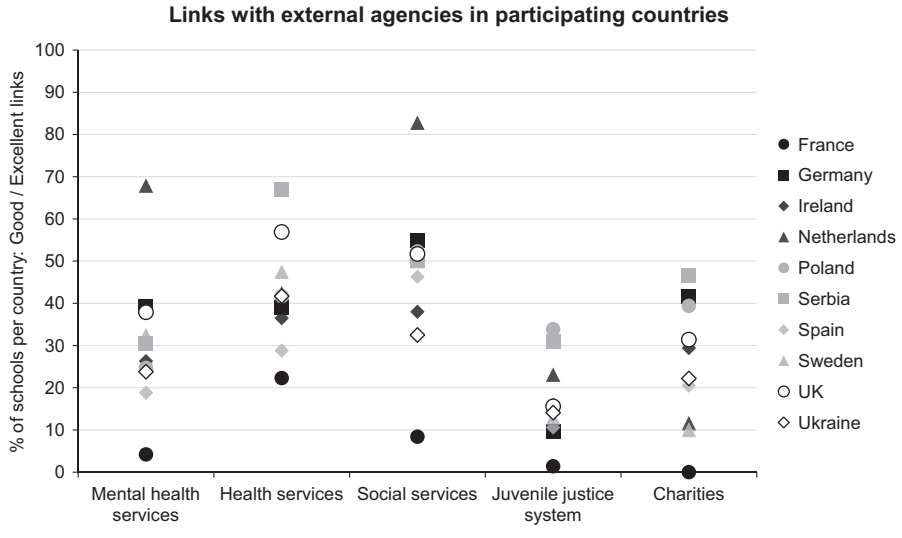

Figure 2. Demonstrates the country-level variation in links with relevant external agencies across the 10 participating European countries

Table 3. Barriers to delivering mental health support in schools

	Not at all %	A little %	Somewhat %	Quite a lot %	Very much %	Average response[a] *M*(*SD*)	Percentage of country variance
School funding	9.4	12.6	22.6	29.5	25.9	3.50 (1.26)	10.1
Availability of specialists	8.9	13.8	25.5	31.7	20.1	3.40 (1.21)	11.8
Links with agencies	12.9	21.6	36.4	20.9	8.2	2.90 (1.12)	17.2
General attitude	19.2	20.5	33.5	18.6	8.2	2.76 (1.20)	9.9
Lack of national policy	11.5	13.8	25.0	28.5	21.3	3.34 (1.27)	13.5
Staff capacity	5.7	11.8	21.5	32.5	28.4	3.66 (1.17)	14.0
Staff attitudes	27.4	25.5	24.8	16.4	6.0	2.48 (1.22)	10.5
Parent attitudes	12.0	23.8	31.4	23.8	8.9	2.94 (1.14)	9.0

[a]Average from a possible score ranging from 1 to 5, score of 5 indicating very much a barrier.

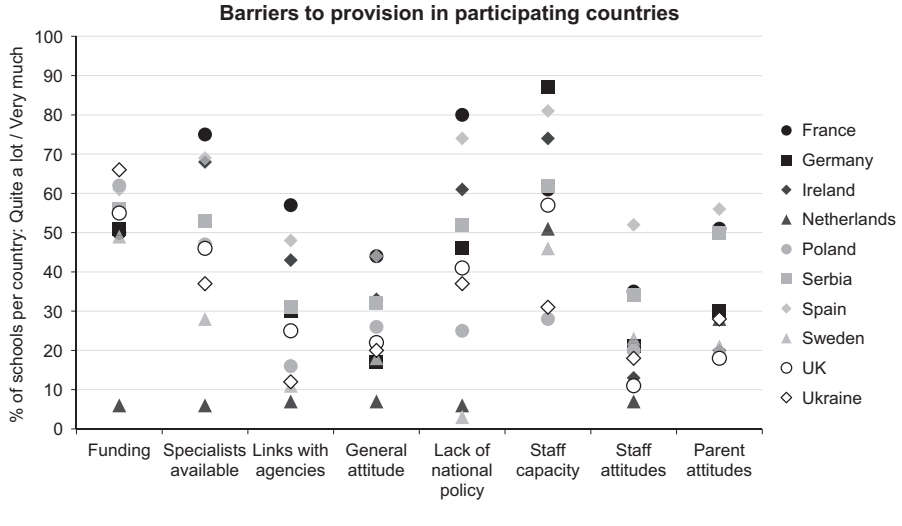

Figure 3. Demonstrates barriers to providing mental health support across the 10 participating European countries

better understanding of the relationships between policy, practice and implementation.

A large proportion of schools indicated that supporting the wellbeing and mental health of their students was not a priority, although the proportion varied by country. This finding may be due to the ever increasing focus placed on academic and learning outcomes in schools (Shoshani & Steinmetz, 2013), but could also reflect a lack of resources to be able to prioritize mental health support in the light of limited budgets and availability of trained staff; which were both identified as major barriers to provision across most countries. Given that children's wellbeing is conducive to better learning, with developing mental health symptoms being

associated with poorer academic outcomes (Patalay, Deighton, Fonagy, & Wolpert, 2015), the arguments for focusing on wellbeing support as well as academic outcomes are well-supported. It is also noteworthy that even in countries where national policy encourages mental health support in schools (e.g. United Kingdom, the Netherlands), more than a third indicated that this is not a high priority within their schools. Differences between countries in the level of priority given to mental health support might also reflect economic differences between countries as is observed more broadly for mental health services available in countries (Levav et al., 2004) and country differences in the conceptualization of the role of schools in promoting student wellbeing (Burke & Stephan, 2008).

Approximately half the surveyed schools indicated that they had a policy within the school regarding students' mental health. Secondary schools were more likely to implement a policy, probably reflecting the bigger size of these schools and the higher incidence of problems in adolescents (Green et al., 2005). However, the proportion of schools that reported having a policy varied greatly between countries. An observation of the countries with higher likelihood of having school policies demonstrates an alignment with the presence or absence of national policies regarding mental health in schools. For instance, almost 75% of Dutch schools indicated having a policy regarding mental health provision and they did not indicate the lack of a national policy as being a substantive barrier, possibly reflecting the existence of national policies and guidelines around school mental health provision in the Netherlands (Forti et al., 2014). Additionally, the presence of broader national policies and legislation related to mental health (which are present in most surveyed countries), does not seem to be associated with school priority and policy in these countries, as these vary widely. Possible explanations for this include the fact that the existence of national level policy need not mean that they are implemented uniformly within countries and differences might reflect ineffective implementation of national policy (Burke & Stephan, 2008).

Schools overall reported varying quality of links with local agencies, which might be an important indicator of schools' ability to support children experiencing difficulties. Schools reported better links with social services compared with mental health and other health services, which might reflect the longer standing establishment of social services in most countries and the close links and co-operation with schools that have been developed over this time. Only a third of schools reported good/excellent links with mental health services, which might be an area of focus for improvement, as good links with mental health services would facilitate more integrated support for children with mental health difficulties (Teich et al., 2008; Wolpert et al., 2011). The country-level variation in the quality of links in some cases reflects the extent of priority given to student wellbeing in schools. For instance, in France a small proportion of schools (<5%) reported good links with mental health services, moreover, only 17% of French schools indicated that student wellbeing is a priority and only 15% had school policy in this area. The lack of priority given to nonacademic outcomes in French schools (Gumbel, 2010) possibly relates to their limited focus on building these external links with relevant health agencies, highlighting the need for policies that encourage schools to also focus on their students wellbeing.

Staff capacity, school funding and lack of specialists were cited overall as the greatest barriers to providing sufficient provision. These were immediately followed by a lack of national policy and quality of links with agencies. However, there was a large country-level variation in these barriers, sometimes reflecting the existence of policies or specialist provision in various countries. It is noteworthy that across all surveyed countries, attitudes towards mental health was not identified as being a major barrier, possibly reflecting a positive trend in reduction of stigma around mental health problems in European countries (Angermeyer & Matschinger, 2005; Evans-Lacko, Corker, Williams, Henderson, & Thornicroft, 2014). Although, notably, it still remains a concern for more than a third of surveyed schools.

Although the presence of data from multiple countries is a considerable strength of this study, in many of the included countries (e.g. Germany, United Kingdom) education is devolved and not administered centrally. This might mean that different states within a country have varying levels of mental health focus and provision; something that future investigations with a greater country-level focus might explore. In addition, the differences in education structures and available school details resulted in varying strategies for selecting participating schools across countries and varying sample sizes. It is also important to note that these data reflect school staff's perceptions of priority, sufficient support, quality of links and key barriers. Although staff perceptions are highly relevant as staff are key for any school-based implementation to succeed (Elmore, 2007), combining these data with more objective evaluations of priority (e.g. funding/time spent), sufficient support (what is actually done in schools) and country profiles of school-based mental health resources (e.g. World Health Organization, 2001) would help further understand existing provision and future policy and practice. Additionally, although we attempted to reduce sampling/selection biases by inviting all schools to participate for whom contact details were available, it is likely that schools with an interest in mental health might have been more likely to complete the survey leading to a possible overestimation of the extent of priority, policy, links with agencies and existence of sufficient support and a possible underestimation of the perceived barriers. Lastly, although we used both the terms mental health and wellbeing to ensure we captured information across the whole breadth from promotion to treatment in the wider context of mental health, it is possible the concepts were differently interpreted by participants across countries.

Conclusion

The results of this study suggest that policy creation in relation to mental health and wellbeing in schools is paramount as a lack of national policy is perceived by schools as being a serious barrier to mental health and wellbeing provision. We observe that countries where such policies exist place higher priority on the schools' role in providing support. Lack of funding and limited staff capacity remain the most serious barriers

to schools being able to support students' difficulties and promote their wellbeing. The findings of this study can also inform the allocation of resources to schools as they highlight the barriers to provision that limit schools' abilities to provide support. For instance, reducing the barriers to accessing external agencies and specialists where necessary might be a key area where policy and wider reform might help. The wider reform and policy become additionally relevant as the limits on the capacity of external agencies (The Centre for Economic Performance's Mental Health Policy Group, 2012) would also have to be borne in mind and bolstered to allow them to support schools in supporting their students' mental health difficulties. It is also of relevance that secondary schools were more likely to have a school policy regarding mental health and better links with external agencies. With the increasing focus on and relevance of earlier screening and intervention, fostering these links with primary schools might prove beneficial as well.

In conclusion, this study provides much needed insight into the attitudes and perceptions of schools towards mental health provision for students in schools across Europe, alongside the barriers they face in providing this much needed support. Through cross-national research such as this, it is hoped that the education systems of countries can share experiences and examples of good practice and lessons can be learnt about the policies and support that can facilitate schools' capacity for providing adequate mental health support to their students.

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Supporting information

Additional Supporting Information may be found in the online version of this article:

Appendix S1. Relevant survey questions.

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