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Project Title	<i>Development of an Intervention to Improve Mental Health Support and Training for Secondary School Staff – A Feasibility Study and Pilot Cluster RCT</i>
Project code	SPHR-BRI-PH1-WIS
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External Collaborators / Partners	Poppy Jaman – Mental Health First Aid England Kevin Armstrong – Teacher Support Network Carol Watson – Bristol Healthy Schools Manager
Start Date	1 April 2012
End Date	1 May 2015
Outline	<p><u>Background</u> School staff, in particular teachers, are consistently shown to have increased risk of stress, depression and anxiety compared to the general working population. If left untreated, such mental health issues may lead to poor performance at work (presenteeism), sickness absence, and even ill health retirement. Further, school staff report feeling ill-equipped to support vulnerable students, due to a lack of support for their own wellbeing, and a lack of training in mental health.</p> <p><u>Methods</u> The WISE pilot study was an evaluation of a secondary school intervention, in which: i) a small group of staff were trained in Mental Health First Aid (MHFA), and went on to provide a confidential peer support service for colleagues to use when stressed or distressed ii) youth MHFA training was delivered to the wider staff body, to equip them to recognise signs of distress and provide initial support and help.</p> <p>Following a feasibility study, in which the intervention and outcome measures were tested in two schools, six schools took part in the pilot study; three received the intervention and three were a comparison group. We measured staff wellbeing (using WEMWBS), depression (PHQ-9), absence and presenteeism, and student wellbeing (WEMWBS) and mental health difficulties (years 8 and 9) (SDQ) before the intervention began, and one year later. We also conducted observations of the training sessions, and interviews and focus groups with staff, some of whom had completed the training, some who had not. Peer supporters completed logs / diaries recording use of the service.</p>
Findings	<p><u>Results (including findings in relation to the objectives):</u> Invitations to participate in the pilot study were sent to the head teachers of 32 schools in Bristol, North Somerset and South Gloucestershire; 8 requested further information, of whom 7 arranged a meeting with us, and 6 took part in the pilot. No recruited schools left the study. The pilot schools included a total of 1024 staff and 2,616 students in years 8 and 9 at baseline.</p>



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In total, 623 (59.9%) staff (74.1% of teachers) and 2265 (86.6%) students completed baseline questionnaires. At follow up, 544 (54.7%) staff (69.2% teachers) and 2274 (87.0%) students completed the questionnaires. In total, 8 training observations, 6 interviews with senior staff contacts, 10 focus groups and 5 staff interviews were completed.

Qualitative findings

The training was delivered either as complete days with cover paid for, or broken down into a number of in-service training sessions, depending on what suited the schools. Generally, it was received positively by those who attended, with specific benefits cited as new knowledge and skills, reassurance about current practice, opportunities for discussion of difficult work situations, and awareness of one's own mental health. There was a common view among participants that student mental health is deteriorating and youth MHFA was seen as very relevant in this context. Suggestions for improvement to the youth version included ensuring that tutors and non-specialist teachers attended as they were perceived to have the most to gain from the course, reducing the length to make it easier for more teachers to attend, and making the content less factual and more skills focused. The training from both courses was not systematically 'cascaded down' to colleagues, but in one school trainees used staff meetings and assemblies to introduce some of the material.

Peer supporters covering a range of roles and experience in the schools were recruited based on nominations from staff questionnaires. It was not felt to be appropriate for senior leaders to be peer supporters, but they were seen to have an important role in supporting and promoting the service, rather than treating it as a 'tick box exercise'. All those who attended the training remained as peer supporters for the duration of the study. Peer support tended to be delivered immediately and informally, with staff approaching supporters as and when they needed to. This was seen as appropriate in the fast paced and reactive school context, where little time and space was available for pre-planned, formal conversations. There was a strong sense among participants that school staff are under a great deal of pressure, and that the peer support service had the potential to reduce some of this. Examples of how the service had provided help ranged from staff who had wanted to talk about a difficult lesson they had just experienced to individuals with more serious and enduring mental health difficulties who needed to access outside services. The existence of the service was also considered by some participants to have raised the profile of staff mental health, in a context where performance management had largely suppressed conversations around this issue. Peer supporters described benefiting themselves from feeling they were making a positive difference in the lives of those they helped and receiving training that helped them fulfil a support role that they held. However, the potential for peer supporters' mental health to be negatively affected was also discussed, for example if they no longer had any time for themselves, or if they worried about whether they had done enough to help staff who had approached them. Non-trained staff were generally positive about the existence of the service, although barriers to its use were cited, including not knowing about it, preferring to gain support from people that they already had a strong relationship with inside or outside of work, and not wanting to be a burden on the peer supporters. It was also noted that the service needed time to become trusted and embedded in school life. A few participants talked about using the service themselves, because they did not want their staff team to know about their problems, or because they had not been in the school long enough to develop support networks. One service user described how she would not have been able to continue with the day if she had not been able to access support at her moment of need. Participants discussed the need for ongoing promotion of the service to ensure sustainability, including at the beginning of each academic year to inform new staff. There was no evidence that delivery of the training or establishment of the peer support service was more or less challenging,



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or that the intervention was considered more or less relevant depending on a school's socioeconomic catchment area.

Quantitative findings – process evaluation

Data shown are from the pilot schools only. When data for the feasibility schools were included, the results were not substantially changed. A mean ratio of 1 peer supporter per 20 staff members were able to be recruited all of whom completed the training. According to the peer supporter logs, the median number of people helped by each supporter during a two week period was 2 (range 0-10), with 0.8 (range 0-4) people helped in addition to what would have happened anyway. The median time per supporters spent helping others during a two week period was 1.13 hours (range 0-9). In total, 6.3% respondents in the follow up staff questionnaire reported using the peer support service, and 14.1% said they would if they needed to.

According to the follow up questionnaires, once baseline measures were controlled for, those who completed either the adult or youth MHFA course had greater confidence in helping a colleague (OR=6.34[3.18, 12.64], $p<0.01$) and helping a student (OR=4.85[0.78, 29.91], $p=0.09$), and greater odds of providing help once a month to distressed colleagues (OR=1.54[0.76, 3.11], $p=0.23$) and students (OR=2.10[1.57, 2.81], $p<0.01$) compared to all other staff. Those who completed either course also had greater mental health knowledge (difference=1.84[0.13, 3.56], $p=0.04$), and less stigmatising attitudes towards depression (difference=1.87[0.93, 2.80], $p<0.01$) and anxiety (difference=2.01[0.42, 3.59], $p=0.02$). Finally, those who completed the training had better wellbeing (49.8 versus 47.4, $p=0.09$) and lower depression (4.0 versus 5.4, $p<0.01$) compared to all other staff, once baseline scores were adjusted for.

Quantitative findings – main outcomes

The ICC for the main outcome measure (staff WEMWBS) was 0.01 (95%CI 0, 0.03) at baseline, and 0.00 (0, 0.02) at follow up.

Once baseline scores and FSM were adjusted for, there was no evidence of a difference in staff wellbeing or depression in the intervention arm compared to the control arm (WEMWBS 47.7 versus 47.2, $p=0.72$; PHQ9 5.4 versus 5.3, $p=0.60$). Likewise there was no evidence of differences in absence (Odds Ratio (OR) 1.15 [0.96, 1.38], $p=0.56$) or presenteeism (OR 0.96 [0.46, 1.89], $p=0.86$) in intervention vs. control schools. Restricting the analysis to teachers only did not change the findings. Results for the complete case and imputed datasets were similar.

Once baselines scores, FSM and school year were adjusted for, students in the intervention arm had higher wellbeing (48.1 versus 45.8, $p=0.12$) and lower difficulties (11.2 versus 13.2, $p<0.01$) compared to those in the control arm.

Conclusions:

We successfully conducted a feasibility study followed by a pilot cluster RCT of an intervention in secondary schools that i) created a confidential peer support for staff ii) provided training for staff in youth MHFA.

Qualitative findings indicate that the adult and youth MHFA training was perceived as relevant and useful by school staff. However, a shorter youth MHFA course with more of a focus on skills would be even more suited to the schools context. The idea of a peer support service was also viewed positively by school staff, and a number of stories were shared by peer supporters and service users as to how it had helped individuals. However, for such a service to become widely used and to be sustainable, certain key features emerged as important: a) all the peer supporters should complete the MHFA training, b) there should be sufficient peer supporters, from a range of roles, to ensure that all staff seeking help would be familiar with at least one of them; c) there should be a clear confidentiality policy; d) potential users should be able to choose which supporter to



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	<p>approach; e) there should be ongoing promotion of the service and a senior staff member to 'champion' it. In a future trial, fidelity to these features would be necessary, while allowing the detail of how the service is used to be adaptable to suit the contexts of the different schools.</p> <p>The study was not powered to detect an effect of the main outcome measure (staff wellbeing). The secondary outcomes student wellbeing and student mental health difficulties did show a positive effect in the intervention group compared to the control group. There were also positive signs that those who had completed the MHFA training had improved in terms of mental health knowledge and attitudes, in confidence and actual helping behaviour, and in their own wellbeing and depression scores, although this was a non-random sample. The pilot has provided us with the necessary information - ICCs and SDs for the main outcome measure at baseline and follow up, size of schools and response rate - to calculate sample size required for a full RCT. We were also able to gain the necessary data regarding cost of the intervention (trainer fees, trainer travel costs, costs of cover and costs of venue hire), costs of peer supporter's time, and costs of staff absence (based on anonymised absence data with salary grade information attached). The criteria for proceeding to a full RCT were not all met, but pilot findings enabled us to develop strategies to meet them in a future trial:</p> <ol style="list-style-type: none"> 1. We recruited a mean ratio of 1 peer supporter to 20 staff members, rather than the 1 in 15 which was our target. In fact we would aim for a higher ratio than this in a full RCT, due to the finding that staff did not always know much about the service, or did not feel they knew the peer supporters very well. We would make the number of peer supporters to be trained a requirement contained within a research contract between the school and the study team and would run several joint training sessions across schools to enable a higher number to be trained within each school. 2. 50% of the schools originally written to were not recruited. However, in a full trial we would identify a relevant staff member to approach first via local Healthy Schools coordinators within public health teams, for example a pastoral lead rather than the head teacher. We believe this would improve recruitment rates. 3. Response rates were higher among teachers than support staff. Teachers had significantly poorer wellbeing and higher depression than support staff, we have therefore decided we would focus on teachers only in a full trial. Among the teachers, the response rate was lower than the target 75% at follow up. This was largely due to data collection meetings being cancelled, or individuals not being present. In a full trial we would build in more time and resources during follow up to return to schools on several occasions, thereby increasing response rates. We would also include the requirement to hold a data collection meeting in the research contract. 4. According to the peer supporter logs, more than one intervention a month was delivered on average. The amount of support delivered by each supporter varied a great deal; in a full trial we would work with peer support teams to try and ensure that requests for help are shared more equally. <p>We conclude that the evidence is sufficient to conduct a full RCT of the WISE intervention, incorporating the improvements outlined above. This would enable us to establish if the intervention has an effect on teacher mental health, and if these effects are sustainable over a longer time period. An application for funding such a trial has been submitted to the NIHR Public Health Programme funding board.</p>
<p>Outputs</p>	<p><u>Academic dissemination:</u> Findings from the study were orally presented at the South West Public Health Scientific Conference, February 2015: "Mental Health Support and Training for Secondary School Teachers: The WISE (Wellbeing in Secondary Education) pilot randomised controlled trial".</p>



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	<p>One paper is under review with the Journal of Affective Disorders: “Teachers’ mental health, associated risk factors, and relationship with student outcomes: a large cross sectional study in English secondary schools” – for submission to the Journal of Affective Disorders</p> <p>Two further papers are in draft form:</p> <ol style="list-style-type: none"> 1. “A cluster randomised controlled trial of a support and training intervention to improve the mental health of secondary school teachers and students – the WISE (Wellbeing in Secondary Education) study” – for submission to the BMC Public Health 2. “The Elephant in the Classroom: Are ‘School Improvement’ strategies reducing teachers’ capacity to improve schools?” – for submission to the British Educational Research Journal <p>A summary report will be available in paper form, and published on our project website: http://www.bristol.ac.uk/social-community-medicine/projects/wise/</p> <p>Non-academic dissemination: An oral paper was delivered at the Manchester Festival of Public Health, University of Manchester, 2nd July 2015: “A pilot cluster randomised controlled trial to improve the mental health support and training provided to secondary school teachers (the WISE project)”.</p> <p>A poster presentation was given at Public Health England’s Annual Conference, September 2015: “A pilot cluster randomised controlled trial to improve the mental health support and training provided to secondary school teachers (the WISE project)”.</p> <p>A lay summary report will be shared with non-academic collaborators (Mental Health First Aid, Teacher Support Network, Bristol City Council Public Health practitioners) and will be made available on their websites.</p>
<p>Impact</p>	<p>The study is highlighted in Public Health England’s recent guidance “Promoting children and young people’s emotional health and wellbeing” (March 2015) in a chapter devoted to the importance of school staff’s development, health and wellbeing.</p> <p>Findings regarding the acceptability and relevance of Mental Health First Aid (MHFA) for schools have been fed back to MHFA England, and as a direct result of this, MHFA England have developed a schools’ version of the training programme, which is more appropriate for this particular setting and is now available to all schools. This feedback has been very timely, as MHFA is currently gaining a lot of publicity in both local and national media for its use within the workplace and schools (e.g. http://www.thetimes.co.uk/tto/education/article4429671.ece, http://www.leicestermercury.co.uk/New-project-tackle-mental-health-issues/story-26523927-detail/story.html). As a result of our collaboration with MHFA, David Gunnell helped them to edit and update the section of their training manual covering self-harm and suicide.</p>
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<p>Further information</p>	<p>Contact: Judi Kidger judi.kidger@bristol.ac.uk</p>



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