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Developing the content of a brief universal acceptance and commitment therapy (ACT) programme for secondary school pupils: InTER-ACT

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ABSTRACT

Mental health difficulties often start in childhood and the number of young people experiencing mental health difficulties [are] is rising, particularly since the Covid-19 pandemic. School-based programmes have been identified as an effective way to provide support for young people and present an opportunity to offer universal programmes, which can increase equity of access, facilitate resilience and reduce stigma. Whilst there is an emerging evidence of the benefits of preventive mental health programmes delivered in schools, there is a need for more robust evidence and methodological rigour in the development and descriptions of these programmes.

Acceptance and Commitment Therapy (ACT) is one approach that may be appropriate as a framework for preventing and reducing mental health difficulties in schools. This paper describes the content development of a UK-based universal school programme using ACT: the In-school Training in Emotional Resilience (InTER-ACT) programme. It describes the steps taken across the stages of content development, from planning the programme, delivering the programme in a school, receiving feedback and integrating the subsequent revisions. The final version of the programme, including summaries of session content, is provided.

Consistent with an ACT ethos, the personal values of the researchers, and the influence of these on the programme are discussed, providing a novel integration of methodical detail and authentic, reflective practice. This article provides a transparent and detailed overview of the iterative processes involved in developing the content of an evidence-based pastoral care programme in a way that is systematic, rigorous and responsive to teacher and pupil feedback.

Introduction

It is common for difficulties with mood and emotion regulation to commence in childhood: for 50% of adults with mental health difficulties, the onset of symptoms was prior to age 15 (Kessler et al., 2007) with the median age of onset of

anxiety and mood disorders estimated to be 6 years and 13 years old, respectively (Merikangas et al., 2010). Between 10% and 22% of children and adolescents experience a mental health difficulty (Costello et al., 2005; Green et al., 2005; Merikangas et al., 2010), and the rate of mental distress for young people appears to be increasing, an increase that appears to be exacerbated by the Covid-19 pandemic. For example, in a follow-up survey conducted in the UK in 2020, one in six (16%) of children aged 5–16 years were identified as having a probable mental health difficulty, compared with one in nine (10.8%) in 2017 (Vizard et al., 2020).

Demand for mental health support has seen a parallel increase. Between 2013 and 2018, referrals to NHS Child and Adolescent Mental Health Services (CAMHS) increased by 26%, but as many as 24% of children referred to CAMHS did not receive any input; estimated to equate to approximately 55,800 children who were referred for support, but declined access to any intervention in 2017 to 2018 (Crenna-Jennings and Hutchinson (2018)). Even when referrals are accepted, waiting lists can be long, with one in five children waiting more than six months to be seen by a specialist mental health service (NHS Digital, 2018).

If young people do not receive support for mental health difficulties, difficulties are likely to persist (Costello, Mustillo, Erkanli, Keeler & Angold, 2003), leading to poorer outcomes as adults, such as difficulties with interpersonal functioning, poorer physical health and lower income (Comer et al., 2011; Copeland et al., 2014).

Benefits of a universal non-targeted intervention in schools

With reductions in emotional support available to young people, responsibility for student well-being is increasingly falling to schools, with 90% of costs related to child and adolescent mental health estimated to be incurred by the education sector (Knapp et al., 2016). Children themselves report that when seeking support for mental health concerns from a professional, they are most likely to approach a teacher (NHS Digital, 2018).

Schools have been identified as an ideal environment to deliver mental health programmes for young people outside of healthcare settings. Pragmatically, schools are where young people spend a large proportion of their time and as such can potentially mitigate negative impacts of other social factors (O'Reilly et al., 2018). Schools have also been identified as cost-effective and flexible places for delivering interventions (Marks, 2012) and school-based programmes can remove obstacles that may prohibit engagement with external services, such as travel, time and cost (Barrett & Pahl, 2006). There is also an educational rationale for well-being interventions in schools as lower emotional well-being has been found to predict poor academic achievement (Agnafors et al., 2021).

Universal, school-based programmes, which provide non-targeted interventions to prevent mental health difficulties might be particularly advantageous; by including all students, they may facilitate resilience and prevent mental health difficulties from occurring (Cuijpers et al., 2008), reducing the number of young people subsequently requiring support from services (Donovan & Spence, 2000; Muñoz et al., 2010). In addition, universal interventions can reduce stigma by moving away from the problem-focused narrative of targeted input (Merry et al., 2012). Providing interventions to all students in a class also ensures that students without any mental health difficulties, who may still benefit, are not excluded (Fazel et al., 2014). Finally, universal interventions might be easier to incorporate into school schedules and do not require screening to identify those who will attend.

The Covid-19 pandemic has further highlighted the need for mental health support for children and young people, and how schools have a role in providing this support. A survey completed with young people after they returned to school in September 2020 indicated that 69% of young people described their mental health as 'poor' since returning to school (Young Minds, 2020). Over half of the young people who responded reported they would like lessons about well-being and mental health, and respondents also said they would like universal support, rather than support only being available to those who are deemed to need it most (Young Minds, 2020). Senior members of staff in both primary and secondary schools have also reported that supporting children with their emotional and mental health and well-being has been one of their top priorities since the Covid-19 pandemic (Sharp et al., 2020).

Recent policy and government guidance across the United Kingdom further emphasises the need for mental health and well-being support within schools, stating that whole school approaches should be adopted and that the curriculum should prioritise emotional and mental well-being (Mental Health Foundation Scotland, 2020; Scottish Government, 2020; Welsh Government, 2021). Additional funding for schools to support mental well-being in response to the Covid-19 pandemic has also been provided (Department for Education, 2020a, 2020b; Welsh Government, 2020).

In the last 20 years, many schools have introduced interventions to help prevent anxiety and depression, with results showing promising findings (Calear & Christensen, 2010; Nehmy, 2010; Neil & Christensen, 2007, 2009; Werner-Seidler et al., 2017). A particularly popular theoretical approach for school-based interventions has been mindfulness; an approach for which there is strong evidence of improvements in diverse student outcomes, including resilience, concentration, emotion regulation and academic performance (see Phan et al., 2021, for a review). However, the need for more rigorous designs to minimize bias in further mindfulness-based school intervention research has been noted; this is important for ensuring higher quality evidence to inform school-based practice (Phan et al., 2021). Similarly, more generally, despite

positive emerging evidence, the need for a stronger and broader evidence-base for universal, preventative mental health programmes in schools has been highlighted (O'Reilly et al., 2018).

Suitability of ACT for a non-targeted intervention

Acceptance and Commitment Therapy (ACT) is one approach that may be appropriate as a framework for preventing and reducing mental health difficulties in schools. ACT is a third wave cognitive and behaviour therapy, which aims to increase psychological flexibility, identified as a 'fundamental aspect of health' (Kashdan & Rottenberg, 2010). Psychological flexibility refers to a set of skills for relating to thoughts and feelings, which enable individuals to be fully present whilst persisting or changing behaviour according to the demands of the situation, in line with their personal values (Hayes et al., 2006).

Psychological flexibility involves six related processes: 1) acceptance of thoughts and feelings as they arise, without attempts to change or suppress them; 2) defusion (recognising that thoughts are just thoughts); 3) present moment awareness (mindfulness); 4) self-as-context (a transcendent sense of self, which is able to notice thoughts and feelings from an observational perspective); 5) valued living (recognising the personal qualities one wishes to bring to actions) and 6) committed action (taking actions consistent with these personal values).

ACT is a transdiagnostic approach and emphasises core principles to help alleviate psychological distress, making it appropriate for individuals both with and without a mental health difficulty (Hayes et al., 2013, 2011). Although the primary aim of ACT is not specifically to reduce mental health symptoms, it has been found to reduce symptoms of mental distress as a secondary gain (Hayes et al., 2006).

The evidence for ACT improving well-being amongst adults is extensive; a recent review of twenty meta-analyses showed that ACT was an effective treatment for all conditions studied, including anxiety, depression and transdiagnostic groups (Gloster et al. (2020). Evidence for ACT for young people is less developed, but increasing. A recent meta-analysis of the efficacy of ACT for children found that ACT was more effective than treatment as usual or no treatment, for anxiety, depression and other mental and behavioural difficulties (Fang & Ding, 2020a). Although ACT was not found to bring about superior outcomes to Cognitive Behavioural Therapy (CBT), ACT may be advantageous in some ways to this approach, particularly in the context of a non-targeted intervention, due to its unique focus on encouraging positive value-based actions, rather than purely symptom reduction, which may therefore lead to 'broader substantive changes in psychological functioning' (Fang & Ding, 2020a, p. 226). The focus within ACT on clarification of personal values, with the aim of creating a rich, satisfying and meaningful life, is also inherently empowering for

young people, representing a refreshing departure from dominant educational (and broader societal), narratives privileging achievement and the competitive pursuit of goals and targets.

The use of ACT in school settings

ACT might be particularly suitable as an approach to underpin a universal, resilience-focused intervention in schools due to its focus on improving quality of life, along with its transdiagnostic ethos. An ACT intervention delivered within schools in a non-targeted format significantly broadens its reach, 'shift[ing] ACT work from primarily clinic-based (small-group or individual) delivery format into a universally accessible life-skills curriculum within a context that all, or the vast majority of children, can access' (Gillard et al., 2018, p. 278)

Moreover, when delivered to whole classes of students, the universal group context may be inherently beneficial; by enabling young people with diverse experiences to engage in experiential exercises together, core ACT principles, such as common humanity and universality of emotional distress, can be naturalistically conveyed. This also helps to avoid any implications that young people are responsible for struggles with their mental health; rather the problem is seen as follows: i) having a mind that can be inherently tricky to manage at times, and ii) receiving unhelpful and inaccurate messages from society about what makes people happy (and indeed, that the pursuit of happiness is a valid goal) (Harris, 2008).

A number of articles describing ACT interventions in schools have been published in the last 6 years, most reporting favourable findings for young people, although methodological limitations and variance in application limit conclusions regarding how ACT is best used in schools. The majority of school-based ACT interventions have taken place in Australia (Burckhardt et al., 2016, 2017; Livheim et al., 2015) the USA (Murrell et al., 2015) and some European countries such as Belgium (Van der Gucht et al., 2017), Sweden (Livheim et al., 2015) and Finland (Puolakanaho et al., 2019). More recently, Fang and Ding (2020b) and Takahashi et al. (2020) have described ACT interventions in schools in China and Japan, respectively. No studies have, however, been reported on the use of ACT in secondary schools in the UK and there is a lack of reported implementation details regarding the development of workshop content and structure.

We sought to develop a UK-based universal school programme using ACT, which was both acceptable and feasible to deliver in the school environment and to clearly document each stage of the programme development in order to inform evidence-based practice.

The in-school training in emotional resilience (InTER-ACT) programme

We aimed to develop a universal, evidence-based ACT programme for use in UK schools. In this paper, we focus on the iterative processes involved in the development of the programme content. This involved two primary stages as outlined below.

Stage 1

(i) To develop a universal in-school ACT programme, with a focus on brevity (to increase uptake and minimise disruption to school timetables).
(ii) To assess the acceptability and feasibility of delivering this programme with a universal population of students from a UK secondary school.

Stage 2

(i) To refine and revise the programme content in light of feedback from young people, teachers and programme facilitators.
(ii) To train dyads of school counsellors and teachers to deliver the revised programme in order to increase the reach of the programme.

Within this paper, we seek to answer the following questions:

(1) How do you translate a therapeutic approach into a format that is accessible and engaging as a brief and universal programme within a classroom setting?
(2) What is the final content of a three session ACT universal workshop in terms of session-by-session learning objectives, experiential exercises and delivery format?

Materials and methods

Stage 1

Participants
A secondary school in England agreed to participate in the initial acceptability and feasibility study, allowing the researchers to deliver workshops within PSHE (Personal, Social and Health Education). Participants were 31 year-8 students (aged 12–13 years). The target class was identified pragmatically based on the school timetable and the availability of the programme facilitators.

Procedure
Values informing Workshop Development: In the interests of embodying ACT consistent processes throughout the research design, the two researchers who were to deliver the ACT workshops (author 1 and author 2) identified the core

values, or personal qualities, they wanted to bring to the development of the workshops. These values included: fairness; collaboration; authenticity; rigour and creativity. These values informed the actions taken by the researchers throughout the development process; thus, it seems pertinent to describe them in more detail:

- Fairness: This was reflected in attempts to make the workshops universally accessible to all, both in content and in availability to a non-targeted population.
- Collaboration: The experiences of young people and their teachers were integral to the workshop development. Furthermore, there was collaboration between the authors who work in both clinical and academic contexts.
- Authenticity: It felt important that the workshop content reflected ACT concepts and explanations that particularly resonated with the authors.
- Rigor and Creativity: These two values can often be seen as dialectically opposed but were both felt to equally influence the quality of our actions. The research process was underpinned by rigour and the researchers drew thoughtfully from the pre-existing evidence base, including in the choice of outcome measures and feedback methods. However, there were also times during the process when creativity was invited, whether in the generation of content or an ability to be flexible in an unfamiliar classroom environment.

Workshop Development: Three ACT-based workshops were developed by authors 1 and 2, both clinical psychologists with extensive ACT training and significant experience working clinically with young people within an ACT framework. The workshops contained integrated concepts and terminology from the DNA-V model, a model of ACT for working with adolescents, which aims to teach skills to develop social and emotional competences (Hayes & Ciarrochi, 2015). Workshops consisted of didactic teaching using PowerPoint presentations, ACT videos from YouTube (pre-developed by other practitioners, not specifically for young people, but deemed accessible), student participation via a live response website (Mentimeter), and experiential group exercises.

Workshop Delivery: Three ACT workshops of an hour in duration were delivered between February and April 2018 by author 1 and author 2, spaced approximately 4 weeks apart and timetabled within the class' scheduled PHSE lessons.

All student participants completed a battery of measures via an online portal, pre, post, mid-way and 6 weeks after the workshops. Measures evaluated expected outcomes of ACT interventions (such as psychological flexibility and mindfulness), positive indices of psychological well-being (such as stress, well-being and quality of life), and mental health difficulties. Outcome data will not be reported within this article.

Evaluation of the workshops' acceptability and feasibility

In line with our values of rigour and collaboration, and consistent with guidance from Weist and Murray (2008) on prioritising quality in mental health promotion in schools, we established a comprehensive quality assessment programme to ensure that improvements could subsequently be made to the InTER-ACT programme in a way that was directly responsive to young people and other stakeholders' feedback.

Information regarding the acceptability and feasibility of the initial programme was elicited via:

(1) experience of workshop questionnaires completed by the students who attended the workshops,
(2) a focus group with 15 students,
(3) interviews with a school-teacher who observed each of the workshops,
(4) interviews with the workshop facilitators,
(5) a written learning log completed by the facilitators after each workshop.

The focus groups and interviews with school staff and workshop facilitators were all transcribed (by author 3), then analysed using content analysis, following a process of condensing the data into 'meaning units', identifying codes and grouping the codes into categories (Erlingsson & Brysiewicz, 2017). Table 1 summarises the feedback received.

Stage 2

Our aims for the InTER-ACT programme always prioritised accessibility of content and breadth of reach. Stage 2 therefore involved revising the workshops in light of the extensive feedback, and subsequently, to enable a more extensive roll-out of the programme, developing the programme for delivery by teachers and school counsellors.

Session content redevelopment

This section describes the development of the revised workshop content and the training of the school counsellors and teachers.

The content of all three workshops was substantially revised in the light of the feedback and experience of delivering the workshops (see Table 2, Table 3 & 4). Key changes included: removing exercises involving Mentimeter to ensure universal accessibility (even though we provided spare devices for those who did not have one, issues with Wi-Fi and access had created frequent problems); reducing the number of different exercises per workshop so that more time could be given to conveying core concepts; integrating more facilitator disclosure, including diffusion knowledge and skills (learning to interact differently with difficult thoughts), summarised in the key message *'thoughts are just*

Table 1. Key findings from content analysis of qualitative data.

Source	What worked well	Challenges	Ideas for improvement
Experience of workshop Questionnaire	Session length about right Normalising to hear other students' experiences Workshops helpful and enjoyable Content felt relevant to the students	Understanding some of content – felt it needed more explanation Videos not easy to understand	Videos that were specifically for young people Improve technology glitches associated with using Mentimeter
Focus group with students	Variety of experiential activities (watching videos, the survivor game, mindfulness exercises, taste exercises with jellybeans, choosing values, using phones)	Videos confusing/not understood by young people Questionnaires too long	Sitting by friends during workshops to feel more comfortable Having materials to share with parents about the workshops
Teacher observer	All concepts understood well Concepts liked by students	Workshop facilitators not using the same behaviour cues as staff Lots of content to cover	Weekly workshops More repetition Refresher sessions later in year Asking the teacher about which students to pick for activities
Interviews with ACT facilitators	Mixture of taught content and interactive exercises Having a class teacher present (for behaviour management) Three workshops the right amount	Teaching in a classroom and pitching content for everyone Judging what students have understood Time-consuming to prepare	Reducing the spacing between the workshops
ACT Facilitators Workshop Logs[a]	Group experiential exercises with whole class participation Quiz format and key ideas slides to help students hold on to key constructs Facilitators using personal disclosure	Facilitators struggled to clearly convey the DNA-V concepts, which seemed to cause confusion amongst the students Exercises which required multiple volunteer students disrupted the focus away from the key concepts, due to over-excitability of students	Remove DNA-V concepts and use explanations facilitators use routinely in clinical practice Remove exercises which included multiple student volunteers – replace one key exercise with a video

[a]Data from log-books was reviewed by facilitators for intuitive themes, not via content analysis

thoughts'; integrating more revision (e.g. quizzes and recaps) to improve learning consolidation, and revising and simplifying value identification with new handouts.

A significant change to the workshop content was the decision to remove the DNA-V constructs from the workshop content. Consistent with the identified value of rigour, in developing the initial content, we made the decision to draw

Table 2. Content and learning objectives for workshop 1.

Workshop 1: Thoughts are Just Thoughts	
Primary psychological flexibility processes targeted: defusion/self as context	
Learning Objectives	*Content and Specific Exercises*
Understanding that . . . • It's normal to have negative thoughts. • Such thoughts have helped us survive, but nowadays they are often not helpful or accurate. • Trying to control our thoughts is futile (it doesn't work) and struggling to do so is tiring and stops us being engaged with what's happening right now. Knowing how to . . . • Notice our thoughts and untangle from them.	• Ground-rules, e.g. respecting others and confidentiality. • Exercise tuning into our inner voice/thoughts – writing down every thought that goes through mind over two minutes. • Video and discussion re normalcy and evolutionary context to negative thoughts. • Exercise trying to *not* think about, and to *only* think about certain things and how this isn't possible. • Exercise trying a defusion skill.

Table 3. Content and learning objectives for workshop 2.

Workshop 2: Pause, Observe, Describe	
Primary psychological flexibility processes targeted: present moment awareness (mindfulness)/acceptance	
Learning Objectives	*Content and Specific Exercises*
Understanding that . . . • We cannot control how we feel. • Our mind is constantly 'time travelling' to the past and future. This can cause difficult feelings (e.g. sadness and anxiety) and means we are often on 'auto-pilot'; doing one thing, thinking about something else. • Connecting to the moment can help us to feel more grounded. • We can allow feelings to come and go without them controlling what we do, e.g. we can feel anxious and still do something new. Knowing how to . . . • Recognise when our attention has drifted. • Connect to the moment using five senses and body awareness. • Bring a kind, curious, non-judgmental attention to experiences.	• Quiz to recap previous session's core concepts. • Questions testing out if we can control how we feel. • Mindfulness exercises: sensory focus and mindfulness sitting practice. • Mind is like a puppy analogy (Kornfield, 2003). • Facilitator disclosure re personal negative thoughts and experience of using skill of 'just noticing' thoughts in order to be able to still do what matters. • Exercise practicing skill of 'pause, observe and describe' with fluctuating feelings triggered by watching an emotive YouTube video.

Table 4. Content and learning objectives for workshop 3.

Workshop 3: Taking Steps Towards What Matters	
Primary psychological flexibility processes targeted: value identification & committed action	
Learning Objectives	*Content and Specific Exercises*
Understanding that . . . • What we get told makes us happy, may not do! • Values represent qualities we bring to our actions; they are what we care about and what we want to stand for. Knowing how to . . . • Tell apart a value and a goal. • Take steps that are consistent with personal values.	• Quiz to recap previous session's core concepts. • Discussions re what we get told (from adults/ social media/adverts) about what matters most in life & what actually makes people content. • Pair work identifying recent examples of when felt most alive and connected with the moment. • Discussions re values and what they are. • Exercise identifying own top personal values and committing to enact a value-based goal. • Recap of all key concepts.

on DNA-V, as this was the only published delivery approach developed for using ACT with adolescents. Despite extensive experience in working clinically using ACT, DNA-V was personally unfamiliar to us as an ACT intervention framework. As these ideas were shared with young people within the workshop, they seemed to create a level of confusion, which may have related to our lack of ownership of the constructs. After some reflection, we decided that the use of the DNA-V was inconsistent with the value of authenticity. The DNA-V content was therefore removed and the value of creativity embraced in reworking the content, utilising descriptions and explanations developed during our many years of clinical practice.

In addition to content changes, feedback from young people about their appreciating visual content, but finding the videos initially used hard to follow, was embraced and responded to by working with an illustrator to improve the accessibility of the content and promote a strong visual identity for the InTER-ACT programme. In collaboration with Louise Gardner, children's illustrator with specific interest, experience and knowledge about ACT, a bespoke video was developed to convey the evolutionary context of negative thoughts and their universality (https://www.youtube.com/watch?v=0BF1hJaNtms) and an InTER-ACT owl mascot (see Figure 1) was created. An owl was selected due to its associations with wisdom, as well as its ability to fly above scenes, and thus gain a broad, step-backed perspective, consistent with diffusion and self-as-context conceptualisations. We also wanted to ensure that the character was gender-neutral, both in its own appearance and in terms of its appeal. Multiple illustrations involving the InTER-ACT owl were developed and integrated throughout the workshops to help to clearly convey key concepts and to increase engagement.

To maximise fidelity of delivery, and to increase the confidence of the teacher/school counsellor facilitators' in delivering an unfamiliar programme, a detailed (near-verbatim) transcript for each workshop was developed and integrated within the notes section of each PowerPoint slide.
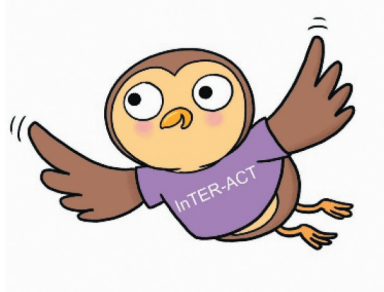

Figure 1. The InTER-ACT mascot.

Finalised content

Tables 2, 3 and 4 above summarise the final content for each workshop, along-side the primary psychological flexibility processes targeted and the learning objectives.

Training school counsellors and teachers

We decided on a facilitator dyad of one member of school staff (either teaching staff or pastoral care staff) paired with a school counsellor who worked in or for the school. This pairing was chosen to combine the expertise and knowledge of the school and classroom environment, offered by the member of school staff, with the mental health awareness of the school counsellor. This was based on our experience as mental health practitioners of finding classroom facilitation daunting, alongside our belief in the contributory value of background training in mental health. Interestingly, this co-teaching approach echoes recommendations by Van der Gucht et al. (2017) regarding concerns that delivery of a school-based ACT programme facilitated by non-mental health facilita-tors only (teaching staff), may have partially contributed to non-significant outcomes.

Dyads of school staff and school counsellors from seven different schools across the UK attended two days of training. Training consisted of one day focusing on developing a core understanding of ACT concepts and theory using explanation, metaphor, videos, experiential exercises and discussion, followed by a day of training in the InTER-ACT protocol. Due to the Covid-19 pandemic, the two days of training had to be delivered entirely online. As online training prohibited the modelling of the dyad facilitation process, the two trainers (author 1 and author 2) were filmed delivering the pro-gramme as a pair (to an imagined class) and this film was embedded in the training on day two. Throughout day two, we paired the dyads of school staff and school counsellors who would be working together in 'break out rooms' so they could develop their collaborative working relationship. The slides for each workshop were pre-divided into sections for 'facilitator one' and 'facilitator two' to avoid variation in delivery format, but we did not stipulate whether 'one' or 'two' had to be the counsellor or teacher, allow-ing the pair to choose this themselves.

Next steps

Now that the training has been delivered to seven dyads of UK school staff and school counsellors, and the three-workshop programme has been completed within six participating schools (one school was delayed by Covid), we can progress to the next stage of the research. This will involve: 1) evaluating

training satisfaction, 2) coding audio recordings of the workshop sessions for fidelity to ACT concepts and adherence to the workshop protocol, 3) qualitative process evaluation with school staff, 4) statistical evaluation of outcome data from the participating students and 5) questionnaire feedback to ascertain satisfaction with the workshop content.

Discussion

The aim of this work was to develop a UK-based universal school programme using ACT, which was both acceptable and feasible to deliver in the school environment. By clearly describing each stage of the programme development, including the iterative process and the key principles underpinning all the work, it is hoped that our learning will provide valuable practical guidance to inform colleagues developing other universal programmes, especially at a time where a well-being curriculum is becoming a high priority within schools, and one that is increasingly mandated by government.

Strengths

The InTER-ACT project meets many of the criteria identified by Weist and Murray (2008) as essential for ensuring quality of mental health promotion in schools. We have ensured an inclusive approach by adopting a universal programme format. Rigour is embedded through the workshop development through systematic quality and efficacy assessment and an iterative process of continual improvement. In addition, we have been responsive to feedback from young people, ensuring their views are integrated into the quality improvement process. We have worked in collaboration with multidisciplinary colleagues, forming effective relationships between health and education colleagues, along with developing strong connections with expert contributors, such as a professional illustrator. Finally, we have also ensured staff are engaged and supported through highly responsive informal and formal communication channels and valued their opinions and perspectives through their involvement in the evaluation process.

Reflections on the process

As the first attempt by the authors to develop a universal brief programme for a classroom setting, there were a number of reflections on the process that may prove useful for those taking up a similar challenge. We noticed there was a significant transition to adapt from our clinical work as health professionals working one-to-one with individuals referred for specific mental health difficulties, to developing content suitable for a universal programme. We had to adjust

from providing a tailored, in-depth, personalised approach, to making the content accessible and relevant to the majority. In addition, the brief programme format necessitated distilling and simplifying ACT learning and skill development into a focused set of core concepts with maximum generalisability. With hindsight, we were naïve about these challenges, and we should have involved an experienced teacher and a pastoral care member of staff at an earlier stage in the development of the content. This could have helped, for example, to inform how much breadth and depth to cover, as well as which exercises may create more disruption, than learning opportunity.

When revising the workshop content after Stage 1, we were surprised by the extent of adaptations required. Although the revisions were time-intensive, we really valued being able to draw on feedback from multiple stakeholders to improve the relevance and accessibility of the content. In addition, the first-hand experience of running the workshops was invaluable in directing changes and helped us to not be too attached to the content originally generated as we had personal experience of what worked and what did not.

During the revision process, we found it helpful to hold in mind the values that we initially identified as important in our approach to the development process. Replacing DNA-V with a bespoke programme, grounded in our clinical, personal and research experiences with ACT, whilst drawing on our own values-driven approach, brought a sense of joy and energy to the process, despite discomfort at times. We would encourage other clinicians and researchers to be willing to step into the challenge.

Finally, at the level of a whole-school approach, we are interested to see how the training in the InTER-ACT workshops may be reflected in a change within the level of the school culture and pastoral responses to young people in distress. We are hopeful that one member of teaching staff training in, and delivering, an ACT workshop, will start a ripple effect of change in how young people, staff and the school begin to relate to thoughts and feelings. To this end, a second round of qualitative interviews with school staff and school counsellors will take place several months after the conclusion of the workshops to explore generalisation effects. Of note is that we have also had a lot of expressions of interest from the school staff facilitators in training their colleagues in InTER-ACT, so we are looking to develop advanced train-the-trainer training; this represents a whole new exciting project.

Limitations

The conclusions drawn from the Stage 1 evaluation of the group content and experience were limited by the fact that the workshop took place in one education setting, with one teacher, one class and a self-selected focus group. Given the considerable changes made to workshop content at Stage 2, it would have been helpful to seek further feedback from young people and teaching staff on the adapted content, including the illustrations and video before

running the adapted workshops, but unfortunately, time did not allow for this. Finally, the Covid-19 pandemic led to a number of revisions that had not been anticipated, such as running the training for school staff and school counsellors online. This format may have limited the extent to which facilitators could effectively model and convey the open, accepting and present ethos of ACT, which is crucial to its delivery.

An additional potential limitation that should be noted reflects broader concerns regarding schools as forums for well-being interventions. It is important to acknowledge that the school environment may contribute to mental health difficulties by increasing stress and pressure for young people due to the focus on performance and achievement. In a study (Anniko et al., 2019) assessing adolescents' perceptions of sources of stress over three years, school was consistently identified as the highest source of stress, far exceeding reported stress from other sources. That said, the values-focused approach of ACT may provide a welcome counter to these concerns, shifting the emphasis away from a striving for attainment of measurable outcomes, towards the pursuit of a richer and more meaningful life – such that the focus becomes less what a student wants to achieve, but more what they wish to stand for.

Conclusion

To conclude we would like to offer some of our learning points that other practitioners seeking to develop new programmes within the school setting might find helpful:

- Always keep in mind the primary goal of the programme and the theoretical rationale for this; for us, the central aim was to increase the psychological flexibility of students, grounded in the strong evidence base for such processes being associated with higher well-being and resilience.
- Aim for students to gain an in-depth understanding of a small number of key concepts (rather than packing in multiple skills, which may lead to superficial learning and confusion). We found it helpful to ask ourselves, 'if nothing else is retained, what one skill/insight would we like students to take away from this session?'
- Breakdown the challenge of implementing a large-scale programme into discrete stages. Work collaboratively with colleagues, so each stage has a project lead and implementer.
- Expect things to go wrong and ensure robust contingencies are in place, although we admit a worldwide pandemic didn't feature within even our most catastrophic planning! We did learn, however, that even

within disappointment, there are potential benefits. For example, online training for school staff and counsellors was not ideal, and we missed the connection and camaraderie of face-to-face interaction; however, it nonetheless enabled us to broaden the trial to a much larger section of the UK as we were no longer constrained by feasible travel boundaries.

- Identify your values and let these be a guide to action; keeping in mind collaboration and authenticity meant that we could walk into a lively classroom even in the presence of considerable apprehension. Being guided by rigour helped us to step up to the task of substantial amendments and to negotiate the ongoing demands of a large-scale research project.
- Be courageous; have faith that the intervention idea you have in mind can become a viable reality!

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Disclosure statement

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