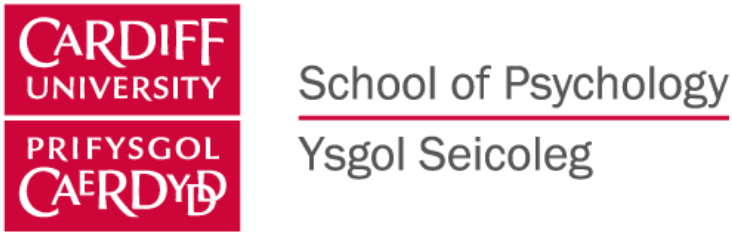

Teacher delivered Mental Health Interventions: A systematic review and a qualitative evaluation of school-based staff's experiences in delivering a brief universal ACT intervention

Thesis submitted in partial fulfilment of the requirement for the degree of:

Doctorate of Clinical Psychology (DClinPsy)

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Contents

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Thesis preface

The aim of this research was to review studies that conducted brief teacher delivered mental health interventions in secondary schools since 2010. This research also explored how school counsellors and teachers experienced the process of receiving training in a brief universal Acceptance and Commitment Therapy (ACT) based programme and delivering this programme to students in the classroom.

The systematic review aimed to understand the current evidence base for brief universal teacher-led interventions that are delivered to a whole class of students irrespective of mental health needs to improve well-being and mental health. Interventions of 10 hours or less were included in this review as this seemed feasible for teachers to deliver in one school term. Seven databases were searched including British Education Index, CINAHL, ERIC, Medline, PsycInfo, Scopus and Web of Science. 2289 papers were screened and 9 studies met the inclusion criteria and were included in the review.

Findings from the review showed that there was variation amongst the interventions delivered by teachers and the quality of the interventions was mixed. Studies varied in their methodology, outcome measures and follow-up time. Several studies did find improvements following their intervention, however the majority of the studies did not find significant improvements. A number of studies did not include detailed descriptions of materials used in programmes, assessments to measure whether the programme was delivered as intended by developers or the exact duration of sessions which impacts future replicability. There is a limited pool of high-quality interventions for teachers to choose from and further research should involve teachers and young people in the development of whole school programmes to ensure the programmes are feasible and engaging.

The empirical paper focuses on a qualitative study designed to explore how school counsellors and teachers experienced the process of receiving training in a brief universal ACT-based programme and delivering this programme to students, as well as evaluating the factors that facilitated the implementation within a school setting. Understanding more about their experiences will help to consider what may have facilitated or inhibited the learning and application of the programme and to shape the delivery of future training and interventions. School counsellors and teachers were interviewed after they had delivered the intervention and again at a 6-month follow-up. Grounded theory was used to analyse the interview data which resulted in a model of engagement being developed, this consisted of eight phases (*pre-existing stance, perceiving the approach to be a good fit, buying into the approach, practicing skills, talking authentically, students engaging, believing in the approach, sharing with others)* that the school counsellors and teachers moved through. These phases contributed towards their engagement in the approach and their students' engagement in the programme.

This review summarises the evidence for brief universal teacher-delivered mental health interventions conducted in secondary schools. This is the first review focusing on teacher delivered whole school interventions of 10 hours or less. There is a lack of clarity about whether brief teacher delivered mental health interventions are effective. Evidence relating to the interventions, facilitation, measures, quality, fidelity and outcomes are reviewed and considerations for future research is presented. The empirical paper describes the first qualitative study to look at the processes underlying the delivery of a universal ACT intervention in a school setting, highlighting a lack of qualitative studies investigating ACT interventions. The model of engagement presented the phases that facilitators move through to support their engagement with ACT and the engagement of the students. The model also emphasised the importance of the role of vulnerability in facilitators and students. Recommendations for future training with school counsellors and teachers are made.

Brief universal teacher delivered mental health interventions in secondary schools: a systematic review

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Abstract

Background

There is a high prevalence of young people with mental health difficulties. A third of those will not gain access to treatment due to staff shortages and high referral rates. School teachers are in an ideal position to deliver mental health interventions. Teachers are under pressure and therefore an evaluation of brief interventions is needed. This systematic review aimed to evaluate universal brief teacher-led mental health interventions within secondary schools since 2010.

Method

British Education Index; ERIC; CINAHL; Medline; PsycInfo; Scopus and Web of Science were searched. Articles were included if they described universal teacher-delivered interventions in secondary schools that aimed to improve mental health or wellbeing, were 10 hours or less in duration and were published between January 2010 and April 2022.

Results

Nine studies met inclusion criteria. Across the reviewed studies, programme focus varied greatly. Studies included randomised and non-randomised trials, pre-post interventions and studies including follow-up varied between 8 weeks and 12 months. Type of control, outcome measures and quality varied across studies. Two interventions found significant improvements for young people in at least one area. Seven studies attempted to improve fidelity, however none of the studies formally assessed intervention fidelity. Studies lacked detail in programme materials and session duration.

Conclusions

Results show that there are limited high-quality interventions for teachers to choose from. More formalised fidelity assessments are required to assess whether interventions are delivered as intended by developers. Future programmes require further detail in programme content and session duration to aid replication.

Keywords

Universal intervention, Whole school; Teacher; Mental Health; Well-being

Introduction

Young people and mental health

Children and adolescents form almost a third of the global population, and it is estimated that approximately 20% of adolescents experience a mental health problem in any given year (Merikangas et al., 2010). General psychological distress in adolescents has increased, from 19% in 2012 to 24% in 2018 (Hall et al., 2019) and the COVID- 19 pandemic is reported as having further increased distress among young people (NHS Digital, 2020). Half of the lifetime mental health problems start by the age of 15 and nearly three quarters by the age of 18 (Kim-Cohen et al., 2003), creating a substantial global socioeconomic burden (Prince et al., 2007). There are effective, evidence-based treatments for adolescents with mental health difficulties (Reynolds et al., 2012), but less than two-thirds of them will access professional help (Sadler et al., 2018).

Despite a high prevalence of mental health difficulties in adolescents, a large proportion of them will not access timely, evidence-based treatment within specialist services (Frith, 2017). The perceived stigma in accessing mental health services (Lawrence et al., 2015) and the shortage of mental health professionals (Rimmer, 2021) make it difficult for many to access the therapeutic support they require. In the past decades there has been a significant increase Child and Adolescent Mental Health Services (CAMHS) referrals (Gyllenberg et al., 2018) but there remain large unmet needs among young people (Lempinen et al., 2019). In 2020 to 2021, 497,502 children were referred to NHS mental health services (Children's Commissioner, 2022) yet approximately a quarter of referrals were not accepted into specialist treatment (Crenna-Jennings & Hutchinson, 2020). For those who do receive treatment, the median waiting time in CAMHS in England is 60 days; twice the government's proposed standard of four weeks (Crenna-Jennings & Hutchinson, 2020). There is a significant treatment gap in CAMHS in England between those that need support and the resources

and provision available with currently only a third of young people with a diagnosable condition accessing treatment.

General Practitioners (GPs) are key in referring young people to specialist services (Young Minds, 2021). However, in a recent survey, 77% of GPs stated that they were not confident that referrals they made to NHS Children and Young People's Mental Health Support (NHS CYPMHS), would result in treatment (Young Minds 2021). In recent years, two-thirds of Local Authorities in England have cut their spending on 'low-level' mental health support, including additional pastoral support in schools (Children's Commissioner for England, 2019). In a study by Lambert et al. (2020), GPs highlighted the need for increased lower-level support for adolescent's mental health and reported feeling 'stuck' when young people were rejected from NHS mental health services and there were no alternative provisions. Only 8% of GPs felt there was good community support for young people with mental health problems in their local area (Young Minds 2021).

Left untreated, mood disorders and stress in adolescence can have a significant and detrimental effect on well-being, functioning and development (McGorry et al., 2014) and can lead to higher levels of drug abuse, self-harm and suicidal behaviour (Laye-Gindhu & Schonert-Reichl, 2005; Pompili, 2014), which often persist into adulthood (Ford et al., 2007). The failure to address young people's mental health difficulties has lifelong consequences (World Health Organisation (WHO), 2004), it is therefore important that early intervention and prevention strategies are developed for this population.

School-based mental health programmes

Educational settings have been identified as the ideal environment to deliver preventative mental health programmes as many schools often already referral pathways and ways to support student mental health (Rickwood et al., 2007). Emotional wellbeing is now required to be part of the

core school curriculums across the UK and in Wales, this was made mandatory from 2022 (Welsh Government, 2021). It has been emphasised that schools should be implementing evidence-based interventions (Public Health England, 2015).

Schools are increasingly taking a proactive and preventative approach to addressing student wellbeing and the evidence base for school-based programmes that aim to promote well-being and prevent mental health problems in adulthood is growing (Cuijpers et al., 2008; Mackenzie & Williams, 2018). Universal interventions can minimise potential inequalities in accessing the intervention and reduce the stigma and social comparison that can present when interventions are targeted at particular students (O'Connor et al., 2018).

Previous reviews

Social and Emotional Learning (SEL) Programmes

The efficacy of school-based mental health interventions has been evaluated in a number of systematic reviews and meta-analyses. Previous reviews have focused on a number of areas including anxiety and depression (Werner-Seidler et al., 2021), mindfulness (McKeering & Hwang, 2019) and social and emotional learning (SEL) programmes (Durlak et al., 2011). SEL programmes have been most widely researched and have been undertaken in schools across the UK, USA, Australia and Europe (Elias et al.,1997) and have been found to support positive mental health and raise academic attainment (Public Health England, 2015). SEL programmes teach young people to develop self-awareness, self-control, and interpersonal skills. Durlak et al. (2011) and Sklad et al. (2012) conducted meta-analyses on school-based universal SEL programmes. Both meta-analyses found participants of SEL interventions showed enhanced social and emotional competencies. O'Connor et al. (2018) conducted a review of universal mental health programmes to add to this

literature. They found most studies reported that school based mental health programmes had some positive effect on students; however, they noted two SEL studies that had no effect (Jones et al., 2010; Wigelsworth et al., 2013).

Anxiety and depression programmes

Werner-Seidler et al., (2021) conducted a meta-analysis evaluating the effectiveness of school-based depression and anxiety prevention programmes and identified 118 RCTs. Results indicated a small effect size in reducing symptoms of depression and anxiety compared to a control. They found that targeted prevention programmes (for young people with risk factors or symptoms) were associated with significantly greater effect sizes relative to universal programmes for depression. At follow-up, effect sizes were larger for externally delivered programmes compared to programmes delivered by school staff for both depression and anxiety, indicating that it may be beneficial to have external facilitators delivering school depression and anxiety programmes.

Mindfulness based interventions in schools

There is growing evidence for mindfulness-based school approaches (Kuyken et al., 2013). Several programmes have been developed, including the .b Mindfulness in Schools Project (Burnett, 2013 implemented in the UK), The Still Quiet Place (Saltzman 2014; implemented in the USA), and Mindfulness Matters (Snel 2013, 2015; implemented in the Netherlands). Mindfulness based interventions are appropriate for young people who are experiencing mental health difficulties, are within a normal range of mental health or are thriving. Therefore, a wide range of young people can potentially benefit (Huppert, 2009). Preliminary evidence supports their benefit for the well-being of students (Weare, 2013). Several reviews have been conducted on mindfulness-based interventions within schools (Zenner et al., 2014; Felver et al., 2016; Carsley et al., 2017; McKeering & Hwang, 2018).

Carsley et al. (2017) found that when trained teachers delivered the programme, there were stronger effects at follow-up compared to delivery by an external facilitator. As teachers remain with their students once the studies have finished, it is likely that they may continue using part of the interventions within class. McKeering and Hwang, (2018) found that mindfulness-based interventions decrease negative affect and anxiety. Their review suggested that a mindfulness-based programme is a suitable well-being preventative programme for adolescents.

Brief interventions

Mental health interventions facilitated by mental health professionals can be costly. School based programmes can also require a high degree of time and commitment from school administrators and teachers to implement, such as reorganising the curriculum and timetables, attending training sessions and preparing for the sessions, which may result in increased stress for teachers (Shankland & Rosset, 2017).

Haugland et al. (2020) examined the effectiveness of brief (5.5 hours) school-based CBT versus standard duration (15 hours) for adolescents. Results showed that both CBT interventions reduced anxiety, impairment and depressive symptoms. Although findings suggested lower satisfaction with brief CBT and a large number were lost to follow up after one year. Haugland et al, (2020) felt that increasing the brief intervention to 8-10 hours may be beneficial and would still have advantages over the 15-hour programme, namely lower costs and reduced school absence.

Brief universal ACT school-based interventions (van der Gucht et al., 2017; Takahashi et al., 2020) have found mixed results. Takahashi et al. (2020) described a 5-hour intervention delivered by psychologists and findings showed a decreased in avoidance and hyperactivity/inattention. While

Van der Gucht et al. (2017) described an 8-hour intervention delivered by teachers and found no significant improvement in quality of life, emotional problems, behavioural problems and psychological inflexibility. The researchers felt the limited contact hours and the teacher facilitation may have impacted the intervention efficacy.

Teachers as facilitators of school-based interventions

Many classroom-based programmes have been created to be delivered by teachers rather than mental health professionals (Dray et al., 2017), with 41% of school-based mental health interventions involving teachers during delivery and up to 18% of interventions delivered solely by teachers (Franklin et al., 2012). Teachers may be well placed to deliver mental health interventions in schools; they have knowledge of how to manage behaviour and how to maintain students' attention (Leflot et al., 2010). They have pre-existing relationships with students and have continued contact with them, which increases the opportunities for ongoing dissemination of mental health-related content once an intervention has concluded.

There has been an increased acceptance from teachers that schools are not solely a place of academic achievement, but also a place where student wellbeing is important (Beames et al., 2020). This has been further emphasised since the Covid-19 pandemic where schools have needed to address increased rates of student distress, which has raised important questions about how schools can best support their students' mental health (Singh et al., 2020; Thakur, 2020). Shelemy et al. (2019) found teachers felt helpless as a result of their perceived inability to help students, and reported wanting more specialist mental health training to support young people.

However, while teachers seem best placed to deliver these interventions, they are not required to learn about mental health disorders during their initial training (Sibieta, 2021) and generally have limited access to support and supervision from mental health professionals (Sharpe et al., 2016). Research shows that teachers have high workloads which has a negative impact

on their mental health (Hutchings, 2015; Lowry et al., 2022b) and this may limit how well they are able to deliver a mental health intervention. Young people are presenting with increasingly high levels of school-related anxiety and stress. This is due to increased academic demands, exam pressure and having more awareness of their own sense of failure (Hutchings, 2015). Therefore, it is also important to consider how teachers and the school environment can potentially also perpetuate and contribute to poor mental health. It could be argued that teachers are better placed to play a role in part of a wider system, where they are a point of contact for students and liaise with other professionals, signpost and refer students to mental health services as opposed to delivering interventions.

Werner-Seidler et al. (2021) conducted analysis to explore if the facilitator (teacher vs external professional) impacted effect size as part of their review. At short term follow-up, a statistical difference was found, with externally delivered programmes demonstrating a larger effect size, however this difference was no longer evident at medium and long-term follow-up. These results were found for both depression and anxiety school-based programmes.

Shelemy et al. (2020) conducted a review of targeted and universal teacher-led interventions for internalising disorders in adolescents. Interventions ranged from 45 minutes to 54 hours. They concluded that there was mixed evidence to suggest that teacher-led mental health interventions are effective. This review only included studies where symptoms of DSM-V disorders had been measured, thus excluding many studies measuring other aspects of wellbeing, such as emotional wellbeing, resilience and quality of life. These outcomes are important to measure in universal interventions as many adolescents will not reach the clinical cut off for a DSM-V disorder. Many of the interventions included were supported by teachers and not solely delivered by them; it is therefore difficult to ascertain the effectiveness of interventions delivered by just teachers alone.

Teachers are faced with a high prevalence of mental health problems in their students. A recent report found education services were contacted for mental health support at approximately double the rate of health services (NHS digital, 2021). Teachers are more likely than other professionals to be contacted for support for adolescents with pre-diagnosable conditions (estimated at 1.2 million in England) (NHS digital, 2017). These young people would benefit from support, but would not be able to access an NHS service as they do not reach diagnostic threshold (Children's Commissioner for England, 2019). Research by the Centre for Economic Performance (CEP) found that teachers have a bigger influence on students' mental health than their influence on academic scores (Fleche, 2017).

Including mental health in the school curriculum has become a mandatory requirement (Department of Health and Department of Education, 2018). Relying on external mental health professionals to deliver mental health programmes in schools can be expensive and difficult to sustain (Beames et al., 2020).

Teachers can play a crucial role in supporting students with their mental health, however they are already under pressure. Teachers have been found to report higher levels of stress and mental health difficulties when compared to people in other professions (Lowry et al., 2022a). A survey of 3000 UK education staff found that 77% experienced poor mental health due to their work and 54% had considered leaving the profession, with excessive workload and imbalance between work and home life named as the biggest contributory factors (Education Support, 2021). Teachers are key in providing mental health support, but they are under significant strain (Lowry et al., 2022b) and so it would seem brief interventions may be the most viable. Such interventions are also more likely to be feasible to schedule within timetables. A review of the evidence for universal, brief interventions delivered by teachers is therefore required.

Aims of the current review

This systematic review aims to analyse and synthesise published studies of brief universal teacher-led mental health interventions in schools that are delivered to adolescence 11-18 years old. It will examine:

- The format, focus and approach of brief teacher-led interventions
- The quality of these studies
- The effectiveness of these interventions in improving students' mental health and wellbeing

Method

Protocol and registration

The systematic review followed the Preferred Reporting Items for Systematic review and Meta-Analysis Protocols (PRISMA-P) guidelines. The protocol for this review was registered in the international prospective register of systematic reviews (PROSPERO; registration number CRD42022317857). The review set out to report the efficacy of brief teacher-delivered mental health interventions including the study characteristics, design, methodology, quality and challenges of implementation.

Search Strategy

The search terms used (see Appendix B) were formed of four main terms. These terms referred to the context (school setting), target area (mental health), intervention (type of programme) and intervention facilitator (teacher). The search terms and databases to be searched were discussed with a university subject librarian. Limits were placed on the year of publication (2010-2021) and to searching titles and abstracts.

Search terms were used to search databases that contained articles with these terms in the abstract or title. Seven electronic databases were chosen based on the review topic (British Education Index; ERIC; CINAHL; Medline; PsycInfo; Scopus and Web of Science). Reference lists of identified studies and systematic reviews on teacher-delivered mental health interventions were screened.

Screening Criteria

Inclusion and exclusion criteria (see Table 1) were used to screen papers.

Table 1

Inclusion and Exclusion Criteria.

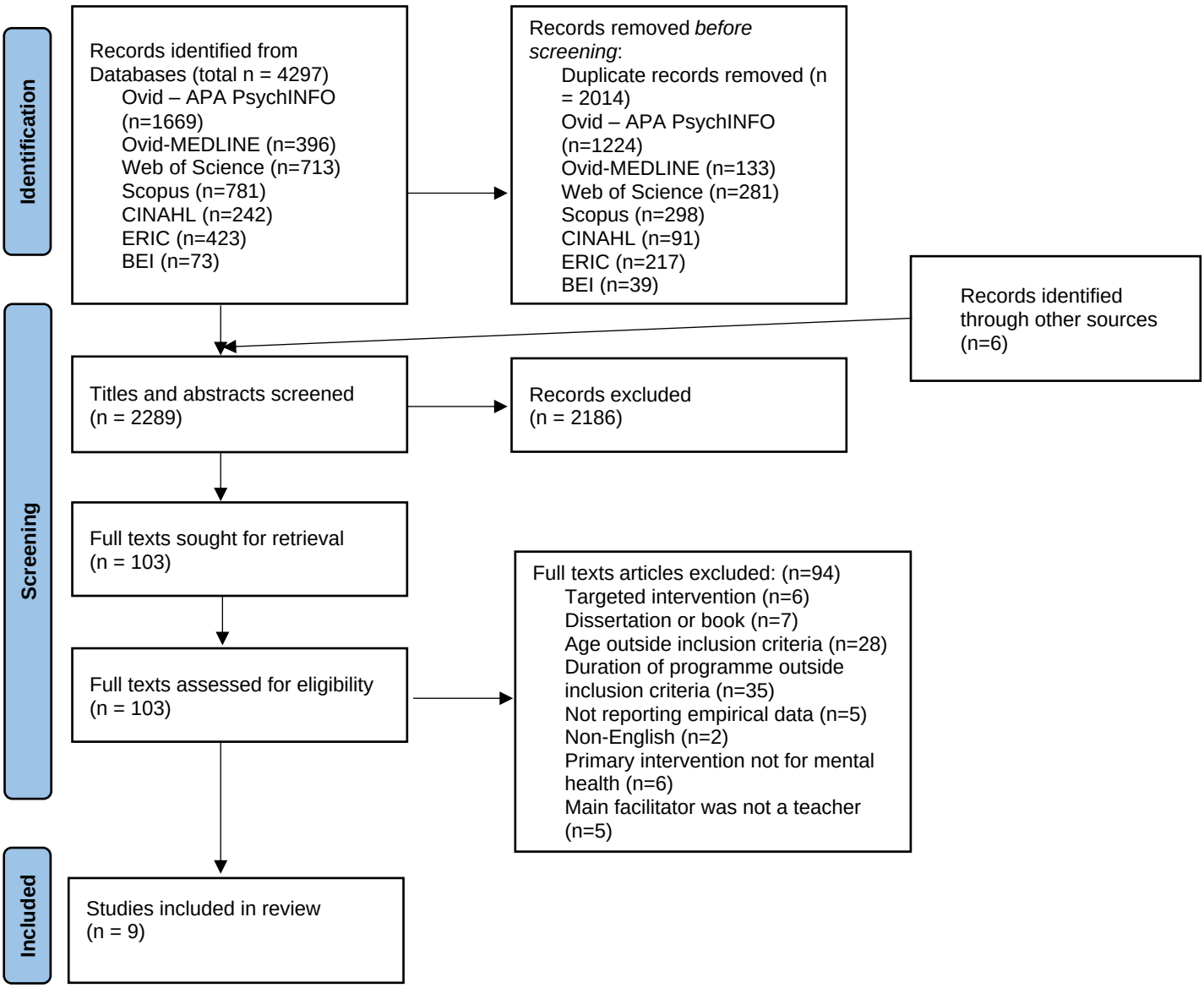
Inclusion criteria	Exclusion criteria
Interventions carried out directly with young people	Intervention primarily aimed at physical health, substance or alcohol use, health conditions or behaviour difficulties
Interventions carried out in secondary schools during the school day	Interventions lasting more than 10 hours
Interventions carried out in a group format (i.e. a whole class)	Interventions carried out in special education
Interventions lasting 10 hours or less	Interventions carried out within an organisational context (i.e. with teachers and not young people)
Content of the intervention aimed to improve mental/emotional health	Interventions targeted to vulnerable or at-risk young people or had specific mental health difficulties (i.e. young people with PTSD from war torn countries)
Intervention was delivered to young people in secondary school aged 11-18 years	Studies reported qualitative data only
School teachers were explicitly described as the sole facilitators of the intervention	Interventions that did not aim to improve mental health or wellbeing
Reporting quantitative data	
Peer-reviewed article	
Intervention was part of a randomised or non-randomised controlled trial	
Published in the English language	
Published from 2010 - 2023	

All studies returned using the search terms were exported to an EndNote database. Duplicates were removed. Titles and abstracts were screened against the inclusion criteria and 102 full texts were attained and scored against the inclusion criteria. Twenty papers were randomly selected and were looked at by the second reviewer, with a substantial level of agreement (k=0.7), these papers were then discussed until there was full agreement. Four papers described programmes of 12 sessions or under but provided insufficient information regarding the session duration and therefore these authors were contacted via email for further information. Three of the

four authors responded with information and one of these papers met inclusion criteria. Nine papers met the inclusion criteria. The screening procedure and number of articles screened and accepted at each stage can be seen in Figure 1.

Figure 1

PRISMA Flow Diagram of Study Selection Process, PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses (Page et al., 2021).



Extraction of Data

Information was extracted from the included studies.

1. Study characteristics (design, method of allocation and randomisation, control group type)
2. Population (sample size, age range)
3. Intervention (intervention aim, intervention type, number of sessions, duration of sessions, method of delivery, facilitator characteristics, facilitator training)
4. Outcome measures (primary measures, reliability, self- and/or third-party reports, data collection points and follow-up)

Assessment of Quality

The Quality Assessment Tool for Quantitative Studies developed by the Effective Public Health Practice Project (EBHPP, 1988) was used to assess the quality of the included studies. This tool is used to provide evidence to support public health interventions and allows the reviewer to provide an overall methodological rating, based on eight component ratings. This standardised tool assesses (1) selection bias, (2) study design, (3) confounders, (4) blinding, (5) data collection methods, (6) withdrawals and dropouts, (7) intervention integrity and (8) analyses. Total scores were collated, with 1 indicating the highest quality level, and 3 being the lowest. An independent reviewer evaluated all of the included papers (n=9) using the tool with 100% agreement.

Results

Study characteristics

Nine studies were included in this review, including a total of 4291 participants. (*n* = 2508 in the prevention intervention conditions, and *n* = 1783 in the control conditions). The sample size in each study varied from 56 (Midford et al., 2017) to 976 participants (Wong et al., 2014). All included interventions were universal and were delivered to whole classes. The location with the highest number of studies was Australia (n=5). The remaining studies were conducted in Japan, the USA, the UK and Spain. Further details about the factors relating to the content and delivery of the interventions can be found in Table 1.

Table 2

Characteristics of interventions studies.

Author	Location	Number of participants	Study Design	Intervention	Delivery	Facilitator training and supervision	Measures	Study Outcome
Britton et al. (2014)	US	N= 100 Intervention= 52 Control= 48	Randomised control trial Control: African history course with matched experiential activity	Asian history course with daily mindfulness meditation practice led by the teachers. Teachers taught breath awareness, breath counting, labelling body sensation, thought and emotions and body sweeps. Students recorded daily meditation practice journals. Teachers followed identical practice instruction transcripts, this was verified by weekly emails and student journals.	The course lasted 6 weeks. Meditation periods initially lasted 3 minutes and over the 6 weeks, built up to 12 minutes.	One teacher completed Roth's Integrative Contemplative Pedagogy (ICP) training and had 5 years daily meditation experience. The other teacher had no previous experience in meditation but they had completed an 8-week mindfulness-based stress reduction course provided by the research team.	Anxiety: YSR Affect: STAI-C Mindfulness: CAMS-R Pre- and post 6-week intervention period.	Post-intervention comparison across intervention and control, mean (SD) Improvements for: Total affect disturbance 355.7 (231.4) vs 403.3 (292.9) Positive affect 551.7 (123.1) vs 528.1 (139.6) Internalising problems 10.4 (6.6) vs 10.6 (10.1) Externalising problems 6.9 (5.2) vs 7.0 (5.6) Attention problems 3.8 (2.6) vs 3.5 (2.8) Mindfulness 33.0 (6.1) vs 32.6 (5.5) Intervention group were significantly less likely to develop suicidal ideation or thoughts of self-harm than controls.

Author	Location	Number of participants	Study Design	Intervention	Delivery	Facilitator training and supervision	Measures	Study Outcome
Calear et al. (2016)	Australia	N= 1767 Intervention= 989 Control= 778	A three-arm cluster stratified randomised controlled trial Two intervention conditions. Control: waitlist	The e-couch Anxiety and Worry program consisted of psychoeducation and toolkits for anxiety. The three toolkits cover CBT, relaxation and physical activity. Sessions include practice and homework exercises.	Two manualised interventions: 1. e-GAD HS – facilitated by teachers with assistance and support from a headspace education officer. 2. e-GAD school – facilitated by teachers. The programmes were delivered in classes lasting 30–40 minutes per week for six weeks.	Teachers used the Y-Worri trial manual, for information on how to deliver the study questionnaires and how to support students in the completion of the e-couch Anxiety and Worry program.	Anxiety: SCAS-GAD; GAD-7 Social anxiety: SAS-A Anxiety sensitivity: CASI Depression: CES-D Mental wellbeing: WEMWBS. Pre- and post-intervention, 6- and 12-month follow up.	Post intervention comparison across conditions (e-GAD school, e-GAD HS, control); mean (SD) General anxiety 5.44 (0.47) vs 4.62 (0.33) vs 5.22 (0.36) Children's anxiety 5.44 (0.42) vs 4.98 (0.31) vs 5.36 (0.33) Social anxiety 35.70 (1.73) vs 34.90 (1.24) vs 35.74 (1.32) Anxiety sensitivity 28.28 (0.81) vs 27.51 (0.57) vs 27.78 (0.60) Depression 17.77 (1.03) vs 16.54 (0.71) vs 17.44 (0.76) Wellbeing 45.90 (0.93) vs 47.21 (0.61) vs 47.90 (0.60) At 6-month and 12-month follow-up no significant difference between groups across measures.

Author	Location	Number of participants	Study Design	Intervention	Delivery	Facilitator training and supervision	Measures	Study Outcome
Halliday et al. (2020)	Australia	N= 116 Intervention= 69 Control=	Non-randomised control trial Control: waitlist	The Positive Education Pilot Program (PEPP) was based on positive psychology which aimed to increased wellbeing and reduced depression symptoms. The first two and the last two sessions focused on positive activities which aimed to increase positive affect, gratitude, meaning and optimism. The middle five sessions used Mood GYM an online depression and anxiety prevention programme.	The programme was delivered in pastoral care time once a week for 9 weeks.	Pastoral care teachers attended three face to face training sessions which lasted two hours each. Training included reviewing programme materials, activities and videos, discussions around mental health and suicide, an opportunity to try activities and collaborate on lesson plans with other teachers.	Wellbeing: EPOCH Resilience: CD-RISC Depression, Anxiety and Stress: DASS-21 Pre- and post-intervention and 9 week follow up	Intervention vs Control posttreatment comparison, mean (SD) Improvements for: Engagement 3.15 (0.90) vs 3.02 (0.91) Perseverance 3.19 (0.84) vs 3.29 (0.84) Optimism* 3.19 (0.84) vs 3.47 (0.88) Connectedness 3.85 (0.88) vs 3.88 (0.98) Happiness 3.56 (0.94) vs 3.65 (0.89) Resilience 23.81 (7.20) vs 26.03 (7.30) Depression 4.84 (4.12) vs 5.71 (4.93) Anxiety 5.10 (4.03) vs 5.97 (4.75) Stress 6.46 (4.04) vs 6.47 (4.58) Depression and anxiety increased in control at t2 and decreased at t3 back to baseline levels following the PEPP intervention.

Author	Location	Number of participants	Study Design	Intervention	Delivery	Facilitator training and supervision	Measures	Study Outcome
Huppert and Johnson (2010)	UK	N= 134 Intervention= 78 Control= 56	Randomised control trial Control: Religious Studies lessons as usual	Mindfulness based intervention based on a programme developed by Kabat-Zinn and colleagues. The classes focused on presenting the principles of mindfulness and practicing mindfulness meditation. Classes covered the concepts of awareness and acceptance. The mindfulness practices included bodily awareness of contact points, breathing, finding an anchor point, awareness of sounds, understanding the transient nature of thoughts and walking meditation. Some classes involved video clips to highlight concepts. Students in the mindfulness condition were also provided with a mindfulness CD containing exercises to be practiced daily.	The training was comprised of four 40-minute classes, one per week. These classes were delivered by Religious Studies Teachers who were trained in Mindfulness and had an interested in training students in Mindfulness.	These classes were delivered by Religious Studies Teachers who were trained in Mindfulness and had an interested in training students in Mindfulness. No further details provided regarding the Mindfulness Training they had.	Mindfulness: CAMS-R Resilience: ERS Wellbeing: WEMWBS Additional measures Baseline and one-week post-intervention.	Intervention vs Control comparison. No significant difference between groups. When mindfulness home practice was implemented Improvements were found in wellbeing and mindfulness*[a]

Author	Location	Number of participants	Study Design	Intervention	Delivery	Facilitator training and supervision	Measures	Study Outcome
Lombas et al. (2019)	Spain	N=524 Intervention= 156 Control= 368	Quasi-experimental design with pre-test and post-test measures. Control: Lessons as usual.	Brief version of the Happy Classrooms Programme (HCP) which focused on mindfulness and character strength activities. The mindfulness practices included meditation, breathing exercises, mindful walking, body scan and mindful eating. The character strengths practices included activities aimed to develop an appreciation of beauty, gratitude, hope, humour and spirituality.	Teachers implemented the programme twice a week for 18 weeks. The estimated total time was 3 hours.	Teachers were trained by the authors of the programme during four sessions for a total of 16 hours.	Mindfulness: MAAS Self-Esteem: RSE Satisfaction with Life: SWLS Depression: CES-D scale Perceived Stress: PSS4 Additional measures included: Psychological needs, emotional intelligence, school aggression, classroom environment, academic motivation and empathy Teacher and student acceptability and teacher implementation fidelity were also measured. Pre- and post-intervention.	Pre-, post-intervention comparison; mean (SD) Non-significant improvements only when pre-treatment levels of mindfulness were medium/high for: Mindfulness 5.6 (.59) vs 4.7 (.97) Depressive symptomology 3.2 (1.5) vs 3.2 (1.13) Perceived stress 3.1 (1.27) vs 3.3 (1.7) No improvements irrespective of pre-treatment levels of mindfulness: Satisfaction with life 5.0 (1.30) vs 4.9 (1.19) Self-esteem 5.4 (.96) vs 5.3 (1.05)

Author	Location	Number of participants	Study Design	Intervention	Delivery	Facilitator training and supervision	Measures	Study Outcome
Midford et al. (2016)	Australia	N= 56	small-scale pre–post pilot study Control: none	The social and emotional education programme taught emotional literacy, personal strengths, coping, problem-solving strategies, stress management, emotional regulation and support seeking	The 10-lesson programme was delivered in 30 minutes to fit in the half-hour period available as part of the school's pastoral care time.	Teachers were trained to deliver the programme, with participatory modelling of each activity.	Psychological distress: K10 Resilience: RYDM Baseline and post-intervention.	Pre-, post-intervention comparison; mean (SD) Improvement for: Psychological distress 25.07 (9.70) vs 23.09 (8.69) No changes were found in resilience, school protective factors or social and emotional skills. No improvement for: Resilience, Social and emotional skills, School Protective factors. Additional measures looking at cooperation, class connectedness and communication improved significantly.

Author	Location	Number of participants	Study Design	Intervention	Delivery	Facilitator training and supervision	Measures	Study Outcome
Ohira et al. (2019)	Japan	N= 238 Intervention= 149 Control= 89	Non-randomised control trial Control: Lessons as usual.	The 'Journey of the Brave' programme was based on CBT and provided students with ways to cope with anxiety in interpersonal relationships. The programme was taught with a student workbook and a teacher's manual. The programme involved psychoeducation, establishing goals, relaxation skills, developing an 'anxiety hierarchy', learning about the cognitive model, cognitive restructuring and assertion skills. Gradual exposure homework was given.	The programme consisted of seven 50-minute sessions delivered once a week.	Teachers attended a 6-h training course. The course included the theory of CBT, role-plays for each session (lasting about 20 minutes per session) and feedback from instructors. The teacher's manual included a Q & A and information on how to proceed with the class, which was created based on questions by teachers in past programmes.	Anxiety: SCAS Emotion-regulation: ERSQ Pre- and post-intervention and 2-3 month follow up.	Pre-, post-intervention comparison across conditions (intervention, control); mean (SD) Anxiety TAU 17.40 (14.39 – 20.42) vs 17.21 (14.20 – 20.21) Intervention 21.24 (18.88 – 23.60) vs 19.21 (16.85 – 21.56) Emotion regulation TAU 60.95 (55.34 – 66.55) vs 60.79 (55.17 – 66.40) Intervention 57.28 (52.89 – 61.68) vs 59.27 (54.85 – 63.68) Non-significant decrease in anxiety score at the 2 to 3-month follow-up for the intervention group compared to the control.

Author	Location	Number of participants	Study Design	Intervention	Delivery	Facilitator training and supervision	Measures	Study Outcome
Perry et al. (2014)	Australia	N= 380 Intervention= 207 Control= 173	Cluster randomised controlled trial Control: usual PDHPE* classes	The HeadStrong programme contained 5 modules: 1) An introduction to Mood and Mental Wellbeing 2) Information about mood disorders 3) Exploring how to seek help 4)How to boost low mood 5) Information about mental health myths	The HeadStrong programme was delivered over a period of 5–8 weeks and was approximately 10 hours of class time in total.	The HeadStrong training program for teachers was an interactive one-day workshop conducted by study researchers. The workshop involved learning ways to support students in need and increasing awareness of mental health resources available to assist teachers.	Psychological distress: DASS21 Suicidal ideation: MFQ Additional measures included: Depression literacy, Depression stigma, attitudes towards help seeking mental health services. Pre- and post-intervention and 6-month follow up.	Pre-, post-intervention, 6-month follow-up comparison across intervention and control; mean (SD) Improvement for: Psychological distress Pretreatment 24.90 (20.77) vs 22.08 (20.38) Posttreatment 23.09 (20.07) vs 20.80 (20.97) At 6 months 21.70 (18.88) vs 23.31 (21.29) Mood Pretreatment 1.36 (2.36) vs 1.04 (1.98) Posttreatment 1.35 (2.63) vs .96 (2.03) At 6 months .99 (2.29) vs 1.24 (2.44) Significant improvements on additional measures looking at mental health literacy and stigma.

Author	Location	Number of participants	Study Design	Intervention	Delivery	Facilitator training and supervision	Measures	Study Outcome
Wong et al. (2014)	Australia	N= 976 Intervention= 752 Control= 224	Cluster randomised controlled trial Two interventions conditions. Control: Health class as usual	The Thiswayup Schools: Overcoming Anxiety and Combating Depression. A universal school-based internet delivered course, based on CBT principles. Each lesson aimed to teach students to identify and manage symptoms of depression or anxiety. Lessons included learning skills, psycho-education, managing thoughts, emotions and behaviours. Students completed an online self-directed lesson in the first part of the lesson where they followed a cartoon teenager with anxiety or depression solving real life problems. In the second part of the lesson, teachers facilitated a discussion around information from the online lesson.	Two manualised interventions: 1. Anxiety course delivered weekly for 6 weeks 2. Depression course delivered weekly for 7 weeks Classes lasted 40 minutes; 15 to 20-minute self-directed online lesson, followed by a class discussion for the remaining part of the lesson.	Teachers received no training, apart from the manual.	Anxiety: GAD-7 Depression: PHQ-5 Psychological distress: K6 Baseline and end of intervention	Pre-, post-intervention comparison across conditions (control, anxiety intervention, depression intervention); mean (SD) Improvement for: Depression TAU 2.55 (2.96) vs 2.67 (2.47) Anxiety course 2.98 (2.97) vs 2.55 (2.41) Depression course 3.08 (2.96) vs 2.32 (2.42)** Anxiety TAU 4.15 (4.58) vs 4.41 (3.22) Anxiety course 4.67 (4.57) vs 3.83 (3.17)* Depression course 4.81 (4.58) vs 3.47 (3.19)** Distress TAU 18.56 (5.34) vs 17.24 (5.80)* Anxiety course 18.43 (5.34) vs 18.38 (5.73) Depression course 18.23 (5.34) vs 18.00 (5.74)

Note. *Statistically significant at p<0.05
**Statistically significant at p<0.01
[a] means and/or standard deviations not reported.
[b] PDHPE = Personal Development, Health and Physical Education

CAMS-R, Cognitive and Affective Mindfulness Scale Revised; CES-D scale, Scale of Depressive Symptomology; CD-RISC 10, Connor-Davidson Resilience Scale; DASS21, Depression, Anxiety and Stress Scale; EPOCH, Measure of Adolescent Well-being; ERSQ, Emotion-Regulation Skills Questionnaire; ESNPE, Psychological Needs Satisfaction Scale in Education; ERS, Ego-Resiliency Scale; GAD-7, Generalised Anxiety Disorder seven item scale; K6, Kessler psychological distress scale (shortened version); K10, Kessler psychological distress scale; MAAS, Mindfulness Attention Awareness Scale; MFQ, Mood and Feelings Questionnaire; PHQ-5, Patient Health Questionnaire; PANAS-C, Positive and Negative Affect Schedule for Children; PSS4, Perceived Stress Scale; RSE, Rosenberg Self-Esteem Scale; RYDM, Resilience and Youth Development Module; SCAS, Spence Children's Anxiety Scale; STAI-C, Spielberger Stare-Trait Anxiety Inventory-Child version; SWLS, Satisfaction with Life Scale; TIPI, Ten-Item Personality Inventory; WEMWBS, Warwick Edinburgh Mental Well Being Scale; YSR, Youth Self Report

Quality Assessment Tool

The quality of studies was rated with the EPHPP Quality Assessment Tool for Quantitative Studies, as shown in Table 2. Four studies were rated as strong, three studies were rated as moderate and two studies were rated as weak. The quality of the study design, data collection and analysis for all interventions are referred to throughout the results section. Areas consistently weakest across interventions were confounders and dropouts/withdrawals. Due to the area of research, blinding of students and teachers delivering the interventions was not possible in some cases, and a number of studies did not appear to report blinding of researchers.

Table 3

Quality Assessment Scores for the Intervention Studies using the Quality Assessment Tool for Quantitative Studies.

Quality Assessment Tool for Quantitative Studies category	Calear et al. (2016)	Wong et al. (2014)	Huppert and Johnson (2010)	Lombas et al. (2019)	Perry et al. (2014)	Britton et al. (2014)	Halliday et al. (2020)	Midford et al. (2017)	Ohira et al. (2019)
Selection Bias	1	1	3	1	2	2	1	2	1
Study Design	1	1	1	1	1	1	1	2	1
Confounders	3	3	1	2	1	1	1	1	2
Blinding	2	2	2	2	2	2	2	2	2
Data Collection Method	1	1	1	1	1	1	1	1	1
Withdrawals and Dropouts	3	3	2	3	3	2	2	1	1
Final rating of both reviewers	**WEAK**	**WEAK**	**MODERATE**	**MODERATE**	**MODERATE**	**STRONG**	**STRONG**	**STRONG**	**STRONG**

Quality Rating 1 indicates highest quality level, 3 indicates lowest quality level.

Risk of bias

There was evidence of selection bias in a number of studies. One study reported that participants were not randomised at class level as the school preferred to have all students in the same year to receive or not receive the intervention and therefore, they self-selected which school year received the programme (Ohira et al., 2019). A number of interventions were delivered by teachers who had agreed to attend training (Lombas et al., 2016) and therefore those that did not volunteer were by default made the control group. Two of the studies conducting mindfulness were delivered by teachers who were already trained in mindfulness (Huppert & Johnson, 2010; Britton et al., 2014) and Huppert and Johnson (2010) reported teachers were enthusiastic about delivering mindfulness to students and so there may be a self-selecting bias which could limit the generalisability of the results.

Study design

Of the nine interventions, five were randomised controlled trials (Britton et al., 2014; Calear et al., 2016; Huppert & Johnson, 2010; Perry et al., 2014; Wong et al., 2014) and four were non-randomised (Lombas et al., 2019; Midford et al., 2016; Ohira et al., 2019; Halliday et al., 2020). The majority (n=8) of included studies involved no intervention control groups, which were compared to the intervention. No-intervention control groups were also referred to as lesson as usual (n=4) and involved lessons provided as part of the curriculum. Two studies specified that control groups had their health class as usual. Perry et al. (2014) asked teachers to refrain from delivering the intervention or content relating to mental health during the health class. Britton et al. 2014 used an active control group where the same teacher delivered the intervention and a curriculum course which, similar to the intervention included an experiential activity. Two studies used a waitlist

control (Calear et al., 2016; Halliday et al., 2020) and one study (Midford et al., 2016) did not have a control.

Three studies conducted power calculations as part of their methodology to determine the number of participants that were required to detect an effect (Calear et al., 2016; Ohira et al., 2019; Perry et al., 2014). Ohira et al. (2019) conducted a power calculation which revealed 200 participants were required for the control and the intervention group each. There was significantly less participants in each group and therefore the number of participants in this intervention may have been insufficient. Wong et al. (2014) and Britton et al. (2014) both reported that their studies may have had insufficient statistical power, however it was unclear whether they had conducted power calculations.

Six studies were rated on the quality tool as selecting participants likely to be representative of the target population. Three studies (Perry et al., 2014; Huppert & Johnson, 2010; Britton et al., 2014) were scored down on this item as their participants attended independent schools. Participants in the Huppert and Johnson, (2010) study were all male and attended an all-boys school. Participants in the Britton et al. (2014) study were from a Quaker school, which may have impacted the generalisability of outcomes as the researchers emphasised that students attending Quaker schools may be used to contemplative practices such as mindfulness due to frequent silent meetings at Quaker schools. The school involved in the Halliday et al. (2020) study had been using a positive psychology approach as part of their school ethos prior to the implementation of the programme and so this may limit conclusions about the generalisability of the intervention studied.

Effectiveness of Interventions

Three studies reported that a universal prevention programme had improved one or more mental health or wellbeing measure**.** Lombas et al. (2019) reported on a mindfulness and character

strength programme which improved mindfulness, symptoms of depression and perceived distress, but only when levels of mindfulness were medium/high before treatment as measured by The Mindful Attention Awareness Scale (MAAS). Therefore, the authors concluded that effect of the intervention on symptoms of depression and perceived stress may be dependent on a pre intervention ability to be mindfulness. This study was rated as moderate in quality due to withdrawals and dropouts not being recorded. Huppert and Johnson (2010) described a mindfulness programme which found no significant differences between the intervention and control groups, however they found significant positive associations between mindfulness home practice and improvement in well-being and mindfulness. This paper was rated as moderate in quality, as participants were not randomly allocated to the mindfulness intervention and were possibly not representative of the general population.

Wong et al. (2014) reported on anxiety and depression prevention programmes; significant improvements were found for anxiety and depression for those in depression programme and significant improvements in anxiety were reported for those in anxiety programme. No significant differences found in psychological distress in either intervention group. However, this study scored an overall weak rating on the quality tool as analysis was limited due to study attrition and data corruption and post-intervention data was only available for less than a third of the participants. Britton et al. (2014) reported on a daily mindfulness programme and found the intervention and control groups both significantly decreased anxiety. They found a greater decrease in total affect disturbance and an increase in positive affect in the intervention group compared to the control, however the differences between the groups were not statistically significant. They noted students only completed journals of mindfulness practice in the intervention group and potential benefits of the intervention could have been due to journaling. It is important to note that it is difficult to find significance in mental health measures within the context of a universal intervention as the sample is nonclinical and scores will vary in the “normal” healthy range (Lowry-Webster et al., 2001). Britton

et al. (2014) scored well on overall quality and was rated as a strong paper due to a robust research design, active control group and few dropouts, however the authors acknowledged the results from this study were not generalisable due to all participants being from a Quaker school. Over half of the studies (Calear et al., 2016, Midford et al., 2016, Ohira et al., 2019; Perry et al., 2014; Hubbert & Johnson, 2010; Halliday et al., 2020) did not find significant differences between intervention and control groups in the primary outcome measures of wellbeing and mental health.

Four studies completed pre and post measures only (n=4) while the remaining five studies completed follow-up measures at 9 weeks (Halliday et al., 2020) 2 to 3 months (Ohira et al., 2019), 6 months (Perry et al., 2014), the longest follow-up was 6 months and then again at 12 months (Calear et al., 2016). This intervention was a digital worry programme (Calear et al., 2016) which found no significant difference between at post-treatment or follow-up. This study was rated weak due to a number of differences between conditions at pre-intervention such as gender and age, there was a high number of dropouts and less then 60% of participants completed the programme.

Outcome measures

Seven studies used between two and four measures, Calear et al. (2016) and Lombos et al. (2019) both reported using five measures specific to mental health and wellbeing. The outcome measure used most commonly to measure symptoms of depression was The Centre for Epidemiologic Studies Depression Scale (CES-D), which was used in three studies, the PHQ-9 was used in another study to measure depression symptoms. The Warwick Edinburgh Mental Well-Being Scale (WEMWBS) was used in two studies and the Measure of Adolescent Well-being (EPOCH) was used to measure wellbeing in one study. The Depression Anxiety Stress Scale (DASS21) was used in three studies to measure psychological distress, one being the shortened version and The Kessler was used to measure psychological distress in two studies (Wong et al., 2014; Midford et al., 2016)

one used the k6 (the shortened version) and one used the k10 (the full version). The Mindfulness Attention Awareness Scale (MAAS) was used in one study and the Cognitive and Affective Mindfulness Scale (CAMS-R) was reportedly used twice to measure mindfulness. The Self-esteem scale (RSE) and the Connor-Davidson Resilience Scale (CD-RISC) were used in one study.

Program content

Three studies evaluated a programme based on cognitive behavioural therapy (CBT), two of which were digital interventions. Wong et al. (2014) conducted anxiety and depression programmes, focusing on psychoeducation and management of thoughts, emotions and behaviours. These programmes were comprised of an online individual component and a group class discussion which was facilitated by the teacher. Calear et al. (2016) taught CBT skills alongside relaxation and physical activity. Ohira et al. (2019) focused more on behavioural interventions including the development of an anxiety hierarchy and experiencing gradual exposure. Three studies were based on mindfulness (Britton et al., 2014, Hupport & Johnson, 2010; Lombas et al., 2019), one of these studies used mindfulness alongside character strength activities (Lombas et al., 2019). Halliday et al. (2020) described a positive psychology programme which included MoodGYM, an online anxiety and depression programme. One study was a mental health literacy programme that focused on educating students about mood and wellbeing (Perry et al., 2014) and one study was a social and emotional education programme (Midford et al., 2016) which focused on emotional literacy, problem solving, stress management and emotion regulation.

Mode of delivery

The amount of teacher facilitation varied across studies. Two of the studies reported the use of digital anxiety and depression programmes (Calear et al., 2016; Wong et al., 2014) which were accessed on computers and teacher input was minimal. In the Wong et al. (2014) study, the teacher facilitated a class discussion based on the online learning in the second part of the lesson. The Halliday et al. (2020) study included the online programme MoodGym alongside the positive psychology activities facilitated by the teachers. One study included an external professional supporting one of the conditions (Calear et al. 2016).

Duration of intervention

All intervention were 10 hours or less. Duration of programmes ranged from 3 hours to 10 hours, with most programs (*n* =8) being delivered in 6 hours or less. The majority of interventions ran weekly (n=7) and two interventions (Britton et al., 2014; Huppert & Johnson, 2010) included daily mindfulness practices. None of the programmes included booster sessions, but several interventions included homework (Calear et al., 2016, Huppert & Johnson, 2010).

Training and Supervision for Teachers

The training that teachers received varied across studies; from none (Calear et al., 2016) to 16 hours (Lombas et al., 2019), with the average being 7 hours. In the study by Lombas et al. (2019) teachers were trained by the authors of the programme over four sessions for a total of 16 hours. The mindfulness interventions gave minimal information about training. Britton et al. (2014) reported one teacher completed Roth's Integrative Contemplative Pedagogy (ICP) training prior to the study and had 5 years daily meditation experience. The other teacher had no previous experience in

meditation, but they had completed an 8-week mindfulness-based stress reduction course. In the study by Huppert and Johnson, (2010) the teachers were training in mindfulness and had an interest in it, however no further details regarding the training were provided.

Teachers delivering the online interventions (Calear et al., 2016; Wong et al., 2014) received a manual, but received little to no training. The training in other studies was more in depth. Teachers delivering the CBT for anxiety programme (Ohira et al., 2019) attended a six-hour training course, which included information about the theory of CBT, role-plays (20 minutes per session) and feedback from instructors. Teachers in the Halliday et al. (2020) study received six hours of training, which included discussions around mental health, a review of the programme and an opportunity to try activities and collaborate on lessons plans with other teachers. The teachers delivering the mental health literacy programme (Perry et al., 2014) received a one-day interactive workshop and the teachers delivering the social and emotional programme (Midford et al., 2016) were given participatory modelling of activities by the researchers, however training duration was not specified. Lombas et al. (2019) described teachers having supervision, which consisted of two 2-hour sessions where the researchers' addressed difficulties and email contact was available at all times with the research team. Other studies reported ongoing consultation between researchers and teachers during the implementation period (Ohira et al., 2019; Midford et al., 2016).

Replicability

The Template for Intervention Description and Replication (TIDieR) checklist (Hoffmann et al., 2014) was completed for each intervention to evaluate whether sufficient detail was presented to enable replication. The checklist includes 12 items (e.g., rationale, procedure, duration) and page numbers are recorded where the relevant information can be found for each study. Scores for each paper can be found in Appendix C. All studies reported the name, setting, rational, facilitators and

duration of sessions. Although it is important to note that studies lacking duration details were screened out of the review due to the 10-hour inclusion criteria. Two studies gave detailed descriptions of the procedures of the interventions (Britton et al., 2014; Ohira et al., 2019) and four studies provided a link or further information to access online manuals or materials (Calear et al., 2016, Lombas et al., 2019, Perry et al., 2014, Wong et al., 2014). Huppert and Johnson, (2010) gave some detail about the procedure but referenced video and audio clips with no links. Midford et al. (2016) gave an overview of the topics included and the types of exercises used, but provided no further details. None of the studies reported modifications that had been made. Strategies used to monitor fidelity were reported in most studies, please see section below.

Fidelity to intervention

Seven studies discussed attempts to improve fidelity with four studies describing teachers having manuals (Calear et al., 2016; Wong et al., 2014; Ohira et al., 2019, Midford et al., 2016). Perry et al. (2014) described a booklet providing guidance for teachers on facilitating activities along with a slideshow and resources. Similarly, Lombas et al. (2016) described a teacher booklet with theory and instructions for the programme activities and resources. Teachers were given a sheet to record time spent doing activities. Britton et al. (2014) described facilitators following identical transcripts, which was verified via email as well as looking at student journal entries, which the researchers felt gave some indication of fidelity. They acknowledged more rigorous fidelity checks in future studies would be essential. Halliday et al. (2020) aimed for a balance between fidelity and adaptability and they described doing this by giving teachers PowerPoint slides ahead of time so they could add personal touches.

Midford et al., 2016 conducted focus groups with teachers and students following the completion of the programme to evaluate fidelity. The sessions were developed to be 40-50 minutes

however these were shortened to fit into 30-minute pastoral care lessons. Students reported high levels of didactic teaching and some students did not complete all activities. Therefore, the researchers felt that the programme had been delivered with partial fidelity. The study would have benefited from the researchers recording/observing sessions to assess the fidelity of the implementation, they could have then provided supervision for teachers to stress the importance of the interactive elements. None of the studies formally assessed fidelity of the teacher to adhere to the protocol to ensure the intervention was being delivered as intended and this would need to be addressed in future studies. Huppert and Johnson (2010) did not report any details regarding fidelity.

Acceptability of intervention

Six studies reported on student and/or teacher acceptability. In the Ohira et al. (2019) study, 70-80% of students reported that the programme had helped them to cope with feelings of anxiety and reported that what they had learnt would be useful in the future. Halliday et al. (2020) used questionnaires and qualitative feedback to assess how satisfied teachers and students were with the intervention. Teachers highlighted high levels of engagement during the positive psychology activities, the positive effects of these activities were reduced however when MoodGYM was introduced, the student feedback corroborated with this. Midford et al. (2016) conducted focus groups with teachers and students, they reported that teachers were positive about the social and emotional programme but felt longer sessions would have allowed them to facilitate sessions in a more interactive way as opposed to delivering content didactically due to limited time. Teachers reported that the students took more from the sessions when they were actively involved.

In the Britton et al. (2014) study, students completed journal entries about their meditation experiences, from these entries and other qualitative student feedback, the researchers found that

94% of students reported practicing meditation daily. Lombas et al. (2019) gave teachers and students questionnaires regarding acceptability. They found that teachers did not find the programme useful for improving student well-being and the researchers suggested that teachers could be provided with the scientific evidence for the programme to help them to understand the benefits for adolescents' well-being. Despite the poor teacher feedback, 57.1% of teachers reported that they would implement the programme in the future, whereas only 38.1% of young people reported that they would like their teacher to keep on implementing this programme. In the Huppert and Johnson (2010) study, acceptability appeared higher with 69% of students reporting that they had enjoyed learning about mindfulness and 74% said that they would keep practicing mindfulness. Two studies did not report on student or teacher acceptability (Wong et al., 2014, Calear et al., 2016).

Discussion

The aim of this review was to summarise evidence for brief universal teacher-delivered mental health interventions, conducted in secondary schools. This is the first review focusing on teacher delivered interventions of 10 hours or less. Evidence relating to the interventions, facilitation, measures, quality, fidelity and outcomes were reviewed.

Interventions

Across the nine reviewed studies, the areas of focus of the universal prevention programmes varied considerably. The reviews included programmes focused on depression, anxiety, mental health literacy, positive psychology and wellbeing, social and emotional wellbeing, and mindfulness and wellbeing. The mindfulness programmes reported mixed results, all three studies found that the

mindfulness interventions did not significantly improve mental health compared to the control. Lombas et al. (2019) however found that when levels of mindfulness were medium/high pre-treatment, the programme did improve mindfulness, depression and perceived stress. While Huppert and Johnson (2010) found a significant positive connection between home mindfulness practice and improvement in wellbeing and mindfulness. The anxiety programmes (Calear et al., 2016; Ohira et al., 2019) did not find significant differences between intervention and control groups at post-intervention or at follow-up. Wong et al. (2014) found significant improvements in depression and anxiety symptoms, however the researchers reported the differences were small and were unlikely to be clinically meaningful. There did not seem to be a pattern between longer duration of intervention and effectiveness, or between effectiveness of intervention and quality rating. Studies by Britton et al. (2014), Midford et al. (2016) and Ohira et al. (2019) were rated as strong studies but did not find significant results, Midford et al. (2016) did report nearly significance on psychological distress.

There was a lack of consistency in outcome measures across the studies. All studies used self-report measures and future research would benefit from young person self-report measures being used alongside parent and teacher reports and objective measures, such as attention, emotion regulation and rates of school refusal.

All interventions were facilitated by teachers, however two were predominately digital programmes (Calear et al., 2016; Wong et al., 2014) and teacher input was minimal. Calear et al. (2016) included external facilitators in of the experimental conditions where teachers received assistance and support from a headspace education officer. Calear et al. (2016) found no differences with the addition of a professional to support teachers.

Most teachers had volunteered to be trained in the intervention, or were already trained (Britton et al., 2014; Huppert & Johnson, 2010). Teachers had different levels of prior training, for

example, in the study by Britton et al. (2014) one teacher had 5 years mindfulness experience and the other teacher had completed an 8-week course and this may have impacted the quality, fidelity and impact on students. It is important to consider the self-selection of teachers to partake in research trials and the extent that teachers are chosen at random or volunteer to implement programmes. Volunteering to deliver an intervention may suggest that a teacher has a previous interest in mental health which may lead to potential biases. For example, they might put more effort into delivering a programme if they want it to be effective. This may introduce further difficulties when programmes are implemented on larger scales as teachers who would not have volunteered may be asked to deliver programmes and this may impact student outcomes.

The overall quality of the papers was mixed, with 4 studies rated as strong, 3 rated as moderate and 2 rated as weak. However, some studies lacked methodological rigor for a number of reasons. The majority of the studies monitored or made attempts to improve the fidelity through using manualised approaches, no studies formally assessed the fidelity of the interventions. Despite Wong et al. (2014) finding significant results, they reported high attrition rates and a significant loss of data which may have impacted the statistical power and therefore they felt the results were not generalisable. Sample size across the studies varied greatly and there were only three studies that reported power calculations prior to the study (Calear et al., 2016; Perry et al., 2014, Ohira et al., 2019). Three of the studies were pilot interventions (Britton et al., 2014; Midford et al., 2014, Ohira et al., 2019) which may have impacted on sample size.

Overall, there is a lack of clarity about whether brief teacher delivered mental health interventions are effective or whether programmes with a longer duration are more effective and more information is needed to draw conclusions. Teachers are in a position where they need to decide which evidenced based intervention to deliver and they are faced with a limited pool of interventions, of which the quality is mixed. From the limited evidence base available it might be concluded that the social and emotional education programme by Midford et al. (2016) would be

the most appropriate to consider when taking quality and psychological outcomes into account. This study was rated as high in quality and student and teacher focus groups reported high acceptability of the intervention. They found an improvement in psychological distress that approached significance, cooperation and communication significantly increased but there were no changes in resilience, school protective factors or social and emotional skills. However, details gathered during the focus groups led the researchers to believe that the programme was delivered with partial fidelity. Therefore, it would be essential to redeliver this programme with fidelity being formally assessed throughout implementation.

Strengths and Limitations

This is the first review looking at brief teacher-delivered mental health interventions for secondary schools. Many reviews have looked at mental health interventions in schools by school staff and other mental health professionals (Werner-Seidler et al., 2021, McKeering & Hwang, 2019, Ma et al., 2020), however there is a growing need for teachers to deliver mental health programmes. The mandatory guidance from governments (Department for Education 2018; Welsh Government, 2021; Scottish Government, 2017) have proposed that schools provide mental health support within the curriculum. Research has shown significant amounts of pressure and burnout within teachers (Madigan & Kim, 2021). There are high rates of teacher attrition, with estimates that nearly half of new teachers will leave the profession within five years (Sims & Jerrim, 2020). Teachers report that a busy workload and stress in the workplace are significant contributors to high attrition rates (National Education Union, 2022). Therefore, exploring brief evidenced-based interventions that can be conducted weekly over a maximum of a single school term seem more feasible for teachers to deliver.

Shelemy et al. (2019) found teachers reported that previous mental health interventions were not feasible given the time and pressure they were under. Teachers have reported that

previous manualised programmes failed to appreciate that teachers may not be able to commit to delivering a programme on an ongoing basis (Taylor et al., 2014). Shelemy et al. (2019) argued that programmes should include an assessment of teacher acceptability to evaluate whether an intervention is feasible as part of a school curriculum.

Schools have been thought to be an ideal environment to deliver preventative programmes. However, it is important to note that schools can be a source of stress and worry for students due to academic pressures. Anniko et al. (2019) found that young people consistently reported highest levels of stress around school, and specifically achieving academically in school, compared to any other area in their lives.

There are several limitations as part of the screening process for the current review. A search of the unpublished literature was not included as part of the screening process which increases the risk of publication bias. Although, it is important to note that the majority of studies included in the review reported non-significant results which reduces the risk of publication bias on the review findings.

During the screening process, a number of studies were screened that did not specify the duration of the intervention and so they were not included in the review. Ten studies were excluded at screening due to the lack of clarity regarding session duration, this is problematic in reviewing and comparing school-based interventions and needs to be addressed in future studies. However, it is important to acknowledge the challenges of educational settings for research. Some authors may be uncertain of the exact session length due to flexibility that they gave schools to enable them to fit the programme within timetables. While this can be beneficial for teachers as this increases the programmes' feasibility, it can create challenges for future replication.

Practical implications and future research

The completed TIDieR checklist confirmed that there needs to be clearer details in studies regarding procedure so that studies can be replicated. Studies need to use power calculations to determine the sample sizes required and studies should aim to include active control groups for comparability. Some programmes allowed for flexibility (i.e., sessions were shortened to fit with lesson times or details of session duration were vague as lesson times varied between schools). Whilst flexibility with timings may be beneficial for teachers working in schools with timetabling pressures, it can create challenges when attempting to compare studies. Even if teachers are given flexibility (within set parameters e.g., 45 minutes to one hour) to run a programme, exact details of session duration needed to be recorded so this can be factored into analysis of the findings.

It is important for future studies to formally evaluate programme implementation. Durlak and Dupre (2008) conducted five meta-analyses with 500 studies which showed that higher levels of programme fidelity was significantly associated with better outcomes; mean effect sizes were twice as high when programmes were implemented as intended by developers. Without evaluations of programme implementation, studies cannot confirm exactly what programme was delivered and how the data should be interpreted (Durlak & Dupre, 2008). Schools can encounter challenges with implementation (Durlak & Dupre, 2008) and universal programmes require extensive planning, infrastructure and support from school staff (Goldberg et al., 2019), however this is often missing (Spoth et al., 2013). Assessments of the school environment, including school ethos, staff attitudes towards mental health, teacher self-efficacy and support from leadership teams and wider community should be included in future research.

Halliday et al. (2020) was the only study which involved teachers in the development of the intervention. This is an area of weakness for existing studies. There is a need for collaboration and consultation with teachers and students during the planning and development stages of a programme (Shelemy et al., 2019). Ideally acceptability and feasibility studies should be initially conducted to trial interventions to learn what is feasible for teachers to implement. These trials would allow for discussions and exercises to be timed to assess how long interventions take to complete. Weist and Murray (2008) set out guidance to ensure the quality of school-based mental health programmes. They identified that integrating students' perspective and utilising teachers' expertise is essential to design viable and sustainable universal prevention programmes.

Online interventions have potential to be effective, as they capture young people's interest and may be more suitable for schools where there is limited time to promote mental health. Online interventions are easier to standardise and to measure engagement more accurately, such as via time spent on applications. Similar to the Wong et al. (2014) study, combining an individual digital intervention with class discussions facilitated by the teacher may be useful. The teachers in the Wong et al. (2014) did not receive training and this may be valuable to help teachers feel confident in understanding the digital intervention. Teachers in the Shelemy et al. (2019) study reported that they saw their role as educational and did not want to be seen as a therapist. The use of a digital intervention may help teachers to feel they are not in an expert position. Training teachers in an online intervention may increase the likelihood that they continue to use elements of this and can disseminate knowledge to other staff and students.

Approximately one in six young people have mental health difficulties (NHS Digital, 2020) and a large percentage of those cannot access treatment due to high referral rates to specialist services and staff shortages. The responsibility of providing mental health interventions is increasingly falling on teachers. Governments have issued mandatory guidance around schools

providing mental health interventions. Teachers are feeling stressed and pressured due to high workloads and rates of teacher attrition have increased. The pool of brief evidence-base interventions from which they can draw is limited and of mixed quality. Future studies should conduct acceptability and feasibility trials to develop programmes in collaboration with teachers and students and assess the fidelity of the intervention more thoroughly to ensure that programmes evaluated are consistent with intervention protocols.

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Brief ACT training for school staff: a qualitative evaluation of experiences in delivering a universal ACT based intervention to young people in secondary schools

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Abstract

Background

Mental health difficulties are common in young people and mental health interventions are now mandatory as part of the school curriculum in the UK. Teachers are in a key role to provide interventions, however they lack mental health training in order to deliver these interventions. This paper reports how school counsellors and teachers experience the process of receiving training in a universal Acceptance and Commitment Therapy (ACT) based programme and delivering this programme to students in the classroom.

Methods

Three counsellors and four teachers were interviewed following their delivery of the *InTER-ACT* programme. Two counsellors and three teachers were then interviewed at a 6-month follow-up. Constructivist Grounded Theory was used to collect and analyse the interview data.

Results

The grounded theory analysis of the interview data resulted in a model of engagement within a context of willingness to show vulnerability. This model consisted of eight phases which included: *pre-existing stance*, perceiving the approach to be a *good fit*, *buying into* the approach, *practicing skills*, *talking authentically*, *students engaging*, *believing in the approach*, *sharing with others*.

Conclusions

The model of engagement showed the circular phases that the facilitators moved through to support their engagement with ACT and the engagement of their students. The model emphasised the importance of vulnerability when learning and using ACT in both facilitators and students. Recommendations for future training with school counsellors and teachers are made.

Keywords

Acceptance and Commitment Therapy; Teacher; Mental health; School; Qualitative

Introduction

Mental health difficulties in young people are common; approximately 20% of adolescents experience a mental health problem in any given year (Merikangas et al., 2010). There is evidence to suggest that mental health difficulties are increasing amongst young people (Deighton et al., 2019). Between 2017 and 2020 rates of these are reported to have increased within the adolescent population from one in nine (10.8%) to one in six (16.0%) (NHS Digital, 2020).

The public health crisis caused by COVID- 19 is reported as having further increased distress among young people (NHS Digital, 2020). A study by a UK online mental health platform reported a 128% increase in sadness and 27% increase in self-harm amongst adolescents, when compared to the previous year (Kooth, 2020). Studies have assessed adolescent mental health in response to the pandemic (Zhou et al., 2020; Ravens-Sieverer et al., 2021; Oosterhoff et al, 2020), which all found significantly increased depression and anxiety compared to pre-pandemic.

Evidence suggests an international need for increased implementation of mental health treatment and prevention strategies to maintain young people's well-being. Approximately 50% of mental health problems emerge before the age of 14, and 75% before the age of 24 (Kessler et al., 2007) and these difficulties can have a lasting negative impact. Despite a high prevalence of mental health difficulties in adolescents, many will not have access to specialist services (Frith, 2017) due to high referral rates (Children's Commissioner, 2022) and staff shortages (Rimmer, 2021). There has been a particular focus in research and policies on schools as a universal access point for mental health support (Werner-Seidler, 2021).

Mental Health Interventions in Schools

Schools are seen as environments for interventions to prevent mental health problems and to protect and promote mental health (O'Reilly, 2018). As most young people attend school, the potential reach of school-based delivery is substantial (Werner-Seidler, 2017). Universal school-based interventions have potential to target large populations of young people to promote wellbeing as they are delivered to all individuals irrespective of diagnosis or symptoms. Difficulties of large-scale screening, missing vulnerable students and potential stigmatisation that may result from targeted interventions are minimised (Burckhardt et al., 2017).

National strategy documents (Department of Health, 2015) have highlighted the need for timely intervention to improve adolescent's mental health. A green paper from the British government in 2017 (DfE, 2019) emphasised the role schools have in young people's mental health and UK government policy now states mandatory promotion of positive mental health in children, at a universal or targeted level (DfE, 2018, 2019; Scottish Government, 2017; Welsh Government, 2021).

Many interventions have been developed for teacher delivery rather than mental health professionals (Franklin et al, 2012). Teachers have an understanding of how to engage students' attention (Leflot et al, 2010), they have relationships with students, which may be beneficial when discussing sensitive topics. There are also opportunities for teachers to disseminate programmes to the wider school (Shelemy et al, 2020). However, teachers may lack mental health knowledge and therefore appropriate training and supervision is important for teachers facilitating mental health programmes (Lendrum et al., 2013).

Shelemy et al. (2020) conducted three meta-analyses on teacher-delivered interventions and found significant improvements in depression, anxiety and PTSD symptoms in students. Effect

sizes for the universal prevention programmes were moderate, however improvements were only sustained at follow-up for anxiety symptoms. Teacher training and ongoing supervision from a mental health professional were critical in increasing efficacy (Shelemy et al, 2020).

ACT for Young People

Acceptance and Commitment Therapy (ACT; Hayes, 1999) is a third wave cognitive and behaviour therapy, where the predominate goal is to increase psychological flexibility. Psychological flexibility refers to skills for interacting with both welcomed and undesired thoughts and feelings, which allows individuals to be present and adapt their behaviour to align with their values (Hayes et al., 2006). Psychological flexibility is thought to be a key process that leads to clinical change (Hayes et al., 2006).

ACT is composed of six processes that aim to increase psychological flexibility: (1) *acceptance*: allowing thoughts and emotions to be experienced; 2) *cognitive defusion*: using techniques to change the relation to thoughts; 3) *being present*: mindful awareness and non-judgementally noticing of thoughts and emotions; 4) *self-as-context:* observing experiences without attachment to them; 5) *values*: acknowledging desired qualities to bring into actions and 6) *committed action*: acting in congruence with personal values (Hayes et al., 2006). Hayes et al. (2006) emphasised that each process is a positive psychological skill in itself and is not an approach to avoid psychological distress.

The evidence for ACT improving well-being in adults is compelling; a review of meta-analyses by Gloster et al. (2020) found ACT was a more effective treatment for anxiety and depression when compared to controls and other interventions (excluding CBT). There are comparatively fewer studies of children. A recent meta-analysis of the efficacy of ACT for children by Fang and Ding

(2020) found that ACT was more effective than the control and comparable to CBT in decreasing anxiety, depression and other mental and behavioural difficulties. This meta-analysis was limited by the number of randomised control trials (RCT) investigating the efficacy of ACT with children, and further high-quality studies exploring ACT for children with different mental health difficulties are needed.

ACT as a Universal Approach in Schools

Findings show that just over 300,000 10–15-year-olds in the UK are unhappy with their lives (The Good Childhood Report, 2021). Young people are struggling with school pressures, friendships and feelings around their appearance (The Good Childhood Report, 2021). 80% of young people with mental health difficulties reported that the Covid-19 pandemic had worsened their mental health (Young Minds, 2021) and they were struggled to cope with the uncertainty of the future and not being able to see friends and family (The Good Childhood Report, 2021).

Gillard et al. (2018) have recognised ACT as a suitable model to promote mental health in young people in schools. ACT has been developed as a transdiagnostic model; it is an approach to understanding psychological wellbeing which emphasises the commonality of experiencing distress (Hayes et al., 2012). The main purpose of ACT is to encourage individuals to engage in value-based living and not to remove mental health symptoms. ACT focuses on interactive and experiential exercises and the use of metaphors to introduce concepts. These exercises are useful when working with adolescents as they can create concrete tools to help them to understand abstract ideas (Halliburton & Cooper, 2015). The focus on values may be relevant for adolescents as they begin to question societal rules and to develop their identity (Fang & Ding, 2020).

Adolescence is a critical period for identity formation where young people may feel pressured by their school and peers. Acceptance techniques could help to increase adolescents' ability to tolerate unwanted thoughts or feelings (Lillis et al., 2009). Mindfulness would help to train attention so adolescents could unhook themselves from negative thoughts and focus on the present (Biegel et al., 2009). Discussions around values could be useful for those continuously comparing themselves to others and struggling with their identity (Luoma et al., 2008). Livheim et al. (2015) have reported engaging in ACT in a group setting helped adolescents to form a sense of belonging and participants shared other people also sharing their difficulties was normalising.

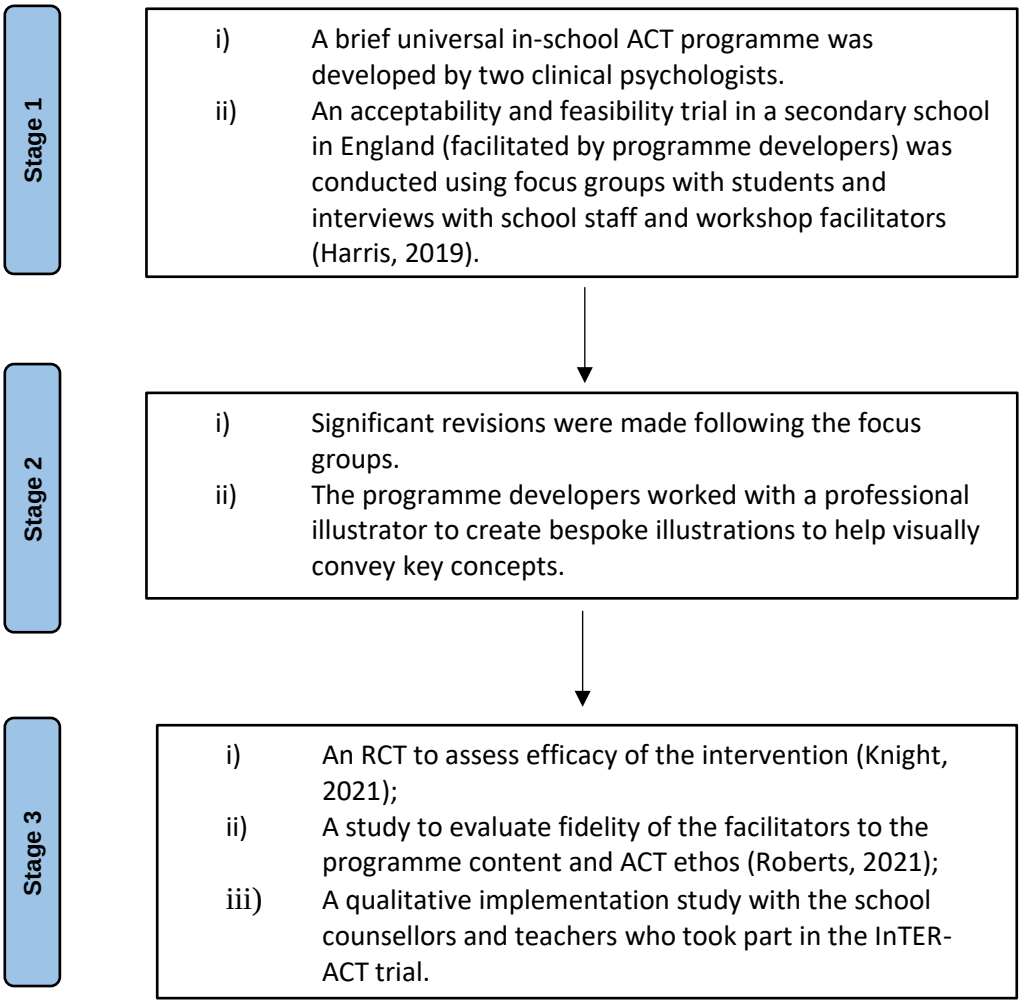
There have been a number of ACT interventions carried out in schools with varying results. Livheim et al. (2015) found adolescents who received ACT reported significantly reduced stress and depression and increased psychological flexibility. Burckhardt et al. (2017), however, found no statistically significant differences between adolescents receiving ACT in depression, stress, anxiety, total negative affect, and wellbeing, and the researchers felt this was likely due to a small sample size. An RCT by Puolakanaho et al. (2019) reported that ACT delivered through a mobile application reduced adolescents' stress and increased their capability to overcome academic setbacks. Bernal-Manrique et al. (2020) found that ACT improved interpersonal skills in adolescents. They noted the sample was from a private school and were unable to collect follow-up data, thus limiting the conclusions of the results.

InTER-ACT

The study described within this paper was part of a broader trial assessing the *In-school training in emotional resilience (InTER-ACT) programme* (Samuel et al., 2021). Prior to this study, the InTER-ACT trial involved two stages, a third three-stage research trial was then undertaken of the school staff delivered programme (see Figure 2).

Figure 2

The stages involved in the InTER-ACT trial.



The qualitative study is the focus for this paper.

The InTER-ACT programme consists of three ACT workshops, an hour each in duration (see Appendix D for workshop content). A two-day training programme was developed to enable counsellors and teachers to deliver InTER-ACT themselves. Facilitation required one counsellor and one teacher. PowerPoints were provided for each workshop to guide facilitators through sessions, with

transcripts for the workshop dialogue, and sections pre-divided between 'Facilitator 1' and 'Facilitator 2'[1].

Using Qualitative Data in Trial Research

Complex healthcare interventions involve social processes that can be difficult to explore using quantitative methods alone (Lewin et al., 2009) and qualitative experience data can be crucial for the development of new trials (Oakley et al., 2006). Well-conducted qualitative studies can support trial design and improve understanding of complex interventions such as identifying reasons for findings; the mechanisms through which changes occur; variations in experiences; examine underlying theories and help to generate further hypotheses (Lewin et al., 2009).

Method

Aims of study

For the InTER-ACT trial, it was essential to know how the training was experienced, how the knowledge and skills from the training was integrated by counsellors and teachers and how the training was applied in the reality of the school classroom.

This study aimed to explore the process of how counsellors and teachers:

1. learnt a new approach that may have been unfamiliar;
2. subsequently engaged students and delivered the intervention within a school context;
3. developed their personal use of ACT skills and with individual students

[1] Facilitators were able to choose which role they adopted, providing some flexibility for sections involving experiential exercises and sharing of personal examples.

Understanding the counsellors and teachers' experiences will help to increase understanding regarding what may have facilitated or inhibited the learning and application of new psychological ideas. This information will help to shape and expand the InTER-ACT training and intervention for children for future delivery.

Ethical considerations

Prior to beginning the study, ethical approval was obtained from The School of Psychology Research Ethics Committee at Cardiff University (see Appendix E).

Study design

The study used a qualitative design approach. Constructivist Grounded Theory (CGT), as described by Charmaz (2006, 2014), was used to generate and analyse the qualitative data collected from interviews with counsellors and teachers.

CGT is an inductive qualitative research method that seeks to understand and explore social processes where there are no pre-existing theoretical frameworks (Charmaz, 2006, 2014). CGT provides systematic guidelines for collecting, synthesising, analysing, and conceptualising qualitative data to construct theories 'grounded' in the data. The approach focuses on generating new theories which assert a plausible relationship between concepts through analysis of data gathered from participants (Charmaz, 2006). A CGT method was chosen as the aims of the study focused on understanding the social and psychological processes central to counsellors and teachers learning and delivering the InTER-ACT intervention.

Line by line coding is completed in CGT to gain a more detailed, nuanced and closer look at what participants are saying. CGT emphasises the integral role of the researcher and their background and perspectives to the way the data is gathered and the interpretations that are made (Charmaz, 2016). Unlike other methodologies such as thematic analysis, CGT is an interactive research process where coding and memo writing is done throughout data collection to develop the theory and to flag potential gaps in the data. Theoretical sampling allows interview schedules to be refined to fill categories and obtain further data to develop emerging theory (Charmaz, 2006). Codes were initially developed around ACT making sense to participants, questions in the interview schedule were then developed around why ACT made sense to them and why ACT being embedded in science and logic felt important to participants. Gathering this further data in follow up interviews filled this category and gave a richer understanding to add to the emerging theory.

Recruitment and Sample

Participants were recruited as part of the earlier InTER-ACT trial and were school counsellors and teachers who had attended the two-day InTER-ACT programme facilitator training and had delivered the InTER-ACT programme as part of the research trial. See Appendix F-I for further information on recruitment, participants in the InTER-ACT trial and documentation.

Participants in the Qualitative Study

Five counsellors and five teachers agreed to be contacted to discuss taking part in the interviews following their involvement in the InTER-ACT trial and were sent an information sheet

(see Appendix J). Of these, three counsellors and four teachers agreed to be interviewed and signed consent forms (see Appendix K); these participants included six females and one male[2].

Initial interviews were conducted with seven participants after delivery of the intervention, during which counsellors and teachers were asked if they consented to be subsequently contacted for a follow up interview. Six of the seven participants consented to this. Six months after the initial interviews these participants were contacted and four participants responded. One counsellor and three teachers (all female participants) were interviewed at a six-month follow up. All participants were debriefed (see Appendix L) following each interview.

Data collection

An interview schedule was developed to guide interviews (see Appendix M). Broad open-ended questions focused on participants' experience of training and delivering the workshops. As per Grounded Theory, the interview schedule was adapted following interviews to allow exploration of emerging themes. Initial interviews of 55 - 90 minutes duration were conducted between December 2019 and March 2020. Follow-up interviews of 40 – 60 minutes duration were conducted between July 2020 and August 2020. The follow-up interviews focused on participants' experiences of using ACT since delivering the intervention and provided an opportunity to test out emerging themes. All interviews were conducted over Zoom, recorded on the computer and audio-recorded on an external audio recorder. Interviews were transcribed verbatim by a transcriber and deleted from the computer and audio recorder within a month.

[2] Participants were from two comprehensive schools and one grammar school in England, and one comprehensive school in Wales. Participants' experience in counselling ranged from five to eight years and teaching experience ranged from three to twelve years.

Data analysis

Transcripts were anonymised at transcription and participants were assigned gender neutral pseudonyms to protect their identities. Transcripts were initially coded line by line. This involved precisely labelling each line with a gerund (Brunero et al., 2018) to summarise an action, process or consequence. Next, focused coding was conducted, this involved identifying which initial codes were significant and made most analytic sense (see Appendix N). Categories were formed through identifying the most integral codes that explain a key process in the data. It was not possible to complete focused coding before subsequent interviews as it was crucial for interviews to be conducted within a close proximity to the programme delivery. However, all line by line coding had been completed prior to subsequent interviews to enable selection of the most significant processes described by participants and test them against further data. Following analysis of the initial interviews, theoretical sampling was carried out, which involved modifying questions based on the existing data and testing out emerging themes and theories with participants. Memos were written (see Appendix O) during and after interviews to capture thoughts, develop ideas and make connections between codes. Memos helped to compare data and codes between participants and to develop categories (Charmaz, 2006). Coding was discussed in supervision to reflect on the data and to discuss codes and construction of categories. Six mind maps were created between August and October 2021 to develop categories (see Appendix P&Q).

Reflexivity

The researcher carrying out the interviews and data analysis was undertaking doctoral training in clinical psychology and had previously worked with young people clinically before beginning doctoral training, which was an area of interest. At the time of completing the research, they were working in a service which used ACT clinically. ACT was viewed positively within this service and this may have predisposed the researcher to view ACT as beneficial for mental health

difficulties and could have impacted the interpretation of data and how the theory was developed. Two transcripts were reviewed by a supervisor with expertise in Grounded Theory following line by line coding and then again after focused coding to increase reliability of coding. The use of memos and supervision discussions around emerging theory and testing concepts and their relationships in subsequent interviews helped to mitigate against bias.

Results

Through conducting interviews, coding transcripts, and comparing between and within interviews, an eight phased model that describes the process of engaging in brief ACT training and intervention was developed (see Figure 1).

Summary of model

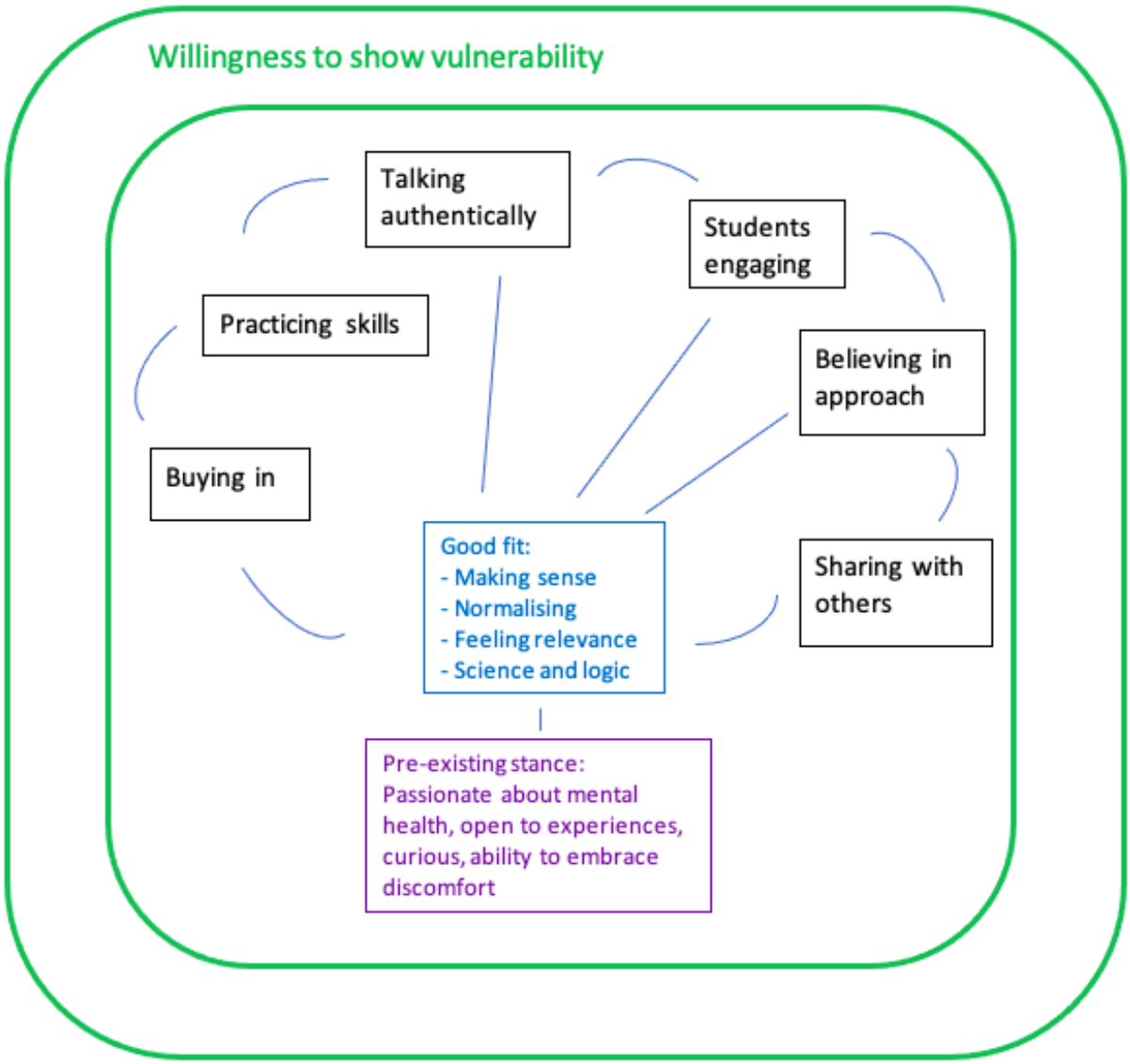
Based on the data, it was found that the process of engagement encompassed eight phases (italicized):

The *pre-existing stance* of the facilitator related to how they approached the training and all participants spoke about having a passion for young people's mental health. Participants talked about *perceiving the approach to fit;* ACT 'made sense' and seemed logical and normalising. Participants described *buying in* to the approach as it felt deeply relevant, which led to them p*racticing* the ACT skills outside of the workshops, so the skills became integrated into their personal lives. Using the skills personally led to participants *talking authentically* and making personal disclosures with students. Participants described *students engaging* when they shared their own personal experiences. Increased student engagement led to participants *believing in the approach* as it was proving to also be a fit for students. Participants described *sharing learning with others* as the

approach seemed to be widely applicable and this reinforced their knowledge of the approach and its relevance further. These phases sit within a context of a willingness to show vulnerability, where several participants shared feeling uncomfortable in experiential and mindful exercises and some participants talked about the importance of embracing this discomfort.

Figure 1.

A visual representation of the grounded theory model of engagement.



An alternative visual model was created for use in training with facilitators to explain the process of engagement (see Appendix R).

In the following sections, a descriptive overview of the model's phases are presented, which describe the process of engaging in the brief ACT training and delivering the InTER-ACT programme. All phases of the model are described separately, although it is key to note the overlap and circularity of the phases.

Pre-existing stance

All participants talked about being passionate about young people's mental health, particularly within the current context of the Covid-19 pandemic. Four participants talked about sharing a genuine passion for young people's mental health with their buddy. Passion seemed to be a prerequisite to attending the training and was self-selecting as it enabled them to commit to training and persevere with the intervention. All teachers talked about their lack of mental health training and not feeling equipped to support young people with mental health difficulties. They described 'fire-fighting' and feeling helpless in the context of the Covid-19.

> *A lot of colleagues and I are having conversations at the moment about how we are dealing with teens who are in genuine crisis (Ellis)*

> *They [teachers] still don't feel like they've got like proper tools with which to help students (Sam)*

Participants came across as enthusiastic and grateful to receive training in delivering a mental health intervention. One participant talked about the benefits of their buddy being keen to receive honest feedback and constructive criticism about their facilitation, which created a

comfortable rapport in their relationship and aided the development of the workshops. Having an intellectual curiosity and openness to experiences seemed to help participants to engage with ACT.

> *You need facilitators who are confident and comfortable enough that they are open to constructive criticism… this kind of intellectual curiosity (Ellis)*

Perceiving the approach to fit

The term 'fit' in the model refers to participants feeling that ACT made sense and felt deeply relevant for them and their students in the current context. For counsellors who had some knowledge of ACT, the training fitted with previous training and they recognised certain techniques. Participants described the training as engaging and talked about using the skills to benefit their own mental health.

> *Having gone through this training has been so important for me. A, for my mental health, particularly coping with the weight of all of these kids' issues and the pandemic and my own kids…But also, to feel like, I know that I'm saying the right things and that I'm doing something that is going to be tangibly helpful and positive for them, that is going to have a meaningful outcome (Ellis)*

> *Yeah, it made perfect sense and, I suppose it's like one of those things where you think, well of course this makes sense, why isn't this in the curriculum? (Alex)*

ACT was a welcome introduction to concepts I felt like I needed in my life, the approach really supports the positive changes I've been attempting to make in my life over the last few years (Sam)

Participants talked about how the training had been useful in terms of understanding their own feelings. Participants shared personal examples of how exercises in the training had impacted their perspective and outlook on challenges in their lives.

It felt like it was a real light bulb moment for me in the training weekend when it was talking about how anxiety spirals (Ellis)

Participants talked about the experiential exercises, illustrations and videos which they felt were engaging to students. They felt the illustrations and videos were relevant and were developmentally appropriate. Throughout interviews participants often referred back to exercises and characters from videos.

I found the illustrations unbelievably helpful…I think they really encapsulated that notion of a picture tells a thousand words (Frankie)

Amongst challenges talked about, being required to stick to a script was discussed. All participants acknowledged that they understood why the script was essential for standardisation of the approach, however several participants talked about wanting to present in their own style or change their style to adjust to students differing learning approaches, which they felt the script hindered.

It felt quite restrictive to have to say things in a particular way…I felt like I had to give a different example from my point of view, just to make it a little bit more real for our students (Sam)

Several participants talked about the ACT approach being grounded in complex science and this felt important. Participants felt that understanding how the brain works was normalising and helped rationalise the approach. It was felt that because the training and workshops were part of a research project from a university and led by Clinical Psychologists, it was viewed as more appealing and credible. Several participants talked about this leading to "buy in" from bright students and school staff that respected the academic background of the approach.

There's a whole school of science here that says that the way they are thinking and feeling is normal and that's pretty revelatory for a lot of them (Ellis)

Buying in

All participants described passion for the project and this was shown through giving up their time (i.e. attending training and preparing for workshops out of work hours). This passion seemed to be a prerequisite to their involvement and was necessary for them to persevere and commit to the time required for the workshops. Without passion, their engagement with the process may have been prohibited.

There was a lot of planning around all of that… there were lots of practical issues that we had to overcome[3](Charlie)

You need to be passionate enough to make the time for it. It's not a negative, but there is no doubt that this was time-consuming and, at times, incredibly stressful, just – because it meant so much to me and I wanted to do it right…you really have to be committed to getting it done to do it well (Ellis)

Practicing skills

Participants talked about using ACT in their own life and becoming more aware of emotions and stressors. Participants described utilising techniques, for example the 54321 grounding exercise and using the 'noticing the thought that' skill. They described how the more they practiced, the more they saw the benefit of the skills and the more they started to believe in them.

I put too much pressure on myself to do everything perfectly…I've really found some of these techniques really quite helpful in just adding to my own personal toolbox (Sam)

I'm feeling quite stressed at the moment…so I do use it on a daily basis…I can notice how I'm feeling and I know I feel sad…those concepts and teaching them as well, has helped me to integrate the ideas, has really helped me with what's happening in my life (Charlie)

Two participants shared powerful examples of practicing the skills with their families.

[3] *Some of the time-consuming activities talked about participants were in reference to the research trial as opposed to delivering the intervention.

The idea of really sitting in those feelings and validating them, rather than either pushing them away or hiding them. That's been quite a revelation…It's just a huge shift on my outlook really (Ellis)

There was variation amongst participants in the extent to which they practiced the ACT skills. Four participants described a degree of discomfort in practicing and/or teaching mindfulness as this did not fit with them. Ali, described a sense of mindfulness being a natural fit for some people, but less so for them. However, there was a recognition of the need for self-practice and awareness of the need to drop the struggle with feelings.

I don't think it's a natural way of being for me personally. Some people are really natural at mindfulness and it seem like a natural extension of what they do, whereas I'm not really so much like that…I have to remember to practice and think oh let's try doing it that way, or not going it that way, as in not fighting with my feelings (Ali)

There's some concept of mindfulness that fit with ACT that I'm not keen on but it doesn't mean I don't teach it. If it's suitable…it's fine. Just because I don't use it per se every day, doesn't mean I can't show someone else to make some use of it (Jo)

Another participant appeared ambivalent towards mindfulness, they described how being less interested in mindfulness meant that they did not practice it, but they acknowledged feeling that they should practice mindfulness as they have seen the positive impact it can have. This shows that it is possible to understand the theory and benefit of a psychological skill, but struggle to use it.

This participant's uncertainty about mindfulness did not appear to impact directly on the workshop delivery as their buddy was facilitating the mindfulness exercises, however they acknowledged they would not use mindfulness if a student approached them for support.

> *The stuff on mindfulness isn't quite my can, I get it and I understand the concept of it and I know how to do it, but I don't practice it, so, I'm not really great at delivering it to others (Frankie)*

> *Having experienced the effects of it in my own life doesn't make me continue practicing it. I still get, I still don't do it, and I should because I've seen that when you do, it makes things better (Frankie)*

Talking authentically

Two participants talked about students being particularly engaged when they spoke authentically; by this they meant when they shared their own thoughts and emotions, or talked about their personal use of ACT. Speaking authentically allowed participants to speak with genuine enthusiasm and give a true representation of using the skills. Their personal disclosures seemed to catch students' attention and facilitated more sharing.

> *I've said to them, I learnt about this this weekend; have you heard this [referring to ACT], have you seen this technique? Just to give them something new to try and have a go at…I wholeheartedly believe in the values of it, so it is something that I try and go back to (Sam)*

> *When we talked authentically about how we were feeling and you know all our thoughts. They really did stop and listen. They were obviously interested to know, and so being able to show vulnerability I suppose (Charlie)*

Students engaging

Participants spoke about the students being engaged by the content and offering their opinions. One participant spoke of a round of applause they received following the first workshop. Participants referred to engagement as a sign of the workshops' fit and relevance and contrasted this with how adolescents disengage when content is not of interest. Several participants spoke about individual students approaching them to talk more about the workshops or to discuss their own mental health.

> *You're not trying to draw stuff out of them, they're offering…their engagement demonstrated the relevance to them. Students who didn't know me before…will seek me out now and say, you know that thing you were talking about, can we talk a little bit more about it? (Alex)*

Participants talked about the importance of the facilitators' approach to the workshop delivery and the need to get this right to ensure student engagement. There was evidence of commitment to get this right, and awareness of the subtle impact of tone and pace.

> *If you didn't have that sort of passion and enthusiasm behind the delivery it could really fall quite flat…you had to have the students engaged. You had to strike the right tone. It had to be comforting and nurturing, but also focused and let's get this done and pacey (Ellis)*

Participants talked about powerful disclosures following using ACT techniques individually with students. Participants talked about becoming a trusted adult following the workshops, despite not knowing students previously.

When we went into that and made room for that feeling and that feeling grew and took over the room and we submerged ourselves in that feeling, that led to a disclosure of domestic abuse at home and what that student has been living with for five years (Alex)

Sharing learning with others

Three participants spoke about sharing techniques with peers and the positive responses they received strengthened their belief in the relevance of ACT. Three participants described how sharing ACT knowledge with colleagues helped to consolidate their learning. Two participants talked about how sharing this knowledge with colleagues helped to give the school a shared language which was useful in conversations between staff and students and can change and shape a system.

I'm in a peer group with two other colleagues... I suggested you know the POD idea and they loved it; it was something that they were both going to try (Charlie)

This information then goes back to multi-layers through the organisation, into shaping meetings and planning (Alex)

Showing vulnerability

Being vulnerable as both a facilitator and as a student during the training and intervention was discussed. One participant in particular talked about experiential exercises within training and how exploring personal thoughts and feelings on a deeper level could feel exposing and unsettling.

Embracing discomfort was seen as necessary, but required vulnerability. It was perceived that some people are able to be vulnerable and embrace that discomfort, and others are not.

> *I was very open with that with the class…and I think the ability to be open about your vulnerabilities with somebody is very important…so I think I was able to get the class to engage really well…because I shared my vulnerabilities…I don't know you, you don't know me, it's really scary for me, just like it's scary for you. So, I think they're like, wow, you know, adults don't say this stuff (Jo)*

> *Definitely some of it feels uncomfortable at first…there is real self-examination involved, which is quite revealing at times. It wasn't uncomfortable, but I guess it was unsettling, so, it's really important to really think about, like just embracing it for sure… you have to be the kind of person that is comfortable with being that confronting (Ellis)*

Several participants talked about the need for vulnerability and they highlighted what allowed them to do that. Two counsellors perceived that they were more able to be vulnerable than the teachers and felt that this came more naturally due to their professional training, as they are used to talking about emotions and using personal disclosure as part of therapy. This was contrasted to the role of a teacher; all counsellors and several teachers talked about perceiving teachers to be less able to be vulnerable in their roles. Participants talked about teachers needing to hold boundaries and manage behaviour in the classroom and self-disclosing or talking about their emotions felt less familiar. Teachers described being good at "compartmentalising" and "hiding" feelings, whereas counsellors were seen as better at dealing with "the emotional side of things".

Several participants talked about mindfulness potentially feeling uncomfortable for students. They felt that students were more open with their feelings if they knew members of staff,

however, most participants described having little contact with the class before the workshops and wondered how comfortable the students felt. One participant talked about mindfulness being a moment of potential vulnerability for students and perceived that privilege may be associated with being able to be vulnerable. Another participant talked about their own perceptions of students being uncomfortable doing mindfulness and recognised that this was a barrier to them teaching it. However, they acknowledged this perception may be bigger in their own mind.

> *The mindfulness is a moment of potential vulnerability. That quiet, that introspection and that need to just sit and listen and follow instruction without kind of questioning. If you are somebody who is naturally tense or confrontational or feeling on edge, then that could be a really uncomfortable thing (Ellis)*

> *Teaching mindfulness with the students…to allow them back to settle has been really beneficial. They actually feel less uncomfortable about it than I perceived them to be feeling…the odd giggle is just the odd giggle. It's not as huge or as big as I, in my mind, was creating more as a barrier to be (Alex)*

Discussion

This study was designed to explore how school counsellors and teachers experienced the process of receiving training in a brief ACT-based programme and delivering this programme to students, as well as evaluating the factors that facilitated implementation within a school setting. The findings from the themes and subthemes generated through the interviews, and the subsequent model, illustrated eight phases that school counsellors and teachers moved through, which contributed towards their engagement in the approach and their perceptions of students' engagement in the programme.

Good Fit

Secondary school teachers come into contact with a high prevalence of students struggling with mental health and so they are in a key position to refer and signpost students to mental health services (Fazel et al., 2014). In the UK, two-thirds of adolescents with diagnosable mental health difficulties have spoken to a teacher about their mental health (Newlove-Delgado et al., 2015). The majority of teachers believe that schools should be a place where mental health issues are addressed (Reinke et al., 2011) and many teachers acknowledge their ability to identify students who are struggling (Rothì et al., 2008).

In this study, all participants talked about being passionate about adolescent's mental health and all teachers expressed enthusiasm for learning skills to support students with little previous training. Amongst teachers, this seemed to be linked to a high degree of concern about students' mental health, alongside a lack of confidence in providing support. The opportunity to attend training in a protocol-led programme appeared to be well received. This is consistent with studies, for example, Moon et al. (2017) surveyed 786 educators and found that 93% were concerned about student mental health and 85% reported a desire to receive additional mental health training. Secondary school teachers in the UK have expressed helplessness resulting from the perceived inability to help students and report wanting training, without taking on the perceived therapist role (Shelemy et al., 2019).

Buy In

When the approach made sense and felt relevant, the counsellors and teachers perceived ACT to fit with them and they "bought into" the approach. The more they could see the relevancy of ACT, the more participants used the skills in their own lives**.** This is interesting as not only does

practice improve buy in and authentic delivery of the content, but research shows that if therapists are not psychologically flexible, they may be more likely to model the opposite of what they are trying to shape in their clients (Luoma et al., 2007). An experiential understanding of the ACT model may result in greater ACT consistent behaviour in the delivery of the training to others. In turn, self-practice may facilitate better outcomes for students.

Systematic reviews have shown that mindfulness-based interventions are encouraging approaches in improving teacher wellbeing and lowering stress (Emerson et al., 2017; Hwang et al., 2017). Klingbeil and Renshaw (2018) conducted a meta-analysis and found a medium treatment effect, indicating that mindfulness-based interventions are effective in improving mindfulness, wellbeing and distress in teachers. Shapiro et al. (2016) proposed that mindfulness practice for teachers is beneficial for students as it increases teacher attention and acceptance which increases emotional regulation and empathy for others. Teachers that practice mindfulness are in an ideal position to teach mindfulness to students which fosters a mindful learning environment (Shapiro et al., 2016).

Some participants in this study reported encountering challenges with mindfulness. This appeared to relate to a degree of discomfort with mindfulness being unfamiliar or not being a natural fit. Future training for teachers delivering ACT or mindfulness programmes who experience discomfort may benefit from additional support. Luoma and Vilardaga (2013) investigated the effects of additional consultation on psychological flexibility and burnout among therapists learning ACT. The consultations included practising techniques, education about concepts, ACT consistent modelling. Results showed that therapists who had the additional consultation reported higher psychological flexibility at a three-month follow-up.

Practicing Skills

The theme of practice that developed is consistent with previous literature regarding practice for mindfulness practitioners. Mindfulness practice enables teachers to communicate experience during their teaching (Griffith et al., 2019) and fosters a sense of equality between teachers and students as they both have a shared relationship with practice (van Aalderen et al., 2014). A study looking at trainee mindfulness teachers stated that mindfulness teachers are unique because their teaching must be rooted in their own personal mindfulness practice (Bowden et al., 2021). Bowden et al (2021) found that practice was crucial for enabling teachers to support themselves when navigating personal vulnerabilities.

The ACT literature emphasises the importance of psychological practitioners learning ACT experientially, as this helps practitioners to develop their own psychological flexibility and model this to clients (Luoma et al., 2007). Wardley et al. (2014) interviewed psychological practitioners following workplace ACT training. Participants were appreciative of the direct experiences of using ACT within the training which they could apply to their private and professional lives. Participants highlighted their dual role; as a participant learning about ACT for their personal experiences and as a practitioner with the intention of delivering ACT to clients.

Talking Authentically and Students Engaging

Participants in this study reported that the more they personally used the skills, the more they could talk authentically to students and share personal examples of using the skills. These personal disclosures appeared to interest the students and led to further engagement. Greater teacher self-disclosure relates to increased participation, attention (Webb, 2014), engagement and motivation in students (Cayanus & Martin, 2016). Increased student engagement led the counsellors and teachers to believe more in the relevance of the approach which encouraged them

to share their new knowledge. Sharing their learning with others and this being received well, then further reinforced ACT seeming like a good fit.

An interesting finding to emerge from this study was the potential benefits of the ACT training for the teachers' and counsellors' own well-being. This is significant as teachers have been found to report higher levels of stress and mental health difficulties compared to people from other professions (Lowry et al., 2022). Research suggests a further increase in stress, anxiety and depression amongst teachers worldwide since covid-19 (Evanoff et al., 2020).

Several studies have found that ACT improves psychological well-being in the workplace (Finnes et al., 2017; Rudaz et al., 2017). Waitlist controlled trials have found workplace ACT programmes reduce psychological distress and work-related burnout (Puolakanaho et al., 2020; Waters et al., 2018). Elahifar et al. (2019) found ACT significantly increased happiness, life satisfaction, positive mood, health efficacy and self-esteem in female teachers. Gillard et al. (2020) carried out an ACT intervention with teachers and found moderate to large effect sizes for improvements in psychological well-being, job burnout, and valued action.

The potential benefits of the InTER-ACT training for teachers' own wellbeing may be worth researching further. Of interest, within the fidelity sub-study of the InTERACT trial, a statistically significant increase in psychological flexibility was found for facilitators when comparing pre-training scores to six weeks after the final workshop (Roberts, 2021). Given the strong association of psychological flexibility with wellbeing (Hayes et al., 2006), this finding suggests there may be measurable personal psychological changes for those taking part in student mental health training such as InTER-ACT, consistent with the qualitative accounts within this study.

Vulnerability

The central dilemma within the engagement model highlighted the challenge for staff and students to be willing to be vulnerable. ACT encourages people to be vulnerable and engaging in mindfulness can be seen to involve openness and curiosity (Hayes et al., 2004). Some participants described vulnerability in relation to personal disclosures with students and being genuinely open about their experiences. Others talked about the vulnerability in facilitating experiential exercises or using mindfulness with students. One participant talked about ACT being uncomfortable initially, but stressed the need to embrace these unsettling feelings.

Strengths and Limitations

The strengths of this paper include the in-depth exploration of the experiences of counsellors and teachers delivering a universal ACT-based programme to students. Qualitative research is beneficial for learning about the '*hows'* and '*whys'* of intervention implementation. This study provides a unique contribution to the evidence base as there is a lack of qualitative studies investigating ACT interventions and this is the first qualitative study looking at the processes underlying the delivery of a universal ACT intervention in a school setting. These findings will help to shape and expand the InTER-ACT facilitator training and future delivery of the workshops. Communication of the findings from this study to the InTER-ACT developers has already informed adaptations to training delivered to counsellors working for a large children's mental health charity.

Research shows that there are high stress levels amongst teachers (Von der Embse et al., 2016) and this has increased since covid-19 (Ozamiz-Etxebarria et al., 2021). Teachers are required to deliver mental health programmes as part of the school curriculum (Scottish Government, 2020; Welsh Government, 2021), however there are few evidenced based mental health programmes accessible to teachers. This study has helped to provide valuable implementation data on a newly developed universal ACT intervention suitable for classroom delivery. Initial findings suggest that,

the process of learning ACT skills for delivering this programme may result in benefits for the school staff themselves in managing personal stresses, which may in turn incur further additional benefits for their students. Research by the Centre for Economic Performance (CEP) found that teachers' mental health was significantly associated with an increase in student's grades and wellbeing (Fleche, 2017).

A methodological strength of this study was that follow up interviews were conducted with counsellors and teachers six months after the workshops were conducted, which enabled theory to emerge and then to be checked and evaluated by returning to the field and collecting more data to test initial ideas (Charmaz, 2006).

A possible limitation is the opportunist sampling and the self-selection of participants which might have led to counsellors and teachers who were already passionate about students' mental health agreeing to take part in the trial, and subsequently, those positive about the intervention, to take part in interviews. This may have influenced the findings, for example, resulting in the majority of participants describing the ACT approach to be a good fit. Three counsellors involved in the interviews had had some previous foundational ACT training. They may have agreed to do the interviews as they felt ACT already fit with them. Participants that attended the training and delivered the workshops, but did not volunteer to be interviewed may have had differing opinions about using ACT.

A final potential limitation is that most teachers described having had little mental health training. This may have meant it was difficult for them to ascertain when they were using ACT skills and when they were using general therapeutic skills. For example, one participant talked about using ACT when listening to students so they could understand their difficulties, however this may be understood as a generic therapeutic skill. A more structured interview approach could have

helped to delineate views regarding specific ACT skills, although this may have limited some of the more in-depth reflections elicited.

Implications for Future Research

Teachers play a significant role in implementing mental health interventions universally in schools and many school-based programmes have been produced to be delivered by teachers rather than mental health professionals (Dray et al., 2017). A review of teacher involvement in mental health interventions by Franklin et al. (2012) found that 40.8% of school-based interventions involved teachers in the delivery and up to 18.4% of interventions were delivered by teachers alone. However, teachers may lack knowledge in mental health difficulties and may not have sufficient training to deliver mental health interventions (Frey et al., 2011). Schoenwald et al. (2004) found an association between highly trained supervisors, therapist programme adherence, and better adolescent outcomes. In the InTER-ACT trial, facilitators could attend a question-and-answer session following training, but did not receive ongoing supervision. Further research could investigate how ongoing attuned supervision between the workshops may impact on facilitators confidence and fidelity to the InTER-ACT programme.

Supervision or reflective practice could help support facilitators to develop openness to uncomfortable emotions so there is less discomfort with the vulnerability required in facilitating the workshops. Supervision with an ACT practitioner would facilitate practicing of the workshop skills, which could enhance authentic delivery of the content. Supervision could help facilitators to notice and defuse from possible worries such as ‘mindfulness isn’t for me’ and helping to develop openness and curiosity in relation to feelings of anxiety or doubt. Potentially, such supervision could be targeted at facilitators scoring lower on psychological flexibility pre-training.

Further research could investigate whether psychological flexibility of the teachers and counsellors was associated with: i) the extent to which they perceived a 'fit' with the InTER-ACT approach; ii) self-practice after the training; iii) subsequent fidelity to ACT, and iv) student outcomes. Finally, a qualitative study in which students reflect on their programme experiences may enable a better understanding of their process of engagement and the differential influence of facilitator related qualities and behaviours.

It can be challenging to fully capture the effectiveness of brief universal school interventions that are aimed at preventing mental health difficulties as a large proportion of young people do not reach clinical threshold for a mental health disorder. Therefore, outcome measures need to assess the impact of developing coping skills and acquiring mental health knowledge rather than clinical outcomes. Alongside these factors, outcome measures should assess wellbeing by measuring quality of life, life satisfaction, resilience, self-esteem, self-confidence and also school behaviour by measuring their attitude towards school, school grades and school attendance (Weare and Nind, 2011). The school environment and ethos could be measured, for example by using the School Engagement Scale (Arthur et al., 2002) before and after a preventative intervention to assess whether there are changes to the wider environment and school culture and whether this in turn has a positive impact on young people's wellbeing (Wignall et al., 2022) Semi-structured interviews, with young people, staff, and parents could also be used to explore the above in more depth (Wignall et al., 2022).

Implications for Clinical Practice

Due to self-sampling, all participants had an interest in adolescents' mental health and most participants expressed an enthusiasm for learning skills to help manage student's mental health difficulties. If the training is rolled out further, it is possible that enthusiasm for the programme

would not be as consistently high. This may lead to lower levels of 'buy-in' and possibly lower rates of self-practice and engagement with the process. Gillard et al. (2020) delivered an ACT programme to teachers, they were informed that the programme would involve mindfulness. Researchers ensured that the teachers had expressed interest and had given informed consent to take part.

At future training for school professionals, the alternative InTER-ACT facilitation tree model could be used to facilitate optimal learning through pre-emptive discussion of factors which may help with engagement in the programme. This model is likely to help teachers and counsellors buy in to ACT as it is based on experiences of their peers.

The following recommendations for future training would be valuable to consider:

- Continue to allow facilitators to choose which of the pre-divided sections they facilitate. This allows those that are not as comfortable teaching mindfulness to choose not to deliver that section.

- Future training could explicitly highlight the necessity to personally practice the skills. Peer supervision groups may be useful for encouraging regular practice and peer reflection.

- Facilitators that do not have a mental health background could be offered an additional training day in psychological flexibility or further support to develop skills within supervision.

- During training it may be beneficial to name the importance of vulnerability and explicitly talk about which sections facilitators would feel most comfortable delivering.

- Presenting the benefits of self-disclosure may be beneficial for teachers for whom sharing personal thoughts and emotions feels unnatural due to it being at odds with their position of authority.

- Having a peer expert by experience (has attended previous training and delivered the workshops) to mentor new facilitators or to speak at the training, may help new facilitators to 'buy into' the approach, and provide support regarding any challenges in programme delivery.

Conclusion

This study explored the process of counsellors and teachers learning a brief ACT-based universal mental health intervention in secondary schools. The grounded theory analysis resulted in a model of engagement which consisted of eight phases within a context of willingness to show vulnerability. The InTER-ACT programme was well received by staff who found the content had 'good fit' which resulted in self-practice and being able to talk authentically about the ACT skills. This engendered good engagement from students, which furthered their belief in the approach. This study provides unique insight into the subtle processes underlying successful implementation of a universal ACT programme. These processes further the understanding of how facilitators are able to impact the engagement of young people and the importance of vulnerability in facilitators and within the classroom. Further research is needed with a broader sample to further assess these phases and to understand how staff negotiate the process of learning and implementing the training, when the ACT-based intervention is not felt to have such good 'fit'.

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Appendices

Appendix A: Author Guidelines for Pastoral Care in Education

Instructions for authors

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Contents

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Please note that this journal only publishes manuscripts in English.

Pastoral Care in Education accepts the following types of article: original articles and shorter comment pieces of 2-3,000 words e.g. reviews of practice innovations, comments on policy and/or any emerging issues in the socio-cultural world that explore the impact on the field of pastoral care in educational settings.

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Should you have any queries, please visit our Author Services website or contact us here.

Updated 15-11-2021

Appendix B: Search terms

(universal OR "school based" OR "class-room based" OR "classroom based" OR "whole school" OR "school wide") AND ("mental health" OR "psycho education" OR psychoeducation OR "behaviour* therap*" OR "behavior* therap*" OR "mindfulness based cognitive therap*" OR “acceptance and commitment therap” OR "art therap*" OR counsel* OR "family therap*" OR "mental hygiene") AND (program* OR intervention* OR promotion OR implementation OR policy OR "planned action" OR course*) AND (teacher* OR "teaching assistant*" OR "school staff")

Appendix C: TiDier checklist

TiDier item	Britton et al. (2014)	Calear et al. (2016)	Halliday et al. (2020)	Huppert and Johnson (2010)	Lombas et al. (2019)	Midford et al. (2017)	Ohira et al. (2019)	Perry et al. (2014)	Wong et al. (2014)	Total by item
1. Name of intervention	268	213	128	267	1645	364	4	1143	90	**100%**
2. Rationale	265	211	128	265	1644	363	2	1144	91	**100%**
3. Materials	268	213	131	-	1645	-	-	1145	91	**50%**
4. Intervention activities	268	213	-	-	1645	-	4	-	-	**34%**
5. Facilitator	268	213	131	266	1645	365	5	1145	91	**100%**
6. Mode of delivery	268	213	131	267	1645	364	5	1145	91	**100%**
7. Setting	266	211	130	266	1645	364	3	1144	91	**100%**
8. Dosage	268	213	132	267	1646	364	5	1145	91	**100%**
9.Planned adaptations	-	-	132	-	-	-	-	-	-	**8%**
10.Modifications	-	-	-	-	-	-	-	-	-	**0%**
11. Planned fidelity checks	269	213	132	-	1645	366	5	1145	91	**92%**
12. Actual fidelity checks	269	-	-	-	-	-	-	-	-	**8%**
Total by paper	**83%**	**75%**	**75%**	**50%**	**75%**	**58%**	**67%**	**67%**	**67%**	

Appendix D: Overview of workshops 1, 2 & 3

Workshop 1: Thoughts are Just Thoughts

Topic	**Key points and Exercises**
Overview of InTER-ACT	Introductions and setting ground rules
Noticing our thoughts	Tuning into own thoughts - Writing down all thoughts passing through mind over 2 minutes
Evolution of negative thoughts	- Animation of 'Worse cas Wally' (threat alert cave dweller) vs 'Laid Back Larry' (nonchalant cave dweller and principle that being alert to danger has helped us to survive - Negative thoughts have helped us to survive - Thoughts are not always helpful or accurate
Controlling our thoughts	Can we control our thoughts? - Don't think about vs only think about exercise - Delete memory exercise Key idea: We cannot turn off or control thoughts
Becoming tangled with thoughts	Exercise – Identifying negative thought - Responding by pushing away vs getting caught up & negative impact of this - Sitting with thought – dropping the struggle
Becoming untangled from thoughts	'I'm noticing I'm having a thought that…' Roleplay demo from facilitators

Workshop 2: Pause, Observe, Describe

Topic	**Key points and Exercises**
Recap from workshop one	Reminder of ground rules and Quiz of workshop one
Responding to difficult feelings	- What we get told about dealing with difficult feelings can be unhelpful ('chill out', 'distract yourself') - Learning another way - Questions to test out if we can control how we feel
Time Travelling Mind	- Mind travelling to past and future - Negative feelings that arise - Learning to be in the here and now can make it easier to cope
Mindful vs Mind Full	Introduction to mindfulness – example comparing person (caught up in thoughts) to dog (present) - Noticing where our mind has travelled to - Bringing attention back
Connecting to the moment	Noticing what is happening within us and around us - 5,4,3,2,1 exercise - Weather analogy – observing our thoughts and feelings coming and going with curiosity

Mindful exercises	Practical exercises - Points of contact mindfulness exercise - Mindful puppy example – watch where our mind has gone and gently bring it back - Pause, Observe, Describe (POD) – facilitator disclosure - POD practice watching emotive video – discussion

Workshop 3: Taking Steps Towards What Matters

Topic	**Key points and Exercises**
Recap last session	Quiz of workshop two
What are values?	Identifying the messages we get vs what the research says is important in life
Our Values	Identifying what is important to us - Discussion in pairs around what makes us feel connected - Identifying what matters to us
Values exercise	- Ranking most importance values exercise - Choosing top 4 values based on what is important to us and how we would like to behave

Moving towards value-based goal	Committing to taking steps towards a value-based goal
Recap	Recap key points from three workshops

Appendix E – Ethical approval

From: psychethics <psychethics@cardiff.ac.uk> **Sent:** 29 September 2020 11:47

To: Victoria Samuel <SamuelV3@cardiff.ac.uk> **Subject:** Ethics Feedback - EC.17.11.14.5006R6A6

Dear Victoria,

The Ethics Committee has considered the amendment to your Staff project proposal: Training School Counsellors & Pastoral Care Staff to Deliver a Brief Non-Targeted ACT Intervention in Schools (InTER-ACT2): Training Satisfaction, Fidelity & Efficacy (EC.17.11.14.5006R6A6).

The amendment has been approved.
Please note that if any changes are made to the above project then you must notify

the Ethics Committee.

Best wishes, Adam Hammond

School of Psychology Research Ethics Committee
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70 Plas y Parc Caerdydd CF10 3AT
Ffôn: +44(0)29 208 70360
E-bost: psychethics@caerdydd.ac.uk
Please note that I do not expect a response to this email outside of your normal working hours
Nid wyf yn disgwyl ymateb i'r ebost hwn y tu allan i'ch oriau gwaith arferol

Appendix F – Recruitment and Participants in the *InTER-ACT* Trial

School counsellors were recruited through a charity providing school counselling in England. School counsellors were required to have a qualification in counselling, or significant experience providing counselling to young people was required. Teachers (working in schools in England and Wales) were recruited opportunistically between September 2019 and July 2020, using personal links of the research team, and via the schools into which the school counsellors worked (see Appendix C and D). Teachers were required to have a qualification in teaching. Consent forms included a separate section regarding taking part in the qualitative study after delivering the intervention (see Appendix E).

Five counsellors and the schools they provided student counselling for agreed to take part. A further six schools were contacted and two of these were able to provide both a teacher and counsellor and agreed to take part in the trial. Therefore, pairings of a counsellor and a teacher from seven schools agreed to take part and undertook the facilitators' training. One school was subsequently unable to carry out the intervention due to Covid-19.

Appendix G: Gatekeeping letter for schools

Address of School [Date]

Dear [school contact],

We are two Trainee Clinical Psychologists on the South Wales Doctoral Programme in Clinical Psychology and we are looking to carry out a study on school-based interventions as part of our university course. We are writing to enquire whether you would be interested in allowing us to involve students from your school with the project. Further details can be found below:

Project title: Training School Counsellors & Teachers/Pastoral Care Staff to Deliver a Brief Non-Targeted ACT Intervention in Schools (INTER-ACT2): Training Satisfaction, Fidelity & Efficacy.

Supervisors: Dr Victoria Samuel (*Senior Research Tutor, South Wales Doctoral Programme in Clinical Psychology,* Cardiff University) and Dr Chloe Constable (*Clinical Psychologist, Children and Young People Service*, 2GETHER NHS Foundation Trust)

Description of project:

Background

It is estimated that 1 in 10 children in the UK have a mental health difficulty. However, only 25% of children and young people with a mental health difficulty have been able to access mental health services. This has led to recommendations that preventative mental health work in schools and evidence-based practice is needed. The project will be evaluating a new type of workshop to improve the well-being of young people and increase their resilience when encountering stressful experiences. The workshop is informed by a new type of Cognitive Behavioural Therapy (CBT), called Acceptance and Commitment Therapy (ACT).

ACT aims to encourage individuals to develop greater flexibility in how they relate to difficult thoughts and feelings so they can focus on working towards what is important to them. Research suggests that ACT is valued by young people and can be helpful in reducing stress and improving

well-being. Earlier research (INTER-ACT1) found these ACT workshops to be more acceptable to young people than a parallel Cognitive Behaviour Therapy (CBT) workshop, as well as feasible to deliver in a school setting. This stage of the study aims to:

- explore whether school counsellors and pastoral care staff can deliver the workshops
- evaluate whether these whole classroom workshops may improve outcomes for the young people attending.

Your Schools Involvement

A counsellor already attached to your school and a member of the teaching or pastoral care team, will deliver these workshops to a class of students in Key Stage 3 (years 7-9) in your school. The teacher or pastoral care staff member identified to co-facilitate these workshops will attend a two-day training course alongside the school counsellor.

Following the training, this pair will be supported by the research team to deliver 3 workshops, allocating lesson slots for delivery over a 5-week period. Our plan would be to compare students attending the ACT workshops with another class of students attending their standard PSHE lessons. This would allow us to make comparisons between both classes. The workshops have been developed by psychologists with specialist training in this area. The workshops do not involve providing students with therapy, they are focused on teaching skills to build resilience based on the ideas of ACT.

Student's Involvement

To evaluate the workshops, we will ask the students in both classes to complete a set of questionnaires at several timepoints (before the first workshop, after the last workshop and at a 6 week follow up). This will be to assess for any changes in wellbeing, psychological flexibility and mental distress.

We will ask students who received the intervention if they would like to take part in short discussions about the intervention, as part of a future project.

Overall, the support that would be required from the school would be:

• Scheduling the workshops within the school curriculum

Key Stage 3 (years 7-9)

• Allowing us to contact all parents/carers of students to inform them about the project and seek opt-out consent for completion of the questionnaires

Regards,
Aless Roberts and Laura Knight

• Facilitating the researchers to collect data as outlined above.

I would be grateful if you could let us know whether the workshops are something that might be of interest to your school. We are happy to answer any questions you may have, and our contact details can be found below. Many thanks in advance for your consideration of this project.

Aless Roberts
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CF10 3AT

Laura Knight
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Dr Victoria Samuel
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Dr Chloe Constable
Clinical Psychologist
Chloe.constable@nhs.net
CAMHS, 2gether NHS Foundation Trust, England

Appendix H: Information sheet for school counsellors and teachers/pastoral care staff Study name: *Training School Counsellors & Teachers/Pastoral Care Staff to Deliver a Brief Non-*

Targeted ACT Intervention in Schools (InTER-ACT2): Training Satisfaction, Fidelity & Efficacy.

Introduction

You are being invited to take part in a research study to help us learn more about whether it is possible to train school counsellors and teachers/pastoral care staff to provide short workshops for secondary school students to help them manage stress and build resilience.

Before agreeing to take part, it is important that you read the information and make your own decision about whether you would like to be involved or not.

Please ask us if you have any questions or would like further information.

The researchers

The research project is being carried out by two Trainee Clinical Psychologists (Laura Knight and Aless Roberts) on the South Wales Doctoral Programme in Clinical Psychology. The research is being undertaken as part of the university course. The project is being supervised by Dr Victoria Samuel (Senior Research Tutor, South Wales Doctoral Programme in Clinical Psychology) and Dr Chloe Constable (*Clinical Psychologist, Children and Young People Service*, 2GETHER NHS Foundation Trust).

What is the research project about?

The aim of the research project is to find out whether it is possible to train school counsellors and teachers/pastoral care staff to deliver short workshops to secondary school students to help them learn ways to manage stress and build resilience. These groups will be based on the principles of Acceptance and Commitment Therapy (ACT). ACT helps people to change how they relate to difficult thoughts and emotions and helps them to take action to live life in line with their values. This is a widely used approach which has been shown to be effective in treating a wide range of mental health problems across age groups, including young people.

Why are you doing the research project?

Research tells us that a significant percentage of secondary school students experience mental health difficulties and can feel stressed at times. We are interested in knowing more about whether teaching young people ACT skills might be a way to help them feel less stressed and be more able to cope. School counsellors, teachers and pastoral care staff have been identified as suitable to deliver the workshops due to their skill sets in working within the classroom and supporting students around wellbeing.

What will I be doing if I decide to take part?

This research will involve school counsellors, teachers and pastoral care staff from a range of different schools attending a two-day training program delivered by Clinical Psychologists who developed the ACT workshop and who are experienced in working with children.

These training days will be held on a Friday 18th and Saturday 19th September 2020.

This training program will teach the core principles of ACT as well as practical training on how to deliver the three session workshops to students. All participants will be given detailed workshop protocols and full PowerPoint slides for each workshop. The online training will be video recorded to enable subsequent viewing by other school staff or school counsellors.

Staff receiving the training will be asked to complete questionnaires which look at knowledge before and after the training, satisfaction with the training and levels of a construct called 'psychological flexibility'. Staff will also be asked to complete a brief background information questionnaire prior to completing the training. Lastly, we will also ask you to complete a final questionnaire on psychological flexibility after you have delivered the final workshop.

Each pair (1 school counsellor and 1 teacher or member of the pastoral care team) will then deliver the workshops to one class of Key Stage 3 (years 7-9) students in their schools. Each of these workshops will need to be audio recorded using an encrypted device to enable the researchers to assess how closely the delivery of the workshops is consistent with ACT principles. The pair facilitating the workshops will be responsible for audio recording the workshops, however clear instructions on how to do this will be provided by the research team.

The workshops will be delivered as part of the PSHE curriculum; therefore, the students will attend the workshops as part of their usual timetable. We are planning that the three workshops (each lasting 1 hour), will be delivered within a 5-week period, over October and November 2020.

Prior to delivering the workshops, each school staff member will be asked to provide a list of classes from Key Stage 3 (years 7-9) of their school so that the researchers are able to randomly allocate one class to receive the intervention (the ACT workshops) and one class to receive PSHE lessons as normal. This will allow the researchers to compare the two groups.

Before, during and after the delivery of the three session workshops, the students in both groups will be asked to complete questionnaires on their well-being, quality of life, perceived stress and anxiety and depression. Each school staff member will be asked to support students from both these classes to create a unique identifier, which students will enter when completing their questionnaires. This ensures the researchers are not able to identify pupils by name when scoring their questionnaires. These unique identifiers will be held by the school so that pupils can be identified if their scores show high levels of distress and safeguarding procedures can be followed. The process of how to create the unique identifier will be provided to each school staff member by the researchers during training.

Do I have to take part?

No, it is up to you whether you want to take part or not.

What if I decide to take part but change my mind later on?

To ensure the students receive the full workshop package, we will require a commitment from you to deliver all three workshops in your school. However, if you decide you do not want to continue taking part in the evaluation element of the project you can withdraw at any stage, and you can ask the research team to discard any information gathered from you up to 1 week following the delivery of the last workshop.

How will my information be used?

Consent forms will contain the names of participants and will need to be retained for five years in accordance with Data and Record Management. These will be held securely and separately from the study data. The questionnaires and the background information form you complete before and after the training program will contain your name and your associated school and be stored securely in password protected electronic files/databases or locked filing cabinets at Cardiff University. This information will be made anonymous once analysis has taken place, which will be within 4 months of the final workshop. The anonymised information will be kept for up to 5 years in password protected electronic files/databases or locked filing cabinets at Cardiff University and deleted after this time.

Each workshop will be audio recorded using an encrypted voice recorder. The content of the recordings will be kept confidential (only shared with the research team), unless something is said which makes us think you or somebody else may be at risk. If this situation arises, we will discuss this with you first wherever possible and share our concerns with the headteacher or safeguarding lead. The recordings will be stored securely in password protected electronic files/databases or locked filing cabinets at Cardiff University and deleted immediately after analysis is completed which will be within 4 months of the final workshop.

The research project is being completed as part of a Doctorate of Clinical Psychology (university course for postgraduate students). The information will be used in a written report (which may later be used for teaching/training or published for wider audiences to read), but it will not be possible to identify which students or staff members took part or link any person to the information they have shared with us.

The data controller is Cardiff University and the Data Protection Officer is Matt Cooper CooperM1@cardiff.ac.uk. The lawful basis for the processing of the data you provide is consent**.**

What can I do if I have concerns about the research project?

You can speak directly to a member of the research team, and they can be contacted using the contact information below. Alternatively, you can contact the Director of the Doctoral Programme in Clinical Psychology. Address: 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT. Telephone: 02920 870582

Who has reviewed the study?

The research project has been approved by Cardiff University School of Psychology ethics committee. They have reviewed the study to ensure we are running it in a way which protects your rights and your safety.

If you have any questions relating to ethical issues and how this study is reviewed to ensure the well-being of the individuals who participate, please contact the Cardiff University School of Psychology Ethics Committee:
School of Psychology Research Ethics Committee

Email: psychethics@cardiff.ac.uk Tel: 029 20870360

Are there any risks or disadvantages to taking part?

We anticipate there to be minimal risks to taking part in the project. The nature of the workshops means that we might be asking you to consider student mental health and well-being. It is possible this may be upsetting, and we would encourage you to talk to somebody from the research team if this is the case.

Additionally, it is possible that learning a new way of relating to emotional experiences and considering your own emotions during the training program may potentially be difficult, however this is felt to be very low risk. In order to address this potential issue, all staff receiving the training package will be fully debriefed and provided with information about where to seek support should they be in any distress.

What are the benefits of taking part?

We are hoping to use the information gathered in this research project to evaluate whether this type of intervention is feasible and practical for delivery in schools. We hope you will be pleased to know that your involvement helps us to continue to develop interventions to help support the emotional wellbeing of young people.

Contact details

Aless Roberts
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Dr Victoria Samuel Senior Research Tutor
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70 Park Place
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CF10 3AT

Dr Chloe Constable Clinical Psychologist
Chloe.constable@nhs.net

CAMHS,
2gether NHS Foundation Trust, England

Appendix I: Consent form for school counsellors and pastoral care staff (electronic)

School of Psychology, Cardiff University Consent Form - Confidential data

[ ] I have read the information sheet and have had the opportunity to ask questions.

[ ] I understand that participation in this study is entirely voluntary and that I can withdraw from the study at any time without giving a reason. I am also free to ask any questions or discuss my concerns with Dr Victoria Samuel (project supervisor).

[ ] I understand that the information I provide will be held confidentially, such that only the research team can trace this information back to me individually.

[ ] I understand that the information I provide will be retained for up to five years when it will be deleted/destroyed. I understand that I can ask for the information I provide to be deleted/destroyed up to 1 week after the delivery of the last workshop and I can have access to the information at any time.

[ ] I understand that the anonymised data I provide will be submitted as part of a doctoral thesis and for publication in a peer reviewed journal. I understand that the anonymised data may also be used for teaching or training purposes.

[ ] I understand that the online training I attend will be video recorded to enable subsequent viewing by other school staff or school counsellors.

[ ] I understand that I will be required to audio record the workshops I deliver using a secure encrypted device.

Please check the box below if you happy to be contacted about being involved in further research that follows on from this project. This would involve taking part in interviews / a focus group at a later stage, focusing on your experience of learning ACT and implementing the training with young people.

☐

The data controller is Cardiff University and the Data Protection Officer is Matt Cooper CooperM1@cardiff.ac.uk. The lawful basis for the processing of the data you provide is consent**.**

I, _____(NAME) consent to participate in the study conducted by Laura Knight and Aless Roberts, School of Psychology, Cardiff University with the supervision of Dr Victoria Samuel.

Signed: Date:

Appendix J: Information sheet for school counsellors and pastoral care staff

Study name: Brief ACT training for school staff: a qualitative evaluation of experiences in delivering a resilience-based intervention to children in secondary schools

Introduction
You are being invited to take part in a research study to help us to learn more about the experiences you have had as school counsellors and pastoral care staff following on from the brief ACT training you have received and the workshops you then delivered to students.
Before agreeing to take part, it is important that you read this information and make your own decision about whether you would like to be involved or not.

Please ask us if you have any questions or would like further information.

The researchers
The research project is being carried out by Sarah Murphy (Trainee Clinical Psychologist) who is on the South Wales Doctoral Programme in Clinical Psychology. The research is being undertaken as part of the university course. The project is being supervised by Dr Victoria Samuel (Senior Research Tutor, South Wales Doctoral Programme in Clinical Psychology) and Dr Chloe Constable (*Clinical Psychologist, Children and Young People Service*, 2GETHER NHS Foundation Trust).

What is the research project about?
The aim of the research project is to explore the experiences that school counsellors and pastoral staff have had following on from ACT training. Through interviews we hope to find out how you found learning the ACT concepts and then delivering the intervention in schools.

Why are you doing the research project?
We are interested in knowing more about what it was like to receive the brief ACT training and how you then applied these newly learnt concepts in order to deliver an intervention for students. We are keen to better understand what facilitates or inhibits learning these psychological ideas and what impact they may have on different areas of your life. This information will help to shape psychological interventions for children and how these interventions are delivered in the future.

What will I be doing if I decide to take part?
This research will involve taking part in an interview, this interview will either be over the phone/video call or face to face. These interviews will be conducted by the Trainee Clinical Psychologist and will roughly last an hour.

Do I have to take part?
No, it is up to you whether you want to take part or not.

What if I decide to take part but change my mind later on?
If you decide you no longer with to take part in the interview having agreed to do so or change your mind during the interview, you can withdraw from the study and any information gathered from you can be discarded in a secure manner if you would like us to.

How will my information be used?

Consent forms will contain the names of participants and will need to be retained for five years in accordance with Data and Record Management. These will be held securely and separately from the study data.

We will record each interview on an encrypted audio recorder which is protected by a password (which only the research team will know). The content of the recordings will be kept confidential (only shared with the research team), unless something is said which makes us think you or somebody else may be at risk. If this situation arises, we will discuss this with you first wherever possible and share our concerns with the headteacher or safeguarding lead. The recordings will be kept for up to 5 years in password protected electronic files/databases or locked filing cabinets at Cardiff University and deleted after this time. Where transcribers are used, they will have also signed a confidentiality agreement and will store recordings on a password protected computer file which will be deleted immediately after analysis is completed.

The research project is being completed as part of a Doctorate of Clinical Psychology (university course for postgraduate students). The information you provide will contribute to a written report compiled for a thesis submission. This may later be used for teaching/training or published for wider audiences to read. Words you have used in interviews may be included as direct quotations but any identifiable information will be removed and all participants will be given a pseudonym to ensure that it will not be possible to link the data back to that person.

The data controller is Cardiff University and the Data Protection Officer is Matt Cooper CooperM1@cardiff.ac.uk. The lawful basis for the processing of the data you provide is consent**.**

What can I do if I have concerns about the research project?
You can speak directly to a member of the research team, and they can be contacted using the contact information below. Alternatively, you can contact the Director of the Doctoral Programme in Clinical Psychology. Address: 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT. Telephone: 02920 870582

Who has reviewed the study?
The research project has been approved by Cardiff University School of Psychology ethics committee. They have reviewed the study to ensure we are running it in a way which protects your rights and your safety.

If you have any questions relating to ethical issues and how this study is reviewed to ensure the well-being of the individuals who participate, please contact the Cardiff University School of Psychology Ethics Committee:
School of Psychology Research Ethics Committee
Email: psychethics@cardiff.ac.uk
Tel: 029 20870360

Are there any risks or disadvantages to taking part?
We anticipate there to be minimal risks to taking part in the project. The nature of the interview means that we might be asking you to consider your own mental health and wellbeing as well your students'. It is possible that learning a new way of relating to emotional experiences and considering your own emotions during the interview may potentially be difficult, however this is felt to be very low risk. In order to address this potential issue, all staff taking part in interviews will be fully debriefed and provided with information about where to seek support should they be in any distress.

What are the benefits of taking part?
We are hoping to use the information gathered in this research project to understand how you learnt and delivered the ACT concepts to students. This will help us to adapt training and continue to develop interventions to help support the emotional wellbeing of young people.

Contact details
Sarah Murphy
Trainee Clinical Psychologist
murphys12@cardiff.ac.uk
02920 870582
School of Psychology,
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Tower Building,
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CF10 3AT

Dr Victoria Samuel
Senior Research Tutor
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Dr Chloe Constable
Clinical Psychologist
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CAMHS
2gether NHS Foundation Trust, England

Appendix K: Consent form for school counsellors and pastoral care staff (electronic)

School of Psychology, Cardiff University

Consent Form - Confidential data

Please put your initials in the bracketed sections

[ ] I have read the information sheet and have had the opportunity to ask questions.

[ ] I understand that participation in this study is entirely voluntary and that I can withdraw from the study at any time during the interview without giving a reason. I am also free to ask any questions or discuss my concerns with Dr Victoria Samuel (project supervisor).

[ ] I understand that the information provided by me will be held confidentially, such that only the research team can trace this information back to me individually. The information will be retained for up to five years when it will be deleted/destroyed. I understand that I can ask for access to the information at any time.

[ ] I understand that my information will be stored securely in an encrypted format, and the information I provide will be anonymised for use in the study.

[ ] I understand that participation will involve my interview being audio-recorded, with possible use of my words being used as anonymised quotations in the research report.

[ ] Where a transcriber is used, they will have signed a confidentiality agreement.

[ ] Audio recordings will be stored in a secure encrypted format and will be deleted as soon as the transcribing has taken place. This will be within 1 month of the interviews taking place.

[ ] I understand that the anonymised data I provide will be submitted as part of a doctoral thesis and for publication in a peer reviewed journal. I understand that the anonymised data may also be used for teaching or training purposes.

The data controller is Cardiff University and the Data Protection Officer is Matt Cooper CooperM1@cardiff.ac.uk. The lawful basis for the processing of the data you provide is consent**.**

I, _____(NAME) consent to participate in the study conducted by Sarah Murphy, School of Psychology, Cardiff University with the supervision of Dr Victoria Samuel.

Signed:

Date:

Appendix L: Debrief following interviews with school staff

Study: Brief ACT training for school staff: a qualitative evaluation of experiences in delivering a resilience-based intervention to children in secondary schools

Thank you
Thank you for participating in this research study. The information you have provided will help us to better understand how participants have learnt and applied ACT following the brief workshops. We will use this information to develop future training and interventions to help young people to decrease stress and build resilience. We appreciate the time you have given to the research project.

What was this study about and what happens next?
This study aimed to increase understanding of the participants' experiences of learning and delivering the ACT intervention and to explore what specifically facilitates and inhibits the learning of the ACT concepts following brief training workshops. We were keen to learn more about how staff were able to apply and integrate the ACT concepts, if they were able to use it in other areas of their life and whether their views of the psychological intervention changed over time.
The next stage of the project will involve analysis of the transcribed interviews in order to identify key concepts and themes. The data analysis approach used will be Grounded Theory, this is a meticulous analysis approach for evaluating qualitative data which involves initial analysis at a line by line level moving to identify common higher- level processes across different interviews. A theory will then be developed which explains how participants integrate the learning of ACT concepts and approach the process of delivering the training. The project will be written up and submitted as part of a doctoral thesis.

We are very happy to share a summary of the main findings once this is complete, if you would like a copy please complete the attached form with your preferred contact details. This will be stored separately from your interview data.

Contact details
If you would like any further information or have any questions, please contact us using the information below:

Sarah Murphy	Dr Victoria Samuel	Dr Chloe Constable
Trainee Clinical Psychologist	Senior Research Tutor	Clinical Psychologist
murphys12@cardiff.ac.uk 02920 870582	SamuelV3@cardiff.ac.uk 02920 870582	Chloe.constable@nhs.net
School of Psychology, Cardiff University Tower Building, 70 Park Place Cardiff CF10 3AT	School of Psychology, Cardiff University Tower Building, 70 Park Place Cardiff CF10 3AT	CAMHS, 2gether NHS Foundation Trust, England

If you have any questions relating to ethical issues and how this study is reviewed to ensure the well-being of the individuals who participated, please contact the Cardiff University School of Psychology Ethics Committee:

School of Psychology Research Ethics Committee
Email: psychethics@cardiff.ac.uk
Tel: 029 20870360

The data controller is Cardiff University and the Data Protection Officer is Matt Cooper CooperM1@cardiff.ac.uk. The lawful basis for the processing of the data you provide is consent**.**

Appendix M: Interview Schedule

Opening questions

1. How long have you been in your role as a school counsellor/working in pastoral care?

2. Could you tell me a bit about what your role involves?

3. How did you come to be involved in the training?

    - Is it an area of interest to you?
    - Was it suggested by your employer?

4. What, if anything, did you know about ACT before the training?

Main questions

5. When you were first introduced to ACT concepts what was that like?
    - Did it make sense to you?
    - Did it fit with other training/learning?

6. Can you tell me about how you found the training overall?
    - Was the training enough/too much/not enough?
    - Did the key concepts make sense to you?
    - To what extent did you feel sufficiently prepared to deliver the intervention?

7. After the training did you do anything further to help you understand the concepts?
    - Did you communicate with your buddy?
    - Did you do any further reading?
    - Did you share your learning with other people?
    - Did you contact the facilitators?

8. What was it like going from initially learning the concepts to delivering them in an intervention?
    - What was it like delivering the intervention?
    - Counsellors – delivering to a classroom – did you know the students?
    - Teachers – being in a more vulnerable role
    - Working with your buddy
    - Did your role in the delivery differ from your buddy?
    - Working within school system
    - Covering the content – explaining concepts
    - Answering questions
    - Resources

9. After having delivered the workshops did anything about your understanding/attitude towards the ACT principles change?
    - Relevance, accessibility for young people
    - Did you change anything in terms of the delivery over the course of the three workshops?
    - Is there anything you would change if you were to deliver this again?

10. How, if it all, have you applied the ACT concepts with young people outside of the workshops?
    - do you intend to use the concepts in the future?

11. How did you feel the concepts of ACT fitted with you personally?
    - personality
    - upbringing
    - beliefs

12. Since the training, how if at all, have you applied and used the ACT concepts in your own personal life?
    - belief/actions
    - ways of coping with day to day challenges
    - do you intend to use the concepts in the future?

13. How do you feel ACT fits with your role within the school/s that you work in?
    - Do you feel it's a good fit?
    - Has it affected the nature of your work?
    - Has it made a difference to how you see/deliver your role?

14. Is there anything about your professional training or your working environment/culture which has helped or hindered you in applying these concepts?
    - ethos of the school
    - ethos of the counselling organisation/charity
    - ethos of counselling/teacher training
    - support of management
    - resources
    - timetables

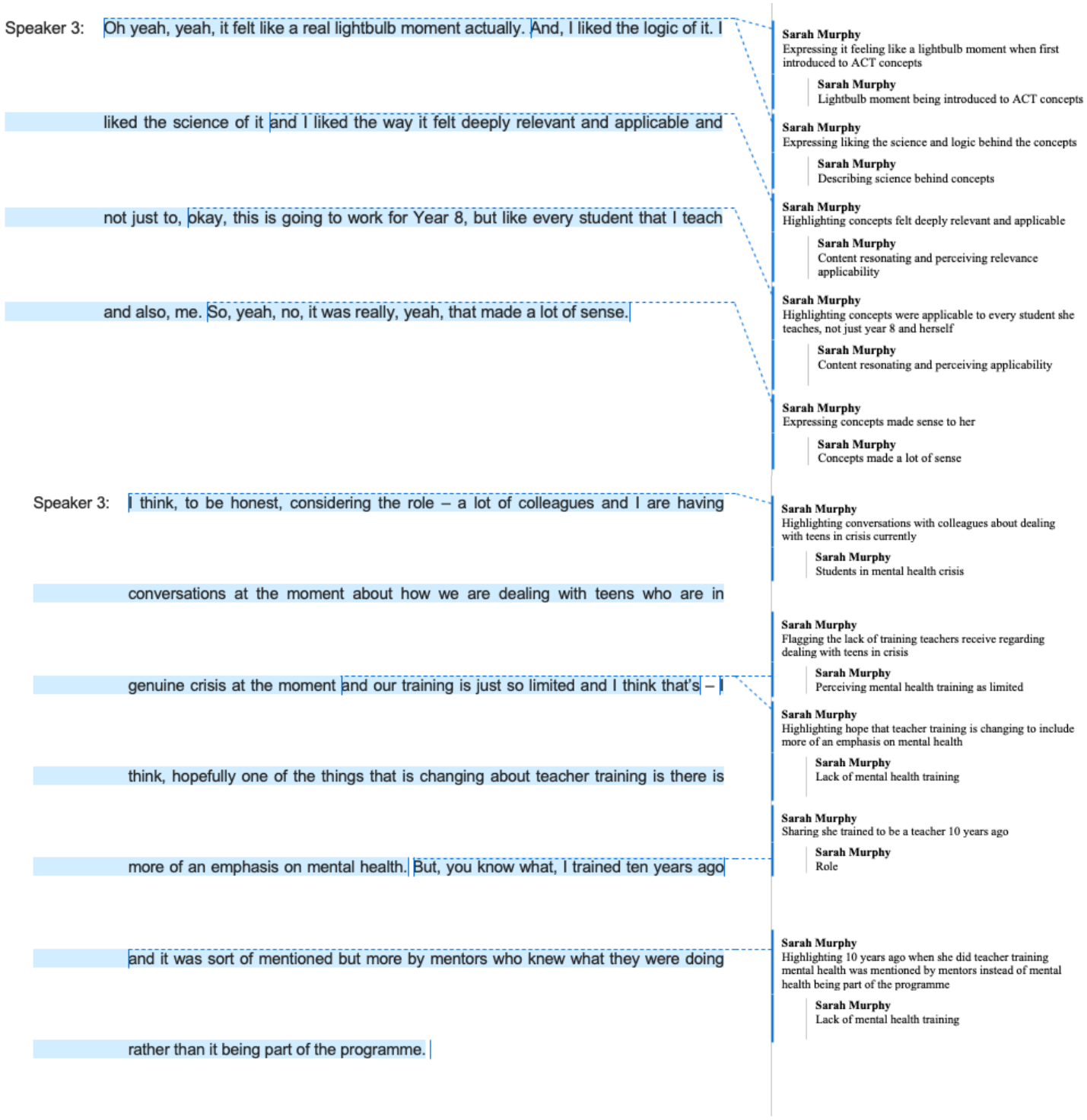
15. Could I ask you to describe the most important things you learned through this experience of delivering these ACT workshops?

Ending questions

16. Based on your experience, what advice would you give to someone who plans to learn these concepts and deliver this intervention?

17. We're coming to the end of the interview now and I'm wondering whether there is anything else you think I should know to understand your experiences a bit better? Is there anything you would like to ask me?

Appendix N: Example of initial and focused coding of transcript



Appendix O: Examples of memos

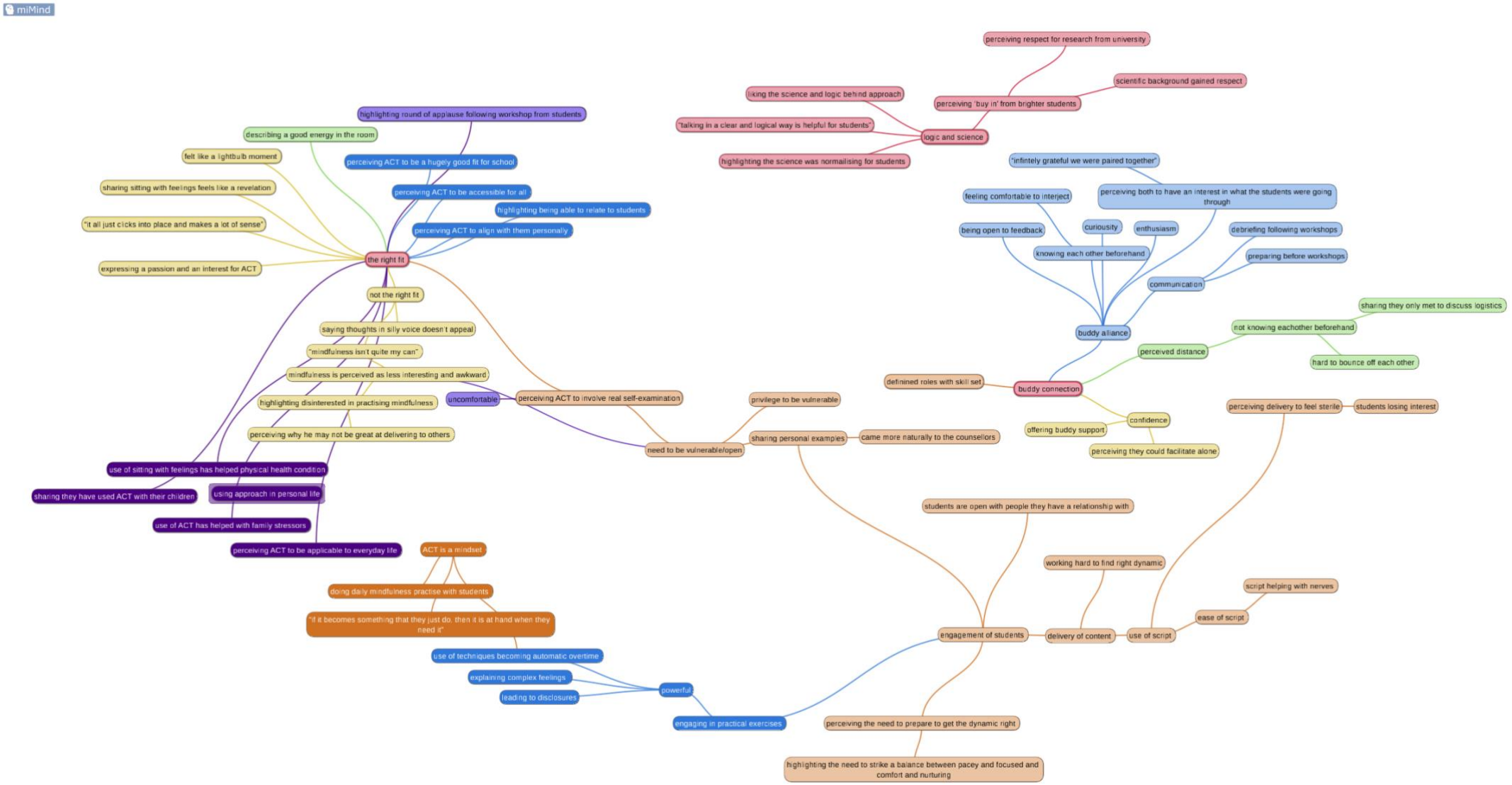
Memo 16th December: Participant talked about seeing the value in facilitators being enthusiastic, curious and open to their own feelings and what others might think. Perceived the more curious you can be the more you will benefit from using an ACT approach.

Memo 12th December 2020: Participant almost seemed surprised she had not discovered ACT before as it made so much sense to her and fitted in with the way she thinks. Talked about personal work she had done and how many concepts felt familiar or were similar to other strategies she had tried.

Memo 9th December 2020: Participant made comparisons between themselves and other family members who were not as psychologically flexible and talked about the impact this had on their behaviour and emotions.

Appendix P: Mind map 1 (created August 2021) – pulling together focused codes from data

Appendix Q: Mind map 6 (created October 2021) – pulling together focused codes from data



Appendix R: *InTER-ACT* facilitation tree