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An Evaluation of Phase One of the Youth Mental Health First Aid (MHFA) in Schools programme: "The training has given us a vocabulary to use."

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CONTENTS

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He has researched the introduction of the revised EYFS (DfE, 2012) and the *Introduction of the Reception Baseline Assessment* (NUT and ATL, 2015) which won the BERA Impact Award (2016). He was PI on the *Ability Labelling in Primary schools* project (NEU, 2017), which demonstrated the negative impacts of ability labelling upon young children leading to poor wellbeing. His latest book (with Dr. Alice Bradbury) *The Datafication of Early Years and Primary Education* (Routledge, 2017) examines the development of hyper-accountability and governance through processes of digitalization.

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ACKNOWLEDGEMENTS

- Youth MHFA training resulted in Champions increased confidence in knowledge, skills and awareness of the complexities surrounding young people's mental health needs within current school contexts.

- Youth MHFA Champions over time experienced enhanced perception of confidence in four out of the six perceptual constructs: (i) their mental health knowledge, (ii) their use of the Youth MHFA ALGEE dialogic process, (iii) their use of mental health evidence-based practice and (iv) mental health inclusive practice within their educational setting. In addition, Youth MHFA Champions reported tentative increases in their confidence towards creating a mentally healthy school environment across whole school and maintaining their own mental health.

- Youth MHFA Champion individualised skills related to professional, contextual and personal characteristics influenced their perception of each of the six perceptual constructs as they implemented and developed mental health provision within their educational setting after their MHFA training. In particular the professional skills base they have through professional and academic qualifications they hold and the support and leadership roles they hold. The educational context within which they work such as the education curriculum provision and the existence of barriers to implementing their Youth MHFA training. In addition their own personal skills in self-regulating their mental health when they experience mental health issues.

- In school contexts supported by Senior Management, Youth MHFA trained Champions reported enhanced ability to challenge mental health stigma and discrimination. In these contexts the training further enabled them to raise whole school awareness of mental health issues throughout the curriculum and pedagogy. Barriers reported included continuing tensions around school's academic performance and a lack of funding for mental health professionals.

- Youth MHFA Champions indicated an increased understanding of their evidence-based practice when provisioning preventative and protective factors to young people with mental ill health. There was a tendency that Champions in leadership roles perceived higher understanding of this than Champions not in leadership roles.

1. INTRODUCTION

The Youth Mental Health First Aid in (MHFA) Schools Programme is located within a plethora of school based mental health policy initiatives (UKGov, 2017a) and is in response to national surveys suggesting that three children in every classroom has a diagnosable mental health problem (YoungMinds 2017, 20) leading the Children's Commissioner to state there is 'a crisis in children's mental health' (2017, 19). In response the current Government is supporting the roll out of the Youth MHFA in Schools Programme between 2017-2020 (UKGov, 2017b).

Youth MHFA in Schools programme training intervention adopts an inclusive, participatory 'whole school approach' (Weare, 2015) that recognises the totality of the school experience in promoting wellbeing and mental health for both students and staff. Targeted to meet the needs of educational environments, Youth MHFA trained staff are expected to become Champions for improved mental health and wellbeing outcomes in schools. Whole school approaches to wellbeing and mental health change and development require sustained, long term and well funded interventions (Weare, 2015).

2. EVALUATION RESEARCH QUESTIONS

The Youth MHFA in Schools programme, Youth MHFA One Day course, was evaluated by the UCL IOE evaluation team addressing the following evaluation research questions:

To what extent, if any, has the Youth MHFA One Day training
1. **Improved knowledge and awareness of mental health conditions?**
2. **Improved understanding of preventative and protective factors to mental ill health including reduced stigma and discrimination?**
3. **Improved confidence in spotting the signs and symptoms of mental ill health and in having conversations with school students about mental health?**
4. **Improved confidence to help support colleagues and school students experiencing mental ill health?**
5. **Enhanced ability to look after school staff's own mental health?**
6. **Enhanced understanding as to how to create a more inclusive mentally healthy school?**
7. **Identify what more needs to be done to support and build upon the MHFA initiative?**

The evaluation also sought staff's views on how the current Youth MHFA in Schools initiative could be built upon, expanded and developed to ensure a sustained, inclusive and participatory whole school culture. This report is organised according to the above research questions and the triangulated datasets of pre and post surveys, focus group interviews and student questionnaires.

3. METHODOLOGICAL OVERVIEW

The methodology was a mixed methods approach comprising of the questionnaire method within group measures and case studies illustrating participants' education setting-based provision. A quantitative and qualitative evaluation was undertaken to gain an understanding of education professionals' perspective about supporting young people with mental health issues within the education setting as Youth MHFA Champions as they implemented their learning from the Youth MHFA One Day course within their educational settings.

3.1   Evaluation Aims

The evaluation aims were informed by the research questions proposed to evaluate the Youth MHFA One Day course (see Research Questions). Six evaluation aims were derived from the research questions and these were developed into six perceptual constructs (see Methods) to propose six areas of perception pertinent to the Youth MHFA in Schools programme objective to enhance school-based mental health provision for young people who have or are at risk of having mental health issues.

The evaluation aims were:

1. To evaluate whether Youth MHFA Champions have enhanced knowledge and awareness of mental health conditions and awareness of early and late signs, co-occurrence and environmental conditions that may influence changes in brain function of young people. This would indicate Champions' perception of recognising signs and symptoms of, and potential reasons for, different mental health issues experienced by young people.

2. To evaluate whether Youth MHFA Champions have improved capability to help support dialogue between Youth MHFA Champions and young people they support who are experiencing mental ill health using the Youth MHFA ALGEE dialogic process. This would indicate Champions' perception of confidence in Asking;

Assessing; Listening non-judgementally; Enabling help seeking and Encouraging self-help in young people.

3. To evaluate whether Youth MHFA Champions have enhanced evidence-based practice in provisioning preventative and protective factors to young people with mental ill health. This would indicate Champion's perception of assessing young people's mental health, researching published information about young people's mental health, knowing government guidance on professional support available for young people, engaging in mental health training and sharing their knowledge of preventative mental health provision.

4. To evaluate whether Youth MHFA Champions have enhanced awareness of creating a more inclusive and mentally healthy school. This would indicate Champions' and their colleagues' confidence in helping young people with mental health issues.

5. To evaluate whether Youth MHFA Champions have improved ability to meet challenges related to barriers, stigma and discrimination when implementing their Youth MHFA training. This would indicate Champions' perception of being able to embed Youth MHFA training and building upon current mental health provision.

6. To evaluate whether Youth MHFA Champions have enhanced ability to look after their own mental health by drawing upon self-regulating behaviours. This would indicate Champions' seld-help, help-seeking and if needed, openness to speak about their mental health with others who may be able to offer them support.

To achieve these aims the evaluation sought to determine:

A. Whether Youth MHFA Champions' professional, contextual and personal characteristics influenced participant perceptions of each of the six perceptual constructs. The characteristics studies in particular were the (i) professional skills base they have through professional and academic qualifications they hold and the support and leadership roles they hold, (ii) the educational context within which they work such as the education curriculum provision and the existence of barriers to implementing their Youth MHFA training and (iii) their own personal skills in self-regulating their mental health when they experience mental health issues.

B. What were Youth MHFA Champions' insights and experiences about their practice in supporting young people with mental health issues as they drew upon their Youth MHFA training to develop mental health provisions within their educational setting to support young people with mental health issues.

3.2 Evaluation Research Approach

A mixed methods research approach was utilised to evaluate the impact of the Youth MHFA training through a quantitative evaluation using a questionnaire and through a qualitative evaluation using case studies to explore and listen to Youth MHFA trained school staff's (Youth MHFA Champions') experiences, viewpoints and understandings of their MHFA training to illustrate implementation of learning from their training within their educational setting.

The research approach was developed collaboratively with Youth MHFA in Schools programme team in order to evaluate the impact of the MHFA Youth One Day course upon practitioners undertaking the training and implementing their learning within their educational setting. In this report findings from phase 1 are shared based upon data collection from Youth MHFA Champions trained in the period June 2017 – July 2018.

Data collection involved administration of a questionnaire before and after Youth MHFA Champions implemented their learning from the Youth MHFA training within their educational setting. The questionnaires were complemented with Youth MHFA 'host' case study secondary schools where a range of school staff focus group interviews were held with 25 school staff in total. 112 student questionnaires were completed at the six Youth MHFA 'host' case study secondary schools by students who had had contact with the Youth MHFA trained school staff.

3.3 Quantitative Methods

The quantitative evaluation was undertaken using a questionnaire to learn about participants' perception of developing mental health provision within their education setting and participants' professional, contextual and personal characteristics (see Aims) that may influence their experiences and thereby their perceptions before and after they engaged in the Youth MHFA One Day course (Youth MHFA training). The objectives were to determine: (1) whether there were indications of participants' enhanced perceptions about each of the six perceptual constructs (see Aims) as they developed mental health provision supporting young people with mental health issues and (2) whether this was associated with participants' professional, contextual and perceptual characteristics.

Questions sought to ask about participants' characteristics such as qualifications, roles and responsibility, type of workplace. Questions asking about participant's perspective of their mental health provision before and after their Youth MHFA training were devised as a group

of questions, each group related to a perceptual construct and participant's responses to each group of question was sought using Likert five point scales.

Internal consistency of question items and Likert five point scales used for each perceptual concept was satisfactory with Cronbach's alpha 0.7 or above. The six perceptual constructs were informed by research and practice and defined as:

      (1) Confidence in their mental health knowledge;

      (2) Confidence in using the Youth MHFA ALGEE dialogic process;

      (3) Confidence in their evidence-based practice;

      (4) Perception of mental health inclusive practice;

      (5) Perception of extent of Youth MHFA implementation and

      (6) Perception of their own mental health self-regulation.

The quantitative evaluation focused upon assessing MHFA Champion's confidence in these six perceptual constructs. Analysis of participant responses to indicate changes in participant insights and experience of implementing their training over time were conducted to determine whether there was any: (a) change in participant responses to individual questions in the questionnaire as they implemented their training over time, (b) change in participant responses to a group of questions respresenting each of the six perceptual constructs, (c) change in the proportion of participants reporting higher or lower levels of perception for each perceptual construct over time and (d) significant associations between participants reporting higher and lower levels of perception for each perceptual construct based upon their individualised skills in relation to their professional, contextual and personal characteristics (see Methods) and the likelihood of effectiveness of these associations.

An example of participant responses over time to individual questions in the questionnaire is shown in Figure 1. The figure shows responses to two questions related to the perceptual construct for mental health knowledge. The bar charts show the percentage of participants (y-axis) responding to each Likert point scale (x-axis) within each of the three groups at three time points. Distribution curve lines are drawn by hand to illustrate the shift in participant responses over time. In this example, the finding suggests Youth MHFA Champions' confidence in their knowledge of early and late signs and symptoms of mental health issues was enhanced over time.

Figure 1: Frequency distribution of Youth MHFA Champion perception overtime of their knowledge and awareness of identifying early stages of health issues in young people.
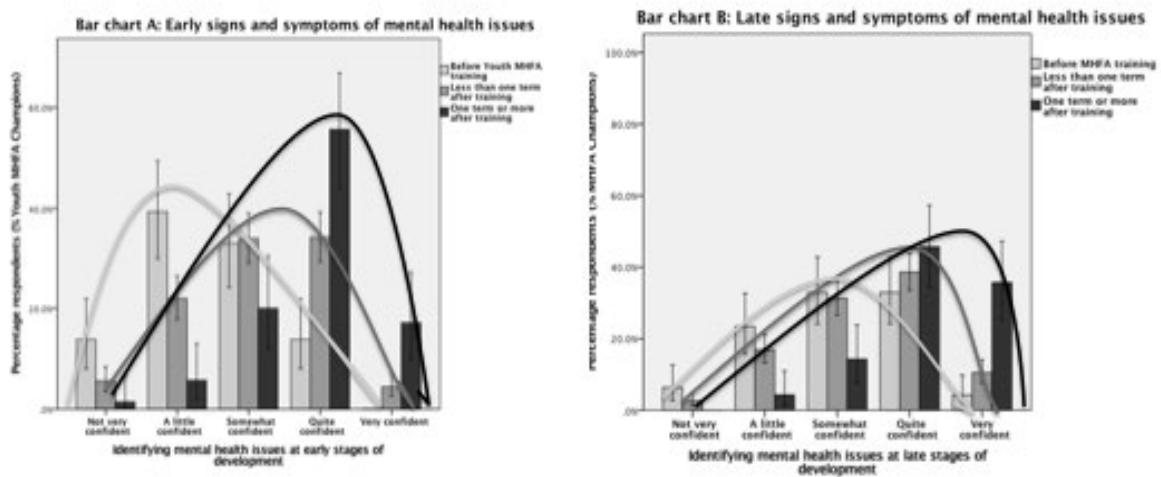
Figures representing change in participant responses to each individual question are not shown, however to corroborate these findings, participant responses for each group of questions representing a perceptual construct were collated to determine if there was any change in the number of participants who report higher and lower levels of perception for each group of questions representing a perceptual construct were collated over time. To do this participants' responses for each group of questions representing a perceptual construct were collated as an average composite score along the Likert 5 point scale. Where this score was above 3 participants were considered to have high levels of perception and where this score was 3 or below participants were considered to have low levels of perception. Findings are shown in Diagrams 1 to 6 for each perceptual construct (see Findings). Within the diagrams, the percentages shown represent the proportion (percentage) of participants who reported higher and lower levels of perception for each perceptual construct.

To determine the scope of participant responses, the average composite scores were used to measure the interquartile range and second quartile median (median) across the three time points. The interquartile range takes into account outlier or extreme responses. The interquartile range provides an indication of the variability in participant responses and the median is a value representing the middle Likert point scale response from participants at each time point t0, t1 and t2. A change in the interquartile range will indicate any change in central tendency and spread for each construct over time. An increase in the median such

that the middle value increased over time will suggest enhanced or improved participant perspectives.

To illustrate this, findings for the perceptual construct mental health knowledge are presented graphically as a Boxplot graph (see Figures 2) showing the trend for change in central tendency and spread for this construct over time. The interquartile range is represented by lines at the top and bottom of boxes, the median is represented by the line inside the box and outlier or extreme responses are represented by the line bars flanking the box and by dots or starts outside the line bars.

As an illustration Figure 2 shows the interquartile range with median (central line within the box). Findings indicate the median for this construct increases over time (t0: 2.33; t1: 3.00; t2: 3.83) indicating participants have enhanced perception of their mental health knowledge as they continued to implement their MHFA training over the academic year. The minimum and maximum scores at each time point were: t0: 1.00 and 4.17; t1: 1.00 and 5.00; t2: 1.50 and 5.00 which indicates variability in responses existed due to outliers and extreme responses but this was reducing by t2. The change in median, minimum and maximum scores for each perceptual construct are repored in the findings (see Findings).

Figure 2: Youth MHFA Champion perception of their knowledge and awareness of mental health conditions and issues.
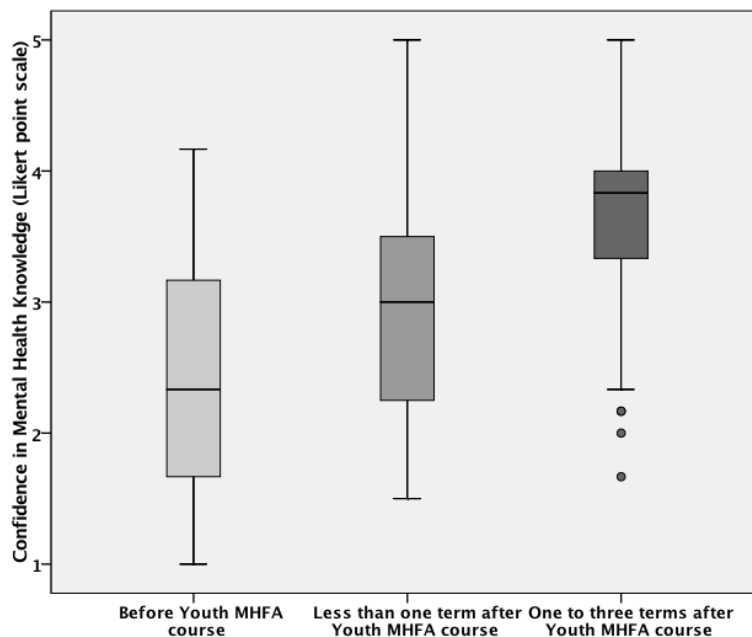
Inferential analysis using Pearson's chi-square test for association and odds ratio for effect size of categorical variables were also determined to see whether or not participants' perceptions of each perceptual construct (whether high or low levels of perceptions) were

significantly associated with aspects of participant characteristics related to their professional, contextual and personal characteristics. Analysis was undertaken using SPSS software. The analysis accepts within group frequency measures (independence) gathered before and after training to: (1) compare the relationship between participants' characteristics and their perception of the perceptual constructs and (2) determine the effects (odds), if any, practitioner characteristics may likely have upon their perception of helping young people with mental health issues within their education setting.

Pearson's chi-square test for association was used to test the null hypothesis which proposes there will be no association between Youth MHFA practitioner's characteristics (independent variable) and perception of their insights and experiences (dependent variable) of implementing mental health before and after the Youth MHFA training. If chi-square statistic calculated indicates a probability value of 0.05 or less ($p \leq 0.05$), then this will indicate there is an association. The odds ratio may verify the null hypothesis that there is no association or, it may indicate whether there is a putative association. If the odds ratio (OR) equals 1 then there is no influence of Youth MHFA practitioner characteristics upon participant percepton of perceptual constructs. If the odds ratio >1 then the odds are that practitioner characteristics are likely to influence their perceptions. If the odds ratio <1, the odds are that practitioner characteristics are likely to not influence their perceptions. In addition, the magnitude of effect is indicated by the size of odds, for instance an odds ratio of 2 indicates the odds of participants' perception are twice as likely to occur as a result of the participant characteristics. Such information may be utilized to verify accepting the null hypotheses or to review the alternative hypotheses proposed to address the research questions and evaluation aims.

3.4   Qualitative Methods

The qualitative evaluation involving case studies of six Youth MHFA in Schools programme 'host' schools and included perspectives from Champions and young people was conducted parallel to the quantitative evaluation. The case study aims were to gain in-depth understanding of Youth MHFA Champions' implementation of learning from their Youth MHFA training in relation to:

(a) The mental health issues being experienced by young people.

(b) The mental health knowledge they'd gained from the Youth MHFA training.

(c) Awareness of preventative and protective factors to mental ill health gained from MHFA training.

(d) The impact of Youth MHFA training towards creating inclusive, mentally healthy schools.

(e) Barriers to implementing Youth MHFA training and ways to address this.

All focus groups were recorded, professionally transcribed and separately analysed by two researchers who agreed the coding and themes thus ensuring validity across the dataset. Findings and conclusions are provided in this report as understandings based upon data collated at the time of writing this report. Further details and insights about the evaluation based upon ongoing data collection will be presented in publication in academic journals (manuscript in progress).

3.5   Quantitative and Qualitative Study Sampling

Participants were invited to take part in the evaluation when they expressed an interest in doing the course. At this time they were invited to take part in: (i) a quantitative evaluation and complete a questionnaire before and then after three months of implementing their learning from the course within their educational setting and (ii) a qualitative evaluation by indicating whether they were interested in being a case study school. Participants were asked to reflect upon their insights and experiences of provisioning this within their education setting when completing the questionnaire and during case study school visits .

For the quantitative evaluation, in total 1,000 school staff were invited and of this we gained 825 responses to questionnaires. This was spread across time before and after their training and revealed we had three groups of study participants: (1) those responding before their training (n=166; 20%), (2) those responding less than one term after their training (n=517; 63%) and (3) those responding one to three terms after their training (n=142; 17%). Participants who completed the questionnaire were found to hold leadership, support and teaching roles. 45% participant respondents were leaders of support provision, middle leaders or senior leaders (of this 10% were support leaders). 55% did not hold leadership roles rather they held mental health, social-emotional learning, medical, pastoral, safeguarding support roles or were teaching assistants, of this 12% were teachers.

For the qualitative evaluation, working with the Youth MHFA in Schools team, the research team purposively sampled six 'host' case study schools from the pool of schools who were interested in being a case study school. The selection critera took into account different socio-economic (measured by Free School Meals, FSM) and geographical areas as well as recruiting comprehensives, academies and a grammar school to ensure a diverse representation of different school organisations. These six schools were identified with the Youth MHFA in Schools team and the schools were invited to 'opt-in' to the research.

All the six schools were Host[1] Training Youth MHFA schools which had a higher number of trained school staff compared to schools nationally. These host schools were chosen because of their higher concentration of trained Champions and so they were more likely to show the impact of the Youth MHFA training and provide richer interview data and evidence of cultural change toward mental health. As a follow up to this initial evaluation it is anticipated that schools with only one Youth MHFA trained member of staff will also be included in the sample.

Similarly to the questionnaires, case study staff were invited to take part in a semi-structured interview schedule (see Appendices) with questions based on the overall research questions established collaboratively with the Youth MHFA in Schools programme team. The interview schedule was also piloted ahead of its use. In addition, a focus group of children from each of the case study schools was invited to complete a questionnaire to gain their perspective of being supported by Youth MHFA Champions within their school.

The six 'host' case study schools built up a rich picture of the opportunities and threats that the Youth MHFA trained school staff faced in building upon their training in the life of their school, as well as the impact upon students who are receiving support from staff. Schools were provided with one day teaching cover to ensure that students' learning was not affected when the Champions were involved in the focus group discussions.

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[1] Youth MHFA in Schools host schools offered their facilities for the training of up to 12 other school staff from surrounding schools including feeder primary schools. In return the host school received up to four free places for its staff. The host schools had therefore positively engaged with the Youth MHFA in Schools initiative and were more likely to engage with the research team in focus group discussions which demanded school time, commitment and organisation.

The Six Diverse, Nationally representative Case Study Secondary Schools

School Location	Type of school	Total students	English as Additional Language (EAL)	Free school meals (FSM)	Ofsted Status	Focus Group Discussion Members[2]
North East	Grammar (selective)	752 boys (11-18)	very low	1%	Outstanding	1 Senior Management 3 Teachers
East Midlands	Comprehensive	1108 mixed (11-16)	very high	19%	Good	4 Teachers.
West Midlands	Academy	760 mixed (11-16)	low	Not recorded	Requires Improvement	1 Senior Management Team (SMT) Teacher 1 Teacher 4 Pastoral Support Staff
North London	Academy	1,296 mixed (11-16)	Very high	20%	Outstanding	1 Senior Management Team (SMT) Teacher 1 Teacher
South London	Academy	1,680 mixed (3-19)	Very high	25%	Outstanding	1 Senior Management 2 Teachers
South Coast	Comprehensive	1035 mixed (11-16)	Low	9%	Good	1 Senior Management Team Member (SMT) 2 Teachers 2 Pastoral Support Staff

Each school had a different history of, and culture towards, supporting mental health. From reading the OFSTED reports and school websites, our observations and talking with school staff it was clear some schools had provided considerable resources and time towards students' mental health, whilst others were embarking upon the journey under difficult circumstances. All schools had dedicated pastoral support staff and rooms to address students' wellbeing and mental health and all had wellbeing and mental health as part of the wider school curriculum. As reported by the school staff, there were distinct and tangible differences between the case study schools regarding the prominence and culture surrounding mental health initiatives such as Youth MHFA. The membership of the focus group discussions (FGD) included only those school staff who had successfully participated and completed the Youth MHFA One Day training. Membership of the focus group discussions (FGD) varied in each school was dependent upon staff availability and included Senior

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[2] All school staff who participated in the Focus Group Discussions were trained Youth MHFA Champions. The Total Number of School Staff in six Focus Group Discussions was 25.

Management Team (SMT) teachers, specialist subject teachers and pastoral support teachers. This inclusive range of staff seniority, qualification and responsibilities allowed for a rich and diverse set of viewpoints.

In addition to staff interviews, in case study schools, students who had contact with a Youth MHFA trained member of staff were asked to complete a short six question written survey (see Appendix). This ensured that only those students who had had some form of contact with a Youth MHFA trained member of staff completed the survey as we wanted to hear from the students the effect of a Youth MHFA trained member of staff. After receiving both the school's and the parent's permission, these students were asked to complete the survey either at home or during a lesson. The ages and genders of the students are noted below.

Student Questionnaires by School Location, Gender and Age

School Location	Gender and Ages	Questionnaires
North East	33 boys; year 7	33
East Midlands	14 girls; 3 boys; years 10, 11	17
West Midlands	8 boys; 7 girls; years 8,9,10	15
North London	10 boys; 11 girls years 7,8,9	21
South London	N/A	Not returned.
South Coast	13 girls; 13 boys; years 7-10	26
TOTAL	**67 boys + 45 girls years 7- 11**	**112**

3.6   Ethical Considerations

The research was conducted within the ethical guidelines provided by the British Education Research Association and the UCL Institute of Education. Prior to gaining their consent, the schools and school staff were sent thorough research Information Leaflets which detailed the research rationale and what was expected of them. The school staff were also sent the Interview Schedule ahead of the researcher visiting the school. Immediately prior to the focus group, the school staff were asked to sign a consent form stating that they understood the purpose of the research and that they consented to the interview being recorded and transcribed (see Appendix). Care has been taken to ensure anonymity of all respondents and the security of data. For ethical reasons relating to maintaining anonymity, the case study schools are identified only by general geographical area witin England. Schools were recompensed with funding for either a half day or full day of teaching cover (depending on the number of interviews) in order to reduce the impact of the research on students' learning.

4. QUANTITATIVE FINDINGS: YOUTH MHFA CHAMPION QUESTIONNAIRE

The quantitative evaluation focused upon assessing MHFA Champion's confidence in the six perceptual constructs identified in Aims (see above). Analysis of participant responses indicated changes in participant insights and experience of implementing their Youth MHFA training over time. Overall, this analysis indicated enhanced participant perception of their knowledge, skills and awareness in helping young people with their mental health to: (i) develop their own self-help solutions to cope with their mental health issues and (ii) seek professional mental health services support in they needed this. Before the training, 30% of participants were already highly confident about their ability to support young people with mental health issues they my have. Following the training, this increased to 59% within one term and then further increased to 87% up to three terms later. This enhanced perception may have been influenced by participants' individualised professional, contextual and personal characteristics. Participants' perception for each perceptual contruct is analysed below in relation to the likely influence of participants' individualised characteristics. For details of the evaluative analysis see Methodological overview.

Participants reported enhanced confidence over time when answering questions associated with the six perceptual constructs. Participants reported increasingly high perception of confidence in four out of the six constructs: (i) their mental health knowledge (including ability to identify the signs and symptoms of mental ill health); (ii) their use of the Youth MHFA ALGEE dialogic process (including supporting young people in identifying their own self-help strategies and support pathways); (iii) their evidence-based practice (including sharing of best practices within their educational settings) and (iv) their mental health inclusive practice (including supporting young people's self-help strategies and seeking professional support). Participants reported a tentative increase in their perception of (v) extent of Youth MHFA implementation and (vi) their own mental health self-regulation.

4.1   Youth MHFA Champions' Perception of Mental Health Knowledge

Youth MHFA Champions had enhanced perception of their mental health knowledge over time. That is, knowledge and awareness of mental health conditions and awareness of early and late signs, co-occurrence and environmental conditions that may influence changes in brain function of young people. Diagram 1 shows the increase in participant confidence of their knowledge and awareness of mental health. Before Youth MHFA training, 28% of participants reported they had high confidence. After the Youth MHFA training this increased to 47% when participants had less than one term to reflect upon and implement their training,

rising further to 86% when participants had from one term to three terms to implement their training.

The interquartile range indicates the median for this construct increases over time (t0: 2.33; t1: 3.00; t2: 3.83) indicating participants have enhanced perception of their mental health knowledge as they continued to implement their MHFA training over the academic year. The minimum and maximum scores at each time point were: t0: 1.00 and 4.17; t1: 1.00 and 5.00; t2: 1.50 and 5.00 which indicates variability in responses existed due to outliers and extreme responses but this was reducing by t2.

Diagram 1: Proportion of Youth MHFA Champions with high perception of mental health knowledge.

| 28% | 47% | 86% |
| Before Youth MHFA course | Less than one term after Youth MHFA course | One to three terms after Youth MHFA course |
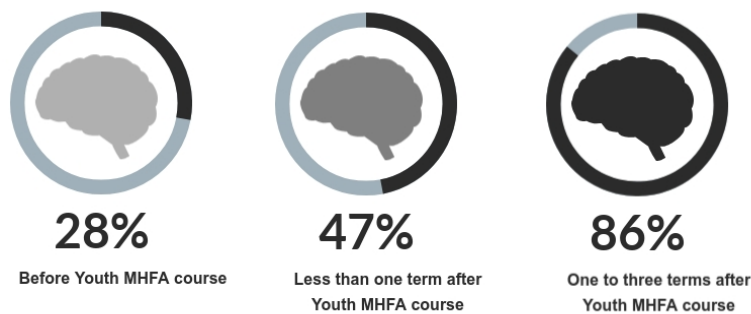
The increased confidence in mental health knowledge was not significantly associated with whether participants held professional and/or academic qualifications related to mental health or not related to mental health (such as curriculum subject specific qualifications) since Pearson's chi-square test showed no significant association (t0: χ^2 (1) = 01.696, p=0.193; t1: χ^2 (1) = 2.445, p=0.118; t2: χ^2 (1) = 0.004, p=0.947). However, the odds ratios were greater than 1 at t0 and close to 1 at t1 and t2 (t0: OR = 1.91; t1: OR = 0.76; t2: OR = 1.04). This indicates that before Youth MHFA training, participants' perception of their mental health knowledge is influenced by the qualifications they hold. Before MHFA Youth training, participants who held mental health qualifications were almost twice as likely to have a high perception of confidence than those holding non-mental health qualifications. However, with increasing time of implementation of mental health provision after Youth MHFA training, participants who held non-mental health qualifications become equally as confident about their knowledge of mental health as participants who held mental health qualificatons. It must be

noted that this finding provides an indication of participants' perceived confidence in their mental health knowledge and not their actual competence in mental health knowledge.
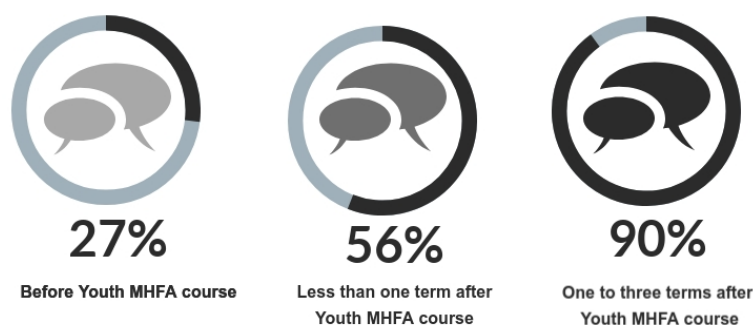
4.2   Youth MHFA Champions' Perceptions of using Youth MHFA ALGEE Dialogic Process

Youth MHFA Champions had enhanced perception of their improved capability of engaging in dialogue with young people experiencing mental ill health. Diagram 2 shows the increase in participant confidence in their capability of using the ALGEE dialogic process to engage young people in conversation about their mental health. Before Youth MHFA training, 27% of participants reported they had high confidence. After the training this increased to 56% when participants had less than one term to reflect upon and implement their training, rising further to 90% when paricipants had one to three terms to implement their training.

The interquartile range indicates the median for this construct increases over time (t0: 2.67; t1: 3.33; t2: 4.00) indicating enhanced perception of using the Youth MHFA ALGEE dialogic process over the academic year. The minimum and maximum scores at each time point were: t0: 1.00 and 5.00; t1: 1.00 and 5.00; t2: 1.00 and 5.00 which indicates variability in responses existed due to outliers and extreme responses at each time point.

Diagram 2: Proportion of Youth MHFA Champions with high perception of their capability to use the MHFA ALGEE dialogic process.

| 27% | 56% | 90% |
| Before Youth MHFA course | Less than one term after Youth MHFA course | One to three terms after Youth MHFA course |

Pearson's chi-square test indicates participants' support role was significantly associated with their perception of using the ALGEE dialogic process, whether they held support roles related to special education needs, alternative and medical support or support roles related to pastoral, welfare, safeguarding and learning support. This association was consistent before and after Youth MHFA training. However by t2 the association in perception reached greater

significance than at t0 or t1 (t0: χ^2 (1) = 4.422, p=0.035*; t1: χ^2 (1) = 0.381, p=0.537; t2: χ^2 (1) = 8.118 p=0.004*). The odds ratios suggest participants' support roles influenced their perception of confidence in using the ALGEE dialogic process. With increasing time, participants' perception of confidence in using the ALGEE dialogic process is not likely to be influenced by participants in support roles related to special education needs, alternative or medical support but are more likely to be influenced by participants in support roles that relate to pastoral, welfare, safeguarding and learning support (t0: OR = 0.42; t1: OR = 0.89; t2: OR = 0.19).

4.3   Youth MHFA Champion Perception of Evidence-based Practice

Youth MHFA Champions had enhanced perception of their use of evidence-based practice when provisioning preventative and protective factors to young people with mental ill health. Diagram 3 shows the tentative increase in participant perception of their use of evidence-based practice to implement their Youth MHFA training within their educational setting. Before Youth MHFA training, 20% of participants reported they had high confidence. After the training this rose to 40% when participants had less than one term to reflect upon and implement their training and 54% after one to three terms. This suggests that while there was increased perception of confidence over time this was experienced by half of the participants.

The interquartile range indicates the median for this construct increases over time (t0: 2.43; t1: 2.70; t2: 3.14) indicating enhanced perception of engaging in evidence-based practice over the academic year. The minimum and maximum scores at each time point were: t0: 1.00 and 4.71; t1: 1.00 and 5.00; t2: 1.29 and 5.00, which indicates variability in responses existed due to outliers and extreme responses at each time point.

Pearson's chi-square test indicated the perception of confidence in engaging in evidence-based practice at t0 and t2 was not significantly associated with whether participants held leadership roles (including leaders of mental health or safeguarding provision, special needs provision, heads of year/phase, pastoral leaders, senior and middle leaders and managers) or did not hold leadership roles (t0: χ^2 (1) = 0.001, p=0.972; t1: χ^2 (1) = 4.420, p=0.036*; t2: χ^2 (1) = 2.576, p=0.108). There was a significant association at t1, but whether this enhanced perception at t1 is due to motivational effects immediately after MHFA training needs further study.

The odds ratio indicates that before the MHFA training participants leadership role did not influence participants' perception of confidence in engaging in evidence-based practice. However, after MHFA training and increasing time of implementing their training, participants'

leadership role influenced their perception. At t1 and t2, participants who held leadership roles were more likely to perceive they engaged in enhanced evidence-based practice within their educational setting (t0: OR = 1.01; t1: OR = 1.47; t2: OR = 1.73). It must be noted this does not indicate whether there is any difference in the actual tangible practice of evidence-based practice being undertaken by participants who do or do not hold leadership roles.

Diagram 3: Proportion of Youth MHFA Champtions with high perception in their use of evidence-based practice.

20%

Before Youth MHFA Course

40%

Less than one term after Youth MHFA Course

54%

One to three terms after Youth MHFA Course

4.4   Youth MHFA Champions' Perception of Mental Health Inclusive Practice

Participants had enhanced perception of awareness that their educational setting was an inclusive practice and mentally healthy school. Diagram 4 shows the increase in participant perception of how far they find inclusive mental health practice within their educational setting before and after they have time to implement their Youth MHFA training. Before Youth MHFA training, 25% of participants reported they perceived their inclusive mental health practice within their educational setting. After MHFA training this rose to 49% when participants had less than one term to implement their training and 76% when they had one to three terms to implement their training.
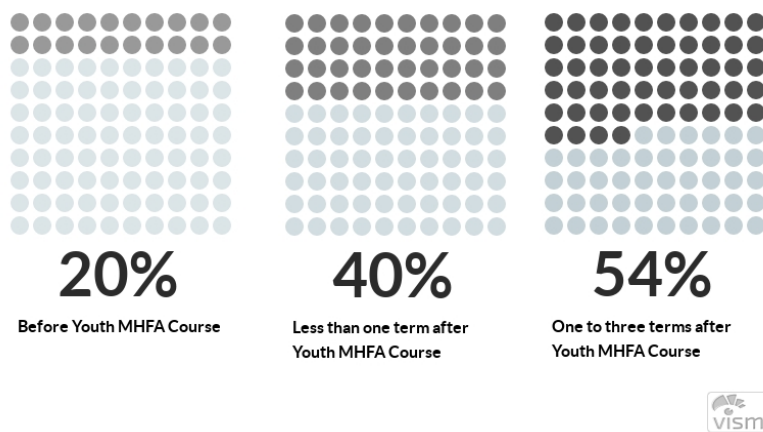
The interquartile range indicates the median for this construct increases over time (t0: 2.56; t1: 3.00; t2: 3.45) indicating enhanced perception of mental health inclusive practice over the academic year. The minimum and maximum scores at each time point were: t0: 1.11 and 5.00; t1: 1.00 and 5.00; t2: 1.15 and 4.89, which indicates variability in responses existed due to outliers and extreme responses at each time point.

Diagram 4: Proportion of Youth MHFA Champions with high perception of inclusive mental health practice..

25%
Before Youth MHFA Course

49%
Less than one term after Youth MHFA Course

76%
One to three terms after Youth MHFA Course
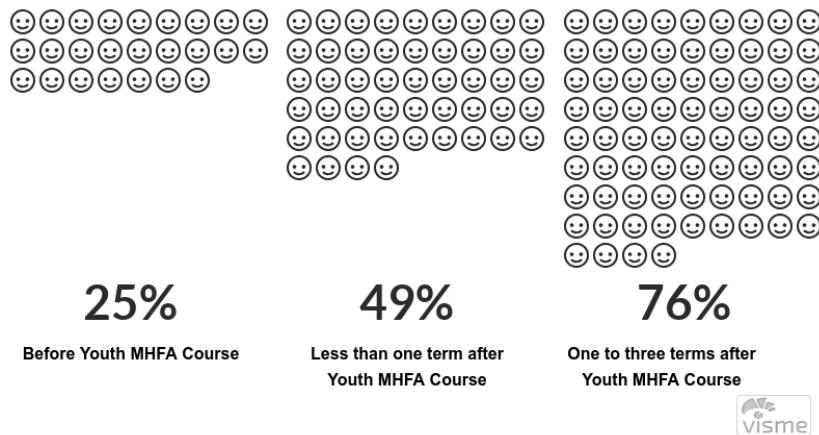
Pearson's chi-square test indicates, before MHFA training, there was a significant association between the educational setting participants worked in and their perception of inclusive mental health practice within their educational setting, whether this was specialist educational settings (including special educational needs school, alternative, SEMH and hospital school provision) or mainstream educational settings (including academies, free schools and faith schools provision). However, there was no association after MHFA training and implementation of training within their educational setting (t0: χ^2 (1) = 6.564, p=0.01*; t1: χ^2 (1) = 1.404, p=0.24; t2: χ^2 (1) = 1.327, p=0.249). The odds ratios indicate that before but not after MHFA training, the educational setting within which the participants worked influenced their perception of whether there was inclusive mental health practice, (t0: OR = 4.28; t1: OR = 0.72; t2: OR = 0.48). Before MHFA training, participants who worked within specialist educational settings were more than four times more likely to perceive inclusive mental health practice within their setting than participants working in non-specialist mainstream educational settings. After MHFA training, with increasing time of implementation, participants' perception of inclusive mental health practice was less likely to be influenced by the participants in specialist educational settings than participants in mainstream educational settings.

4.5   Youth MHFA Champions' Perception of Implementing and Developing Mental Health Provision

There is a tentative increase in participant perception of how far they were able to implement their Youth MHFA training and develop mental health provision within existing mental health initiatives in their educational setting given the barriers they perceived as potentially hindering this (Diagram 5). This consideration was not applicable before Youth MHFA training. Less than one term after training, 52% of participants reported they had high confidence they were

able to implement their training and develop mental health provision within their educational setting. This tentatively increased to 59% one to three terms after participants implemented their training. The interquartile range indicates the median for this construct remains steady (t0: NA; t1: 3.50; t2: 3.50) indicating no increase in perception of the extent of implementation and development of mental health provision over time. The minimum and maximum scores at each time point were: t0: NA; t1: 1.00 and 5.00; t2: 1.00 and 5.00 which indicates variability in responses existed due to outliers and extreme responses at each time point.

Diagram 5: Proportion of Youth MHFA Champions with high perception of implementation of Youth MHFA within their educational setting.
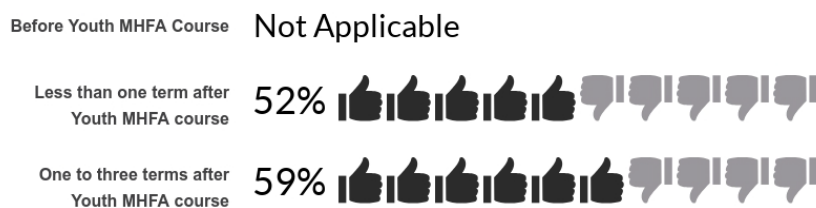
Pearson's chi-square test shows there was no significant association between participants' perception of being able to implement and develop mental health provision and their perception of barriers within their education setting hindering this (t0: χ^2 (1) = NA, p=NA; t1: χ^2 (1) = 0.910, p=0.34; t2: χ^2 (1) = 0.426, p=0.514). However, the odds ratios suggest participants' perception of barriers to implementing and developing mental health provision influences their perception of being able to implement and develop mental health provision within their educational setting. Participants who perceive high levels of barriers were less likely to perceive they are able to implement and develop mental health provision than participants who perceived lower levels of barriers (t0: OR = NA; t1: OR = 0.61; t2: OR = 0.73). That is, participants who perceived low levels of barriers were more likely to have higher perceptions of being able to implement and develop mental health provision within their educational setting.

4.6   Youth MHFA Champions' Perception of their Mental Health Self-regulation

Youth MHFA Champions who reported they struggled with mental health issues perceived a tentative increase in their ability to look after their own mental health, by self-regulation, i.e. developing their own self-help strategies or seeking help from colleagues. This is indicated tentatively by an increase in the proportion of participants reporting they have high levels of perception of being able to self-regulate their mental health (Diagram 6).

The interquartile range indicates the median for this construct remains steady (t0: 3.00; t1: 3.33; t2: 3.33) indicating participant's perception of their self-regulatory behaviour remains steady over time. The minimum and maximum scores at each time point were: t0: 1.00 an 5.00; t1: 1.00 and 5.00; t2: 1.00 and 5.00 which indicates variability in responses existed due to outliers and extreme responses at each time point.

Diagram 6: Proportion of Youth MHFA Champons with high perception of their own mental health.

Pearson's chi-square statistic indicates participants' experience of personal mental health issues was significantly associated with their perception of self-regulation at t0 and t1 but not at t2, (t0: χ^2 (1) = 5.222, p=0.022*; t1: χ^2 (1) = 22.759, p=0.001*; t2: χ^2 (1) = 0.303, p=0.58). The odds ratio showed that before and immediately after MHFA training participants' experience of personal mental health issues was less likely to influence their self-regulation behaviours. By t2 after training participants who expressed they had high levels of personal mental health issues were tentatively more likely to perceive they were managing self-regulation (t0: OR = 0.19; t1: OR = 0.29; t2: OR = 1.28) than participants who expressed they had low levels of personal mental health issues. However, it must be noted findings are based upon a within-group design which means perception of individual Youth MHFA practitioner's perspectives were not being followed over a time course, further study utilizing a repeated measures design would enable this.

5.1. School Staff's Qualitative Focus Group Questions and Responses

Focus group question 1: Is there anything you'd like to say about the general current situation of students and mental health?

A '*significant rise*'

Staff at all the six 'host' case study schools noted a 'significant' and 'massive' increase in the prevalence of students presenting with mental health problems and issues in their schools. It was also noted how these presented at ever earlier ages with younger children. This increase in numbers of students resulted in a changed teacher's role as mental health had become a major everyday problem.

> *I think that I've seen **a significant rise over the last decade**[3] and **it is noticeable the amount of students who now have mental health conditions** that we see, and it has become something that is **part of a teacher's everyday job** to actually be aware of it. The numbers have really gone up.* (North London)

> *We've also seen **a massive increase** in children expressing you know feelings that you maybe wouldn't have associated with that age group in the past.* (South London)

> *I've been here 14 years, and **things really have changed** in that you know 14 years ago the number of students who from a pastoral point of view I would have worked with who had anything that would have come under the umbrella of mental health would have been very few. Whereas **now I would say there is a significant number of boys in school who for one reason or another we would say had some mental health needs.*** (North East)

> ***We've got increasing numbers of students exhibiting mental health issues**, whether it's because there are more problems or because people are more able to talk about, or a combination. **It's probably more time is spent on that than anything else probably**.* (West Midlands)

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[3] Particular phrases have been bolded in the quotes to demonstrate the links between the quotes and the theme.

*We've had a **huge increase in mental health issues** brought to us from the students. And in terms of resolving and supporting these issues it's very difficult to do because there's no quick fix, and it takes a lot of time in terms of building up relationships, eliciting … you know eliciting support. So for us **it's one of the major areas within the school**.* (South London)

The reasons for this increase were speculated upon and connected to a variety of phenomena. These varied from a greater general awareness due to digital social media to increases in stress and pressure, from life experiences such as those connected to being an asylum seeker to the complexities of gender and communicating about mental health issues.

***Social media is affecting children's mental health** because problems that are happening in school are being also taken out of school with social media, carried on all evening, picking up momentum and continuing the next day.* (West Midlands)

*We have found **a big problem with social media** especially – bullying, depression and at the back of that being targeted online at home. And that's obviously had an impact on the family then, so we've had parents that have been in touch with worries and concerns.* (South London)

Contexts and variation

Participants acknowledged the diversity of contextual variations concerning mental health in relation to their students. Staff talked about the specific circumstances of their school or societal factors connecting with the life of the school and those within it. For example in the East Midlands School staff mentioned within the student population:

*In this secondary school where we get older **refugees**, some of the stories that they bring with them – of course it's going to **affect their mental health**.* (East Midlands)

Staff in the selective grammar school for boys also talked about such negative pressures and mental health from a variety of directions:

*I think with the fact that it's also **selective, that then puts additional pressure on boys' achievement**. And that's pressure that parents and carers will put on them … but also the pressure that they put on themselves to feel that they have to try to outperform their peers.* (North East)

One Youth MHFA trained, staff mentioned how a student's awareness was instrumental in developing their school's response:

> *One student who went to another school where they were doing a project and said Miss, I've seen this project.* **They've got this charter, it's about mental health, can we do it***… and from that idea we've now built it into a kind of* **all singing, all dancing mental health plan***, so we go all the way from Year 7 to Year 13 with lessons, staff training, support.* **We have charters***. We meet with the* **local Council** *on a regular basis. We have* **direct numbers for people who deal with mental health. We've written reports, the app***. We have a charter ourselves that they … we hold each other to account. We're about to do a listening piece of research with a University on young people's perceptions of mental health and then in the run up to the local elections what we want to see in the area being improved…* **it's become a very big part of the school it's at every level***.* (North London)

In this case study school, respect for students' voice in mental health issues was taken seriously. This had led to the students directly participating in their school's mental health policies and visions and the development of a mentally healthy and inclusive school. The Youth MHFA training had complemented and supported the school's understanding and approach.

Gender and mental health

Some staff mentioned how hard it can be for students, and in particular boys, to acknowledge and voice their experiences and needs. This gendered theme concerned the particular complexity of boys finding it hard to communicate about any difficulties they might be encountering:

> *Historically perhaps things like eating disorders, self harming, may well have been behaviours that were more associated with adolescent girls, I think we're increasingly seeing concerns there. We also are seeing perhaps* **increasingly young people with OCD***, and that's been a concern. And then I suppose perhaps there are links to other areas where young people are going through difficulties or experiencing life changing situations, perhaps to do with their sexuality,* **perhaps to do with their gender, that I think all impact on mental health***.* (North East)

One school commented on gender identity as an emerging issue:

*When we've got an **increasing number of kids with gender identity issues**, you know that when no one's looking going 'Oh my God, what's that all about?' Well we know how we deal with that - we do this this this this ... so that's then … that creates that confidence in the wider staff. **They might not know how to deal with it themselves but they know there's someone they can go to**.* (Senior Management West Midlands)

Focus Group Question 2: Has the MHFA training enhanced your knowledge and awareness of mental health conditions and issues?

Range and depth

Staff commented very positively on the range and depth of information provided by Youth MHFA training. They noted its impact in increasing immediate knowledge, but also in providing a resource for future use. Participants talked of the training giving them new information on key areas:

> *A lot of the material we covered on the Youth **MHFA course was new to** me.* (North East)

> *The medication side, I think that was really really helpful, because **I never understood that before**, and nobody had ever explained that to me.* (North East)

> *Within the training **the amount of information that we were given on a real range of conditions was brilliant**.* (North East)

Communicating with staff in different schools

Participants' knowledge and awareness of mental health was enhanced through the delivery and exchange of knowledge between participants from different schools and case studies within the Youth MHFA training. This helped participants to learn about, and from, such different approaches:

> *At our training we'd got lots of different schools like a specialist behaviour school there, we'd got primary schools, we'd got lots of different people that actually… they were saying things that we'd kind of gone 'Oh we hadn't even thought of that', and*

*we were saying things that we did, and they were like **'Oh we haven't thought of that'** so it was quite nice.* (West Midlands)

*The approach that the course had was enlightening as it was so **practically orientated** and to be **trained in a really small group** and to be able to ask questions was really good.* (North East)

Staff's comments showed that the Youth MHFA training manual was widely respected and enabled staff to understand how to access and draw on wider sources when needed:

*To be given the information and **to find out exactly what a particular mental illness was**, **and then having the structured response** or structured advice, **really sort of empowers in terms of dealing with the issue.** Because if you're a little bit unclear you've got you know the steps that you can follow through. **I mean certainly the booklet of information where you have got that background where you've got the advice and then you've got resources that you can then use, that has been great**.* (South London)

*The supporting document and documents that we were given was **useful just for a point of reference**. I haven't got the capacity I don't think to be able to remember all of it, but it's nice to know that we've got that on hand if necessary.* (North East)

*The Youth MHFA manual and workbook just allowed us to kind of know it was a safe place to go and it was correct information and we could make a decision. Having the Youth MHFA manual is like going back and you can kind of double check and think is my thinking right on this area? And then you kind of think actually **now I feel a bit more confident or a lot more confident to go into this and this is what I need to do**.* (North London)

MHFA training made staff more pro-active

The following range of comments were representative of Youth MHFA trained members of staff in all the focus groups. They felt that the Youth MHFA training had given them the skills to be 'proactive' 'postive' and 'confident' with students' mental health issues:

***Before the training, you tend to act in a reactionary way more than in a proactive way** – something will happen and you think we'd better deal with that, let's*

*do something on it, let's do some form times on it. And I think **we felt really positive about how much we could do proactively**.* (North East)

*Previously, if there was a mental health issue suspected we would have tried to refer to somebody else and **just sat back and waited for that referral to happen**, whereas **now we're more proactive with all this training and feel more confident about actually tackling some of the issues** and seeing whether we can help them put something in place to help. Whereas now it's more **all the school staff are taking these strategies on board and using them**.* (East Midlands)

The training gave confidence to staff to appreciate that there was 'a lot' they could do for a significant number of children, whilst acknowledging their limitations for students who needed professional support:

*The positive side of it I think is that it made me realise that actually **a lot of the strategies are things that I can do** and that we can do in school and that whilst there are young people who do need that extra level of expertise that we don't have, there are a significant number who don't, who we can support… and I felt more enabled to do that.* (North East)

Participants reported that within a greater societal focus upon students mental health, that the Youth MHFA training had reinforced the need for mental health initiatives to be embedded within inclusive healthy school agendas:

We wouldn't have thought we need to make time for this in the curriculum unless we had done Youth MHFA… and it's not just to be fair the Youth MHFA, it is the whole agenda of young people's mental health at the moment. But obviously that opportunity for us highlighted the need to support students in all areas of their health. (North East)

One of the respondents stated that the training had given him the knowledge to identify possible mental health issues with students and that the training had then allowed the staff to understand more about that students' behavior and attitude within the classroom. He stated that this had given knowledge about the bigger picture of the students' life:

*The training me made aware of mental health, not actually knowing what exactly what it might be, but **knowing that this could be what's happening to them**. Then*

*just step back and **say this is the bigger picture**, give them time and see … **you know support them in this way and see if that makes a difference in the classroom**, I've been doing a lot of that.* (East Midlands)

This knowledge of the bigger picture was then translated into positive relationships with the students rather than disciplinary punishment:

*Yeah, I think the training made us better at dealing with mental health issues, yeah so **now knowing what we're looking at**… he might or she might have a **detention**, but we will speak to the child, we'll use that time in a constructive way, **we'll use that time so he or she can express what they feel**.* (East Midlands)

Youth MHFA training gave confidence to ask difficult mental health questions

All six focus group discussion respondents stated that the training had given them the confidence to be much more direct in asking difficult questions about students' mental issues. They stated that they now 'had a vocabulary to use' when asking students about mental health issues:

*I think that now after the training **we are more up front about it** and we talk to children to say it's okay to have these feelings, let's see if we can find a way for you to deal with them. **The training has given us the vocabulary to use**, so it's telling us that it's okay to talk about, and things that perhaps we would have shied away from previously. It's that confidence thing I think. **Certainly, made me more up front about talking about it and looking at difficult mental health issues**.* (East Midlands)

This vocabulary and confidence extended crucially to having the confidence to ask students about whether they might be suicidal or wanting to self harm. For some members of staff this was a major breakthrough in the knowledge and enabled them to open up crucial conversations with students.

*The key thing I learnt was, that actually **it's okay to ask somebody who might be suicidal those direct questions**, and I think that was one of the major things that came out of it, that actually you can have those quite direct questions. So I think in terms of that awareness **I feel more comfortable**.* (North East)
*Our trainer said to us people think the worst thing you can go and say to that person is **'Do you want to kill yourself? Do you want to self harm?' But it isn't**. Before*

*the training we just wouldn't ask it directly, whereas **yesterday I sat with these year 11 students and said 'Right, what is your thoughts on self harm?** Have you self harmed? Are you thinking of self harming?' and **I was so much more direct and it opened up a conversation**.* (West Midlands)

Even for those pastoral staff who already had this understanding, the training was useful in practicing those difficult questions with each other:

*At the training a lot of us were from pastoral parts of the school rather than curriculum, so we had some experience anyway, but **we still needed to know how to ask those questions**? How do we do this? How would you deal with this? And so we were just testing it out for ourselves **to see what would happen if we had these conversations.*** (North London)

Allowing time and space to talk

One of the respondents emphasized that in her experience, students don't understand why they're feeling in a particular way and that they don't know that they can ask for help nor how to ask for that help. For the following teacher it was important to allow students those opportunities to talk:

*Giving students the opportunity to chat, **let them know it's okay to talk about things**. A lot of them don't want to talk about them, but it's **making those opportunities available** and being hyper-aware that you need to be doing that with them. **Children, don't know that they can ask for help and they don't know how to ask for help**. So it's often the adults having to make that offer to them to be able to unpick it, because they don't understand what's going on, and **they don't necessarily understand why they're feeling how they're feeling***. (East Midlands)

For other respondents the training reminded them of the important practice of focusing upon students and giving them the time necessary to articulate their feelings and listen to them. Once again, the training gave staff the confidence to make and take that time within the busy school curriculum:

*The training was more **about reminding me of my practice in terms of time, and actually sort of stopping… putting the pen down or the computer down** and actually acknowledging that they were sat opposite me telling me something. And, so now I am more mindful of that practice I think to stop and look and focus. **I'm very***

conscious of sort of giving more time and focus. (South Coast)

The training discussion raised the dilemma of you've got what you might do with individual children, and also having the time, the space, in order to take the knowledge that you've got and actually use it properly. **So if someone questions time, it's like well actually these things do take time**. (North East)

Focus Group Question 3: Has the Youth MHFA training improved your awareness in spotting the signs and symptoms of mental ill health in students?

Developing knowledge

Participants talked about the training delivering knowledge of signs and symptoms concerning mental health conditions and students:

> **Definitely the training helped**… *and the things I'm able to notice now in my students,* **stuff that I wasn't even aware before** *– I think that is maybe the biggest benefit from having done the training.* (East Midlands)

Knowledge was also connected to the course providing information to enable participants to identify what they had been encountering for some time. One participant framed the change as:

> **The training made me realise that I now knew what I was looking at**. (East Midlands)

Talking about eating disorders and stress as examples, one participant described this change as:

> *There are things that I wasn't aware that was an issue, but it could be.* (East Midlands)

One teacher described how, after the training, they knew specifically to what to look out for:

> *I now know it's something to do* **with this specifically you know because we've been told on the training that's what the signs are for X, Y and Z sort of**

thing. So I can now say it could be to do with anxiety, or it could be to do with stress, or it could be this. (South Coast)

The following is a more detailed example of such a change in knowledge of signs and symptoms, concerning 'depression':

*One big thing for me from the training was about depression… so the trainer said it's a prolonged period of 6 weeks and if there's been no change within a 6 week period then it's possibly depression and then then alarm bells would go off. **Well before the training I wouldn't have thought well actually how long has this been going on**?* (West Midlands)

Signs, symptoms and increased knowledge of actions to be taken

The knowledge of signs and symptoms were connected to an understanding of actions to be taken and resources to be offered. The following teacher was clear her role was not to deal with mental health issues, but rather to act in preventative role promoting healthy mental school. So example, she found the stress bucket metaphor and Youth MHFA workbook technique extremely helpful:

*I think for me taking the training it really made me kind of focus on signs and symptoms. **It made me really think**… you know this is what I need to be looking out for and kind of signposting things. **Not dealing with it, because that's not my role, my role is to use it and then signpost to the correct… outlets**, but also the resources, we've kind of taken some of those resources and put them into lessons for the students, **like the stress bucket because I think actually they're really relevant**.* (North London)

With younger children in the 3-18 South London, the training had helped the teacher to make a list of 'red flags' for particular students' mental health. This was because it was felt that younger children, unlike older students, may not know how to articulate their feelings:

*The training provided almost like a checklist for red flags. You know you can pick up on patterns of behaviour and monitor things. **So we're looking for identifying factors and where that could go and where you could then refer on to**. So not as immediate as maybe some of the older children that come in and directly tell you, **we're kind of more looking for those red flags and picking up on things that aren't being spoken about**, you know not being able to articulate maybe straight*

> *away what's going on for them, but kind of identifying patterns of behaviour that could link in to things that we learnt on that day.* (South London)

This participant's raised awareness of young children's inability to know and express their feelings is particularly important given that Childline has seen a 36% rise in over four years from young callers needing help for depression and suicidal feelings (Summers, 2017). Participants commented on how the training raised their awareness of such particular signs and symptoms, but *also* helped them to understand the nature of the intervention needed as a response to signs and symptoms:

> *I feel **more aware now of the signs**. And also **the signs that I need to consider that are really serious**, and that **there is intervention needed** if there is an emergency.* (North East)

> *I found it really beneficial to have **a lot more detail**. And then obviously through the training we were given a way to move forward if we had a young person in that position. And what we could do, **we could do from there**, so in terms of being t**he first aid there was a means that you could understand**… you know appreciate what the situation was, **and there was a way to respond**.* (South London)

An example was given concerning different experiences of depression and the kinds of response needed. Being able to draw upon such knowledge is important because recent research (CLS, 2017) with 10,000 secondary school students has shown a quarter of girls (24%) and one in 10 boys (9%) are depressed at age 14. Again, the following teacher felt the training had given them the confidence and had empowered them to make appropriate decisions about depression and what the teacher felt they could and couldn't deal with:

> *We looked at the difference between… being clinically depressed and just being sad or down … **I felt that I was much clearer about that afterwards** and I felt more… I hate the word 'empowered' but that's the only word I can think of… to decide… this is really serious and **I need to point this young person in the direction of this (service), or actually we can deal with this in school**.* (North East)

Another example concerned the way in which one participant developed this aspect of the training, concerning a differentiated response to signs and symptoms, into an immediate engagement with students who were encouraged to understand their own patterns of thinking:

*I think pretty much the following day in an assembly in a very loose way **I said that mental ill health changes and fluctuates daily**… and that's never necessarily a bad thing. So with that I think that then empowered some of the students a little bit to think '**Okay that's just what happens'.** And so **maybe that in itself has helped some of the students themselves spot their symptoms**.* (North East)

This teacher went onto state that she found the training 'very useful' because it enabled her to support students to understand that their own thinking processes were temporal:

*I think whether that was the intention of the training just to deal with it initially **to try to support students when they first start thinking that they're struggling, and to support us to help identify that - that's what I found very useful**, because we're just telling them that it's okay to fluctuate with this issues.* (North East)

Participants made other positive, direct comments in terms of the connection between the training and the lived experiences of working with students in schools:

*There was **a really practical element to the training** in practical ways to deal with young people.* (North East)

In these ways, participants stressed that awareness, developed by the training, was not confined to conditions or symptoms, but also to *structures and actions*:

***It makes you understand maybe what's behind it**, or some of things that are behind it. So you're able to help her more especially the awareness of what to look for… because yeah, that's where it all begins isn't it, even if it is to pass that on to someone who's been delegated to deal with it, yes definitely.* (East Midlands)

Youth MHFA training encourages listening and asking and going deeper
Connected to action and responses, participants talked of a change in their approach to listening and engaging with children that was more aware of wider contextual issues and a 'bit deeper':

*Thinking a little bit deeper. But important reminder to maybe look behind a child's behaviour or how a child's responding to a teacher, and **sort of dig a little bit deeper maybe**.* (West Midlands)

It's spotting those things and trying to unpick what's going on so that we can support them. **Whereas before we just put it down to behaviour and perhaps didn't unpick the reasons behind it as much**. (East Midlands)

Once again another teacher gave an example of this change of digging deeper in response to a students' poor behavior:

Actually I had a kid just before half term, and he pushed another girl, and when it came down to it, you know detention for everyone kind of thing. **But actually after speaking to him** *– he kind of like got angry and* **then when we tore it all apart,** *actually it's because there's been a breakdown in the family, dad's got a new wife, got a new baby, he feels pushed out, he feels alone, sister's moved out – and there was all these other things that came out. Where before I'm like 'You know what, he pushed a girl – give him a sanction for that'… but actually there was more going on.* **So the training helped me to actually dig deeper**. (West Midlands)

The value of Youth MHFA case studies

The connection of knowledge of signs and symptoms with lived details, such as the training case studies, was acknowledged by participants as particularly useful in understanding and applying the training:

It was unique in a way that other mental health training stuff isn't. *The Mental Health First Aid training for me was a lot more practical because it wasn't just about learning different conditions are,* **it was really how to approach them**. (West Midlands)

Cos our trainer was a police officer he was giving us examples in his own life *that he had witnessed at work, and so he had seen lots of things, so he was able to relate, so he was saying these are the signs and symptoms for this, but instead of just talking through something he'd say so I witnessed this at work and then when he was talking about his case studies…* **and we were able to say oh yeah we've seen things like that**. (North London)

The practical case study training built confidence

Participants also saw the knowledge that the training provided them with as *interactive*: as something they could act on, imbuing staff with a form of a language or vocabulary to open

up lines of communication. This was connected to the programme enabling personal attributes in trainees, such as developing the confidence to act on their knowledge:

> *People are scared to trigger something? What happens if we talk about something and we upset somebody or we don't deal with it in the correct way?* **The Youth MHFA actually gives you a really good scaffolding framework to have those skills**. (North London)

> *I think it's about being confident in those conversations, whereas **before the training I don't think I would have had the confidence** to kind of go 'Do this this and this'.* (West Midlands)

The training changes staff's whole approach to mental health issues

Staff talked about the Youth MHFA training shifting their whole approach to engaging with mental health, both broadly, in relation to a more proactive 'approach', and in relation to specific areas of mental health within their teaching, for example in a PSHE class. The following illustrates this more 'proactive' approach with a specific example of a shift away from working primarily from a 'negative' point of view. In this context, the teacher talked about how the training had a direct impact on their work with the PSHE class:

> *I teach a Year 7 PSHE class, and the topic… that we're given for the first part of the autumn term is mental health and wellbeing and emotional wellbeing. **So I used some of the things from the training with that group**. I think certainly the way I delivered that session, and I've taught PSHE for years and years, **was different as a result of that training I think, and I approached it very differently**.* (North East)

The teacher described this shift as building on students' own resilience and in terms of working with the students to develop a sense of a 'toolkit':

> ***They were able to share with each other strategies that they have when their stress buckets get too full**, what do they do, whether they go to their room… I was quite pleased in a way that they seem to have come in with that kind of toolkit ready. That needed a bit of tweaking perhaps to help give them some other strategies – many of them only had one idea – **'I go and sit in my room quietly on my own, listen to my music' or… so I sort of said 'Well what if that doesn't work, what do you then?' And they hadn't got the next step – I think that was quite an enlightening discussion**.* (North East)

One set of comments expressed ideas concerning how the information provided by the training on neuroscience and the ways in which the knowledge gained through attending the training could be cascaded to other staff and to parents:

> M *I think it will help our colleagues in understanding that **these are children and that they will make mistakes** and they are…*
>
> F *And they will push boundaries.*
>
> M *Yeah. **And it's not through their fault, you know mainly, but it's just how they're neurologically programmed**. But as long as we're helping students learn from these things**, so they're not feeling as angry or frustrated or upset you know***, then we're doing all that we can.* (North East)

> *The bit that stuck in my head was from the video and **the whole like sort of science behind it** and how **children have higher levels of certain stress** hormones and that's why they react in certain ways **and why some of them will go down the route of self harm***. (South Coast)

> *The 10 minute video about the neuroscience and particularly **adolescents want to take risks** - that was one thing that I found most informative. **That was amazing***. (North East)

Focus Group Question 4: (i) Has the training improved your awareness of preventative and protective factors to mental ill health?

Youth MHFA Champions as Child Advocates

One of the senior staff members in the West Midlands case study school reported how the training had empowered the school's pastoral staff to make specific and informed preventative and protective decisions about students who presented with mental health issues. These pastoral staff also acted as advocates on the children's behalf to the rest of the school. Before the training the West Midlands senior teacher noted that the staff might be able to identify mental health issues but not the preventative and protective factors that might be used to help alleviate the situation. Specific preventative factors included making other staff aware of particular children's needs and encouraging staff to be more sensitive to them.

*They have a sort of **advocacy role**. So yeah, **they're far more able to speak on behalf of the kids who've got mental health issues**. It doesn't mean that the teachers are any better at listening to it, but it means that **we've got people at the heart of the school who are stating the students case far more strongly**. What I've got sort of in front of me is like mental health champions for the children. So where it was before the training, someone will bring an issue along and say you know for example 'This child is self harming' – **but now I'm getting 'Child is self harming and I've done this this this this and put all this in place to help the child.** And I'm intervening with this teacher so this teacher doesn't do the wrong thing again, because I knew that it was something they said that set it off'. **That's fantastic.*** (West Midlands, Senior Management)

It's First Aid, 'This is as far as I can go'.

As regards preventative and protective factors, the delegates appreciated that the training was clear that it was simply 'first aid' and that they were not being trained as mental health professionals to resolve students' mental health issues. They were clear that their role was to identify mental health issues and then sign post and access mental health professionals for the students. So with the 'first aid' analogy in mind it was interesting to hear the following teacher:

> ***The trainer was really good at reinforcing the fact that it's first aid and we're not there to solve***. *But there's such a risk of people thinking that they can solve things, and it going horribly wrong… if someone broke their leg you're there to stay with them until the doctor comes… we're not learning how to be a brain surgeon kind of thing. It's good to know that we're there to help and point them in the right direction, not there to solve. **It's important to say 'This is as far as I can go'.*** (South Coast)

> ***But also I felt it gave me reassurance in that I'm not expected to have all the answers,*** *and quite possibly nobody has all the answers, but these are strategies that you use to support.* (North East)

Despite the clear role definition of the training being 'first aid', one South London respondent remained unconfident in ability to intervene regarding a student self harming at home. She wanted more training:

*I can give an example of a young lady who's in Year 10 who is self harming, and this young lady lives just with her mum… it's extremely distressing… **we're not equipped because we haven't had years and years of experience of training in those areas**. If the trigger was home life you know… it's very difficult because the advice you're giving, you're not confident with the advice you are giving because we've read it in a book and **we've had a short introduction** and we can read advice online. **But that's what I mean I don't feel confident and equipped**. (South London)*

The absence, removal or inadequate resourcing of mental health services

One teacher noted how the school had become an important resource for both parents and students as services become unavailable outside of school. However, this school had built up its knowledge and awareness because the head teacher died by suicide three years previously:

*In addition we're also dealing with **parents with mental health issues** and then having to support them and their families, because **there aren't necessarily the support systems out there** or trying to get them support from outside, because you know lives are impacting in school too… **recently a teacher died by suicide**. (North London)*

The increasing absence or inadequacy of resourcing was also noted as a problem in relation to the role of referral:

*For this young lady the CAMHS referral is in, but that could be 3 months before first assessment, then 3 months before the second assessment, so **we're still looking at someone dealing with something over a period of 6 months**. (South London)*

This situation led to teachers struggling with students in crises and occasionally taking them to A&E in order to get immediate help:

*The **mental health services where we can refer the children to aren't readily available** or the time limit is long, and ultimately **we've got the student on a day to day basis facing a crisis**. And I don't think the GPs are able to do much more about that. The advice is well if you feel that your child is really struggling or the issue at that time is significant, to **take them to A&E. Because that's the way that they will get the immediate response**. (South London)*

The South London case study school reported that it had suffered a drop in its counselling service for younger children so they are taken to A&E where they will receive attention:

> *The situation's even worse at primary children, you know they're not old enough to access any outside services as in you know **we've had a drop in our counselling service**. There just seems to be an age of at least being 13, so we're finding **that there isn't anything that we can refer the younger children to** apart from CAMHS, and that's 18 months, 2 years before they're ready for assessment*. (South London)

MHFA staff *'holding'* and *'mopping up'* students

One focus group were frustrated that the MHFA training meant that the pastoral staff were increasingly able to 'mop up' children with mental health problems:

> **We are the sponge – we're mopping it up**. *For me I think that **we are sponging up a lot of the outside agencies that are just swamped** and that quite often we could… or students could do with a lot more intensive support from people like CAMHS and Young Minds, but **the waiting lists are that extensive so it means then that we are dealing with so much more**. (East Midlands)

> *Once a child has a difficulty with their mental health, **undoing that is probably never going happen**. **So many times that stays with those children because we're holding students**…. With **our school counsellors as well, who are also massively stretched**. Whereas **if we could put a counsellor in place when we got the warning signs, other stuff might not have happened**…. So **we're more preventing issues from waiting till they get** worse and then having to firefight.* (West Midlands)

> *You know you've passed on all the information about the local agencies that the child can be working with, and then you know straight away they've got **a brick wall of well it's an 18 month waiting** list before you have your initial assessment and then you'll go on your waiting list. It's 14 weeks for Young Minds…and 18 weeks for CAMHS. We've got still students that were referred perhaps last April that have had an initial assessment, **they've waited lots of months for an initial assessment, and are now waiting for a key worker**.* (West Midlands).

Youth MHFA trained staff were able to identify children with mental health issues and then had to 'hold' and manage the students' mental health which 'increased the strain on schools' (Children's Commissioner 2017,17) and meant that Youth MHFA trained staff were 'dealing with so much more'.

Focus Group Question 4 (ii). Has the training assisted you in considering how stigma and discrimination connect to student mental health?

Stigma and staff's mental health issues

In this section we focus on the varied ways that staff found the Youth MHFA training useful in further raising their awareness of the stigma, silences and dismissal of mental health problems within schools. For the focus group respondents, the training made clear the relationship and connection between the member of staff's own mental health self-care and subsequent care of the students' mental health. The training afforded a space that enabled the member of staff to share such professional problems and mental health issues. Raising awareness of the member of staff's own mental health wellbeing was a critically important aspect of the training for the staff. If the stigma in the wider school culture was to be successfully challenged, staff were clear that their profession's own negation and dismissal of their mental health problems, often associated with their stressful work environment, needed to be challenged and changed first and the training encouraged this cultural shift. Work overload and stress (NUT, 2017) combined with a professional stigma around discussing problems had led to a situation where 'nearly half of young teachers say that mental health concerns could force them to leave the profession'. For example the following teacher described the professional stigma attached to admitting that they had experienced a difficult lesson:

> *My main worry is that teachers feel that they're considered to be failing or weak or not able to do their job if they actually go to the primary mental health worker and say "I've had a really shit lesson with a really difficult class and it has left me feeling really really wobbly and like I can't do it".* **If you look at the data referring to mental health services in adults, there's a massive percentage of teachers going in there***.* (South Coast)

> **Sometimes you come out of school and you just feel 'I actually am total rubbish'** *and then a parent will reinforce that for me. And then you think 'I'm going to take that home with me…' cos that does stay with you and there's no one you can really tell that to within the school.* (West Midlands)

Yeah, there's huge problems with stress throughout the school. **Huge problems with stress with the teachers, who then pass it on to the kids**. (Senior Management, West Midlands)

Delegates reported that being made aware of their own mental health and wellbeing through such techniques as the Youth MHFA training 'stress bucket' was the 'best' and most significant part of their training. Through tuning into their own mental health reduced enabled them to better understand and listen to colleagues and students issues which in turn reduced the stigma throughout the school:

For me I think **the best thing I learnt is knowing about my own mental health** *and wellbeing.* (North East)

It's kind of **just having an awareness of my own kind of mental wellbeing at times has definitely helped**. (South Coast)

Thinking about whether your stress bucket's full analogy that we were given on the course has helped me not only identify my own stress levels, but also like to support my colleagues and to know when they're starting to show certain signs of too much stress. (North East)

The training made me think more about **how I can look after myself and that it's ok to do that in order to be able to look after students**. (East Midlands)

Because we can't say to children, oh you know we're raising awareness against stigma **if we don't actually change our own stigma. I think staff sort of admitting to their own difficulties. That's the point where we need to get to**. *It's okay, I can care for someone else who might be having that, but I don't want anybody to know whether or not I've got any.* (South Coast)

Breaking stigma is on agenda, *'but we're not there yet'*

All six focus groups found that the training had usefully enabled them to discuss mental health issues more openly in schools and hence tackle its associated stigma. They also noted that stigma and discrimination was still prevalent within the often traditional cultures of schools. Having mental health issues dismissed, denied and stigmatized was unfortunately still prevalent in some schools:

*We talked about it on the course didn't we, but I think **we were all very aware of what people might say and how they would view it and dismiss it or be derogatory about it**.* (East Midlands)

Even in the highly aware and active North London school, stigma and discrimination remained a problem:

***It is about breaking that stigma which is everywhere, because people will only talk when the stigma has gone.** We are attempting to break the stigma and we talk about mental health in our school a lot and I thought that made me feel really good that actually you know, they understand that it is now part of the culture that they can talk about mental health and we're moving… **we're not there yet, but we are moving towards it**.* (North London)

So, for these schools the Youth MHFA training was useful in furthering the school's agenda of tackling stigma and mental health. The Youth MHFA training had helped some of the staff raise their awareness that stigma and denial of mental health issues was one of the greatest challenges throughout the school culture. This was partly because *accepting* mental health issues as a normal part of life was still challenging within a school culture where discourses of normality continue to exclude mental health issues:

***The training has confirmed** and helped us to culturally accept within the school **to normalise emotion and mental health** and difficulties.* (North London)

*I think that's one of the biggest challenges to make everybody… parents and students and staff… understand that yeah, it's just part of life, and it's something that might happen. The training showed us there are strategies and there are ways of dealing with it… yeah, like I said **it's a fact of life, it's about accepting**.* (East Midlands)

***That came out of the training for me**, to encourage them to understand that a lot of people have a wide range of difficulties and **it's perfectly normal.** Because they're struggling with something it doesn't mean that there's something wrong with them or they're different.* (North East)

***That 'You're not on your own' message I think helps them to not panic**.* (West Midlands)

Participants were aware that within schools raising mental health awareness, challenging stigma and changing cultures was a mountain to climb since school culture did not yet facilitate its open discussion and acknowledgement:

> *If you're talking about genuinely making a difference for mental health for kids in this country then you're talking about you know root and branch change. That's not necessarily a massively expensive thing, but **it's that a school cultural thing***. (West Midlands)

Challenging fear and stigma

Prior to the training some of the members of staff admitted to being scared and frightened of mental health issues and readily admitted to holding stigmatized views because of this fear. For the staff below, the training was important in helping them to break their own fear, anxiety and stigma around mental health issues. In particular the training had broken their fear and apprehension by making them aware of what they could practically say and do if a student presented with mental health issues:

> **I'm not scared any more of all the signs** *and things like that.* **But before I was like 'Oh my God, mental health issues' I'd be like 'Oh how can you deal with all this?'** *– I'd try and give it to someone else, you know!* **I was so scared of mental health cause I didn't really understand it** *so I went to the training, and I felt that* **it really helped me to not be scared of it. I found it so frightening before**. (West Midlands)

> **Before I did the course, I thought mental health, no way, that means someone's going nuts and I can't do anything**… *do you know what I mean, cos I weren't used to it, kind of thing, so* **it was a big stigma in that kind of way, but then the training helped me understand actually I can deal with it.** *And now I feel like I can deal with it.* (West Midlands)

Here the Youth MHFA training was centrally important in allowing staff to openly discuss mental health issues throughout the school. Through such open discussion and group work together the members of staff were given further confidence to challenge stigma and discrimination within their schools.

Changing School Cultural Stigma

In some school cultures, the shame, guilt and silencing remained attached to mental health issues. For example, within the West Midlands school, even when a child had cut themselves badly enough to need an ambulance, the child was still in denial about it:

> *We've had children **who've self-harmed who've tried to hide the fact and wouldn't say,** and it's taken a member of staff to actually find out that they have actually quite badly self-harmed and have needed ambulances.* (West Midlands)

However, within the same school partly because of the above incident and partly because of the Youth MHFA training other students who were now more aware of, caring and listening to each other as a group. Such peer support was considered by the staff as valuable and listening to each other in a group was enabling the following students to break the stigma attached to mental health issues:

> ***I now have students coming to me who have got very very good at doing something about it** not necessarily for themselves but they will come and say I'm worried about my friend because reporting that another student was saying these things, so I took a statement from the students who were saying they were concerned about their friend, because she was stating that you know in various ways she wanted to hurt herself, so then that's a cause for concern, it's flagged up as a cause for concern, and we speak to Safeguarding about it, and you kind of work out how to deal with it.* (West Midlands)

Following the training, all the focus groups reported increased confidence in listening to students and having 'stimulating conversations' with them and that this dialogue had enabled positive communication to develop within the schools:

> *And rather than trying to ignore it and not wanting to get involved or to be seen as nosey**, it's given me the chance to say well if you want to talk you can**, and then it's up to them. **And they've opened up more in my experience**.* (East Midlands)

> ***I think what's really beneficial is to have open conversations about mental health and realise your limitations. I came away from the training and I thought I might now have the skills to have very open conversations**.* (North East)

> *And I think the thing about **the training was really good, that actually you could have conversations with people you know a stimulating conversation, raising***

the profile, raising awareness – and that's got to be good. (South Coast)

Focus Group Question 5: Do you consider the training has had an impact on staff providing help for students with issues concerning mental health?

Youth MHFA is one strand, it's another tool

There was a consensus amongst the focus groups that the training had had a positive overall impact on the staff providing help for students. However, some respondents saw that the Youth MHFA training, as one 'strand', among many 'strands' rather than any sort of all encompassing panacea. They also felt that a one off training was insufficient and wouldn't make 'any difference' but they felt that the Youth MHFA training complemented other initiatives and interventions in the area of mental health and that this was important as there many different packages offered to schools in this area:

> *It's one strand of many strands and things that we do, and **I don't think from one training you're going to make any difference. It's a combination of different strands that's needed**.* (South Coast)

> ***It's another tool in the toolbox.*** *It slots in really nicely with what else you're doing around with all this.* (East Midlands)

> *But also **there's an awful lot of resources and events and things like that are offered to schools. And I think it's made me more aware of actually looking at them carefully and seeing which ones we should use**… rather than just saying 'Oh no, not something else to do'.* (East Midlands)

Focus Group Question 6: Has the training had an impact on creating a more inclusive, mentally health school?

Whole school approach

For the following respondents, the Youth MHFA training highlighted an inclusive whole school approach to mental health awareness, prevention and protection:

> *I mean within the context of the school there are all the adults as well and their mental health wellbeing, so it's part of that, and I think **it has made us much more aware of everybody in the school**.* (North East)

> *So for me in my role as SENCo, my challenge is **how do we stop it being individual incidents and think about a whole school ethos**? (South Coast)*

Training divide between Pastoral and Academic Staff

A major hurdle reported upon by both Midlands and North East focus groups was that the trainees were primarily pastoral staff who had attended the training and not the academic staff. They were concerned that because it was almost exclusively pastoral staff who had received the training that this would then make them solely responsible for mental health issues within their schools and not be spread out amongst the whole staff. The pastoral teams were anxious that because they had attended the training, this meant that the wider teaching staff across the school would not have to take responsibility for mental health issues. This would then be detrimental to the training's whole school approach:

> *That's just the unfortunate nature of doing **a brilliant training programme** - we knew how to empty our own stress buckets and to look after one another's stress buckets… **but then we then wanted to share that information to support our colleagues as well** but we just haven't really found time or prioritised the time to lead the training to support our colleagues. (North East)*

> *I have to look at that broader picture, **because what worries me is all this training and knowledge just disappears to two or three of us people**, and then that's that. (South Coast)*

> *Because if we go out and spend our valuable time doing something **you don't want it to just impact one person**, you want it to have a much bigger impact across the school. (East Midlands)*

Cascading the training

In the North London case study which had a very supportive SMT regarding mental health issues, the Youth MHFA trained staff were able to cascade and share their knowledge with colleagues which led to a referral to professional support:

> ***The training got lots of conversations going** and people wanting then to take it down into lessons, so after the training we worked together some people listed off oh actually they've got this, they've got this, I've seen this, I've noticed this, and **we had a conversation with three or four staff and we we're actually putting all this***

*together. This now suggests that actually they have got a mental health issue, but **individually we wouldn't have seen enough of it**. It was depression and self harm and we asked the student directly about it. So I spoke to the child initially, because I was like who's going to speak to them? They've now gone to see the counsellor today, we have a counsellor two days a week.* (North London)

Focus groups reported that they needed SMT to be Youth MHFA trained if the issues were to be prioritized in the schools. For example, there was a strong feeling in the South Coast focus group that the cascading that had taken place would not have happened if senior staff and department heads had not been trained. Within the South Coast focus group it was felt that senior leaders within schools, such as heads of year, were needed to be trained if school cultures were to be changed:

*We thought who are the best placed people to be doing this training, which is why **we're hoping to train all of our heads of year as advocates on an Inset day**, cos obviously we can't fund to take that many people off timetable.* (South Coast)

***If department heads were trained**, then they may be able to cascade it. **It's about getting someone in every department to have the training** is the best thing, because then you've got like a resource of a person in every department, because it is about having a go-to person in every department isn't it?* (South Coast)

***Getting senior teachers trained to do specific mental health things would give it a level of importance** and needs to be seriously dealt with.* (South Coast).

*So you **might use the senior teachers** and maybe one or two other colleagues might see it, but if we're doing it and we're taking it to staff meetings and talking about it, **it's having a much wider impact**.* (East Midlands)

***It does have an impact on who you train because it depends how it gets fed back and cascaded back in school.** Because otherwise you're just training one person. **Cascade it and have a bigger impact.** We're going to work with the rest of the staff throughout the year because **these strategies are important** and people need the awareness of what could be going on.* (East Midlands)

For the West Midlands focus group were frustrated that it was easier to set up performance management training than mental health training because of the school's emphasis upon performativity:

> But **it's far, far easier to set up an Inset session on whatever else such as performance management?** Yeah, getting the green light to do that is far easier than 'Let's do a day looking at how we can support the mental health of students'. (West Midlands)

Performativity and OFSTED

Staff were frustrated that so little attention was paid by OFSTED to children's emotional wellbeing:

> I mean when you're running a school **you're not going to get judged on the emotional wellbeing** of your children are you? (South Coast)

> I mean if you're talking wider about what would improve things, would be **to change the focus in OFSTED**… you know OFSTED, it's there as part of personal development, welfare, but you know schools have a specific responsibility about **supporting the mental health** of their students. (East Midlands)

YoungMinds (2017, 5) a children's mental health charity, has noted that 'The prominence given to exams and academic attainment within the education system is having a negative impact, with 80% of young people saying that exam pressure has significantly impacted on their mental health'. An illustration of this concerned self and peer pressure:

> There's still the stigma attached to those seen as more intelligent than their peers. And for some of **those children labelled as not 'bright', their mental wellbeing** and their sense of self esteem and their sense of self within the school in my opinion soon drops, and that's why I then think that these lads then can soon become quite disengaged and **feeling quite down about themselves**. (North East)

> **They know if they're in a low set**, so straight away they're like 'Oh you know what, **I'm going to fail anyway**' or things like that if they get moved about – **it makes them just feel so desperate…** in Year 7 and 8, and they might get moved groups because you know for their ability and stuff, and **literally they will break down** because in their head it's 'I've failed my GCSEs because I've been moved from this

*group, and **there's no way I'm ever going to pass**… they just get stressy….* (West Midlands)

*You know I've got one student who's very bright and put a massive amount of pressure on herself that I can think of particularly who is now putting **so much pressure on herself that she's having panic attacks and anxiety attacks in a lesson, so it's counterproductive.** Because then she's not doing the learning, cos she's got herself into so much of a state that she can't think anymore, so then she comes down here in a massive state with a hyperventilation bag… and that sort of cycle of putting pressure on till a kid can't actually cope.* (East Midlands)

Throughout the focus groups there was frustration that the academic focus in schools acted as a barrier to cascading the training to the wider staff throughout the school. This frustration was found not only in the Grammar School which had a reputation for academic prowess but within the academies' focus groups too:

> ***Time for training is difficult here**, but mostly that is because of the nature of this school, because we are… it's an academic school, there's so much curriculum time and there's so many subjects.* (North East)

The relationship beween mental health and academic pressure was mentioned in terms of anxiety, particularly for disadvantaged children who might learn in alternative ways:

> *Another area to add on there that I didn't mention is **anxiety, because the school curriculum has become perhaps very narrow**. And with lots of rigour with regard to exam, exam preparation. And **for students who perhaps learn in a different manner**, although they're being told not to worry about this, you've got time, at that moment in time of course they're preparing for exams, and **having the anxiety that goes with it.** But it's a repeated process more times during a year than perhaps there has been in the past.* (South London)

> ***So so much about our work is down to results**. You know, with a head teacher who recognises the importance of pastoral care that's fine, but **if you've got a head who is just focused on being an exam factory then your kids are in trouble**.* (West Midlands)

In some of the schools MHFA trained staff felt that exam results were given greater importance than the students' mental health and wellbeing:

> *It's the workload it's just too much for everybody across the whole school*… *well… we're under a lot of pressure. I think the children yeah, the young adults, children, a lot of pressure is on them, and it's always about achievement. Yeah it is too much. It's affecting their mental health… in terms of anxiety, stress.* (East Midlands)

> *It is exam stress and just academic pressures, the pressures of workload* – *that is definitely the main one, and I don't know why that's increased or appeared to increase so much over the last 14 years.* (North East)

> *We have huge issues with mental health in Year 11s, because* ***every day you're told 5 times at least a day that this is the most important time of the year***… *particularly the ones who've already done 5 years of hard work in high school and don't need to be worrying about it.* ***It is an enormous amount of pressure****.* (West Midlands)

Focus Group Question 7: What more needs to be done to support and build upon the Youth MHFA in Schools initiative in your school?

In this section we focus upon what school barriers to the Youth MHFA training and what more schools can do to support the Youth MHFA initiative:

Specific Comments on Improving the training

The trainees made several practical suggestions for the training's further development including sharing a diary log with deadlines and writing an action plan:

> *I would like to be given* ***a task and a deadline****, and I think it would have helped me be more proactive with this if at the end of the day maybed we'd written* ***our own little action plan****. Cos that's when you have it in your head what you'd like to do, and then maybe there was* ***a follow-up day 12 months later, 6 months later,*** *where you go back and you actually talk then with everybody else about it.* (North East)

For other trainees such a long term school wide action plan would help them to embed the training into the school culture as they were anxious about any changes deriving from the training might that might potentially be lost:

> *Suppose **a year down the line a teacher does come across an incident, are they going to remember that Youth MHFA training?** So, the challenge is how is it embedded? **What's going to be put in place for schools to allow that to bed in?*** (North London)

> *But I think it's going to be a long term thing, **it's not something that you can put everything in all at once, it's a long term awareness and development of it**.* (East Midlands)

Delegates praised the Youth MHFA training manual and would also like to have ready made powerpoint slides to share with colleagues in their school so that they could cascade the learning with colleagues:

> *For working with other staff in our school, **a slide or two that can be really generic, just to engage others in discussion and with a little bit of guidance**, then that could be useful.* (North East)

Youth MHFA should be part of Initial Teacher Training

> *I would say basic mental health training in teaching qualifications and teaching assistant qualifications if you're within a school and that should be completely normal. 'Oh I'm Mental Health First Aid trained' and somebody goes 'Wow, what's that?' **It shouldn't be something that's out of the ordinary, it should just be the norm**.* (West Midlands)

> *Yeah, I think we have and you know I keep going back to we need to do more of it, **we need to get more training in schools**, because actually to me having done the course, having you know, I think it should be part of initial teacher training and **it should be something all teachers do**. Because you know that's where it should be going. Everybody should be having it or you know everybody who wants it. And I think the one day is great and offering that for free and you know I'm not going to say it's a bad thing. **It's just a shame it's not like 10 people in the school**.* (North London)

Supervision for staff's stress and for secondary trauma

The focus groups were worried about the teacher's own mental health on two accounts. Firstly that the work of being a teacher was stressful and that staff didn't have anywhere to share and discuss that high level of stress they working with:

> *Sometimes you come out of a lesson and you just feel 'I actually am total rubbish' and then a parent will reinforce that for me. And then you think 'I'm either going to take that away …' cos that does stay with you … and **in the National Health Service you have a thing called supervision** where no one judges you… well we don't really have that as teachers, but **we still deal with a high level of stress**.* (South Coast)

In the West Midlands group, the Youth MHFA trained staff shared a distressing incident in which a student had self harmed so badly that required an ambulance as the child was 'bleeding out'. The teacher then had to return to school to deal with the other children who were in shock:

> *We sat with him for an hour and a half virtually bleeding out, and **we went to the hospital in the ambulance** to check they were ok. And then we had to come back, and then **you're expected to pick up another child that's you know got their head on a desk in a lesson and its really tough**.* (West Midlands)

However in all this, the teacher did not get any support or supervision herself to off load her traumatic experiences. Her line manager reiterated the point that schools did not engage in secondary supervision with staff:

> *The thing is there isn't really that structure in the school. There isn't that in any school where it might happen that you've got a line manager who's in a position to listen you know. If you're… well I mean in my case I'm 25 years from training - no one's ever… no one's ever taught senior leadership team how to listen to that sort of stuff. So… unless you happen to have it – **how do you deal with your staff who are dealing with that sort of secondary trauma? – you can't just ignore them**.* (West Midlands)

The anonymised student questionnaire content was based upon the overall research questions and contained six open ended response boxes for the students' handwritten responses (See Appendices). Each of the six case study schools were given 20 questionnaires to hand out to students who had contact with a Youth MHFA trained staff member in the past week. Some schools photocopied more questionnaires and so had a higher response rate than 20, whilst for unknown reasons, the South London school did not return the questionnaires. After completion the questionnaires were sent through the post to the researchers and a total of 112 student questionnaires were received from 5 schools. 15 of the questionnaires were either incomplete or illegible and were discarded so that a total of 97 student questionnaires were analysed and are discussed below.

6.1 School Student's Qualitative Responses to Student Questionnaire

What things does your school do *well* in looking after pupils' mental health?

The students noted how the schools had dedicated spaces with pastoral staff trained in Youth MHFA for the students to talk about mental health and wellbeing:

> *They have nice teachers and places you can go to like P5**, the calm room which can help people feel better***. (South Coast, boy, year group not given)*
> *They have pastoral care who listen to you. (North East, boy, year 7)*
> ***We have student advisors, form tutors and Friends! to talk** to. (North East, boy, year 7)*

The students in the West Midlands particulary noted how much they learnt during whole school dedicated assemblies. In the focus groups the staff had noted how the Youth MHFA training had encouraged them to use a more proactive and upfront approach to mental health in the assemblies:

> *I have learnt a lot during SPARK days. (West Midlands, gender and year group not given)*
> *I have learnt in assemblies. (West Midlands, gender and year group not given)*

The students noted how staff were able to signpost to mental health professionals.

> *I strongly believe school helped my depression by giving me options of support groups and who to talk to. (West Midlands, gender and year group not given)*

The North London and North East students reported that they felt that their school was good at looking after their mental health:

> *We have an anonymous box for issues. (North London, girl, year 8)*
> *We have a peer support system so students can talk to other students about their problems. (North London, girl, year 9)*
> *We have assemblies and a mental health club – it is very well looked after in our school. (North London, girl, year 9)*
> *You can anonymously say something if something is wrong and we have peer support. (North London, boy, year 10)*
> *Our school is good at looking after mental health. I'm glad to stay at a school where they look after your mental health. (North London, boy, year 10)*

Tell us about anything to do with mental health that you have learnt in your school recently

The South Coast students felt that they had learnt to deal with anger and anxiety partly by talking it through with staff:

> *I've learnt ways to deal with my anger and understand more about it and prevent it from getting the best of me. (South Coast, girl, year 10)*
> *When I have anxiety I know I can talk to teachers. (South Coast, boy, year 9)*

The students from the case study schools felt they had learnt about a range of mental health difficulties through assemblies, particularly regarding depression, suicide and self harm. One student wanted to know more about emotional abuse:

> *We have been taught a lot about how to care for people around us and with factors such as suicide. (West Midlands, girl, year 11)*
> *They are quite repetitive which is suicide and self harm. The rest I have to look up and figure out for myself e.g. emotional abuse and how it starts. (West Midlands, girl year 10)*
> *I have learnt in assemblies where to go to talk about depression. (West Midlands girl year 9)*
> *I've learnt about anger problems and suicidal thoughts. (West Midlands, boy year 9)*

> *We have learned about the signs of depression and what to do about it. (North London, girl, year 8)*
>
> *We have learnt about anxiety, depression and OCD. (North London, boy, year 8)*
>
> *I have learnt that bullying can effect mental health and anyone can have mental health issues. (East Midlands, boy, year 10)*
>
> *I suffer stress from exams and depression for not getting things done. (East Midlands, boy, year 10)*
>
> *Mh can cause obesity, anxiety, lethargy and low self esteem. (East Midlands, girl, year 11)*
>
> *People can feel bad about how they are and do bad things either to themselves or to other people (depression, suicide, making others unhappy). (East Midlands, girl, year 11)*

The North London students had been taught peer awareness and one student specifically noted this:

> *I have learnt many types of mental health. My school has taught me how to help my friend if they have mental health. (North London, boy, year 10)*

How good are your staff at listening to pupils about mental health issues?

Students from a variety of schools were keenly aware that whilst some staff members were good at listening, others were more interested in academic work than mental health:

> *I don't think the teachers ask students about their mental wellbeing. They are more interested in work, school etiquette and homework over mental health. (East Midlands, girl, year 11)*
>
> *Some teachers don't really listen. (South Coast, girl year 8)*
>
> *I would rather tell my friends or parents. (West Midlands, girl year 10)*
>
> *They are okay but sometimes they don't listen to us and they pretend to. (North London, girl, year 9)*

Other responses noted that members of staff were good at listening to them:

> *They are very good and supportive when you go to them and they listen and help you when you need help. (boy, year 8, South Coast)*

I would say that if you as a person is close with a particular teacher they have a good bond and listen to each other and sometimes I feel that teachers might avoid asking just in case it makes the student upset'. (girl, year 9, South Coast)

Teachers are very good at listening to you and giving you advice *(West Midlands, gender and year group not given)*
Teachers will listen and give advice. *They will allow options and not rush you to get the answer. (West Midlands, girl year 9)*

Some teachers are better than others at listening to students. If a student looks down they will ask and check if all is good. (North London, girl year 9)
All teachers are really good at listening, they really are*. (North London, girl, year 8)*

Teachers in my college are good at listening and they are caring. (East Midlands, boy, year 10)
Teachers often ask people about their mh and wellbeing sometimes as a group and sometimes individually. (East Midlands, boy, year 10)

How do pupils feel talking about mental health issues to staff and other pupils in your school?

School students from all the case study schools noted how the stigma and taboo associated with mental health remained a barrier for students to openly discuss mental health with members of staff and in their peer groups. School students' understandings and fears around mental health leading to school cultural stigma and taboo needs further research which was beyond the remit of this initial research:

Take away the taboo! *(North London, girl, year 8)*
I feel awkward and not comfortable and ashamed*. (North London, girl, year 9)*
Most people have trouble talking about their mental health *but some can talk easily. (South Coast, gender and year group not given)*
I don't think people would feel comfortable going to a teacher. (South Coast, gender and year group not given)
I'm very open and have a lot of opinions on the subject but I feel quite closed off to speak up as **hardly anyone talks about it in and out of class***. (West Midlands, girl year 10)*

One year 7 boy in the North East Grammar school noted his fear of bullying if he discussed mental health with staff and peers. Further qualitative research, in the form of student focus group discussions, is needed to generate a richer analysis of the relationships between mental health, stigma and bullying:

> *I don't think anybody wants others to know due to bullying* so *I want the school to be more aware of bullying* and kids that are getting bullied. I need them to listen more about that. (North East, boy, year 7)

Some students noted how over time they felt more comfortable as they realised they could get help in the school:

> *I felt uncomfortable talking at first as it was a topic I didn't like talking about but gradually I felt okay about talking as I realised could get help*. (West Midlands, girl year 9)
> *I would feel embarrassed to go and talk about it. (West Midlands, boy year 9)*

Interestingly all the 19 North London students felt comfortable in talking about mental health issues probably because the school had been extremely proactive in addressing mental health issues over a sustained period of several years:

> *I feel confident and comfortable. (North London, girl, year 8)*
> *It is open and confident between students and teachers. (North London, girl, year 8)*
> *It is extremely open and confidential*. (North London, girl, year 8)
> *I think that students feel comfortable talking to adults and other students as* **we talk about mental health a lot in our school**. (North London, girl, year 9)
> *Our school makes me feel more free and happy to talk about* mental health. (North London, boy, year 8)

Students in the East Midlands and North East case study schools reported that they felt embarrassed, awkward and shy to tell staff about mental health issues. This again demonstrates the considerable need and work to reduce stigma in schools:

> *They might be shy to tell a teacher. (East Midlands, boy, year 9)*
> *Some might be confident but some might feel too afraid. (East Midlands, boy, year 10)*
> *They normally do not speak to other students about their issues because it is*

awkward. (East Midlands, boy, year 10)

*I think students are reluctant to go ask for help from teachers and their peers because **talking about mh issues are often something to be embarrassed about so that is why students do not ask for help**. (East Midlands, girl, year 11)*

***I feel nervous and scared talking about mh**. (East Midlands, girl, year 11)*

I might feel sad talking about mental health. (East Midlands boy, year 11)

I feel scared because I don't want people to know that I listen to my friends in my head. (North East, boy, year 7)

***I feel embarrassed and I don't know anyone who doesn't**. (North East, boy, year 7)*

One boy in the North East Grammar school noted his fear of bullying if he discussed mental health and this may have contributed to the stigma and the taboo around discussing mental health with members of staff and peers:

> ***I don't think anybody wants others to know due to bullying** so **I want the school to be more aware of bullying** and kids that are getting bullied. I need them to listen more about that. (North East, boy, year 7)*

What things could your school do better to help pupils mental health and wellbeing?
Students' responses noted what could be improved for mental health provision.Specific suggestions included:

> *I think there should **be a 'worry box' or place you can go to talk about mental health** and we need more pastoral care. (North East, boy, year 7)*

Students also wanted more assemblies and lessons specifically on mental health, and these classes should start in Year 7 as soon as they arrived in school:

> *They could help you more in lessons so you can have support when you need it. (girl year 8,South Coast)*
>
> *Have more assemblies on it. (South Coast, gender and year group not given)*
>
> *Talk to the students in small groups not just assemblies. (East Midlands boy, year 8)*
>
> ***Have lessons earlier on in school in year 7**. (South Coast, girl year 8).*
>
> *Have more MH meetings with everyone just to make sure everyone is ok. (North London, girl, year 9)*
>
> ***Create more workshops and assemblies and create more awareness**. (North*

London, girl, year 8)

One student was wanted to see dedicated mental health staff in school:

*Have more **staff members specifically for mental health**. (West Midlands, boy year 11)*

A student noted the complexity of issues and how many of the problems were beyond the school gates and hence in a sense were beyond the remit of the school and its staff to deal with:

*Some people may have problems outside of school as well as inside school. **So only solving school problems won't really help**. (East Midlands, boy, year 10)*

Students also wanted their staff to refer them more frequently onto professional support:

***They should refer more to professional advice outside**. (East Midlands, boy, year 10)*
*They should **make an appointment with a therapist or a doctor**. (East Midlands, girl, year 11)*

7. CONCLUSIONS

(i) Overall, Youth MHFA training resulted in MHFA Champions' increased confidence in knowledge, skills and awareness of the complexities surrounding mental health needs within current school contexts. Champions and students reported that despite barriers to implementation, Youth MHFA training had given them enhanced confidence in challenging discriminatory mental health cultures in schools. Youth MHFA Champion perception about the barriers tended to remain steady over time.

(ii) The findings show that Youth MHFA training enhanced MHFA Champions' confidence in four of the six perceptual constructs assessed. These were: (i) their mental health knowledge; (ii) their use of the MHFA ALGEE dialogic process; (iii) their use of evidence-based practice and (iv) mental health inclusive practice within their educational setting. There was also an indication of tentative increases in their perception of the other two perceptual constructs: (v) extent of Youth MHFA implementation and (vi) their own mental health self-regulation.

(iii) Youth MHFA Champion individualised skills related to their professional, contextual and personal characteristics influenced their perception of each of the six perceptual constructs after they undertook the Youth MHFA training and implemented and developed mental health provision within their educational setting. In summary:

   a. Before Youth MHFA training, Youth MHFA Champions who held professional or academic qualifications related to mental health were more likely to perceive higher levels of confidence in their knowledge of mental health than Youth MHFA Champions who held academic subject-specific qualifications. Following Youth MHFA training and after one to three terms experience of implementing and developing mental health provision in their educational setting, Youth MHFA Champions who held non-mental health qualifications become equally as confident about their knowledge of mental health as participants who held mental health qualificatons.

   b. Youth MHFA Champions reported that the MHFA ALGEE dialogic process had given them an enhanced vocabulary to initiate mental health conversations with students. This assertion was variously supported by some students' comments and observations. Youth MHFA Champions who held support roles related to pastoral, welfare, safeguarding and learning support were significantly more likely to have higher confidence in their capability of using the ALGEE dialogic process

than Youth MHFA Champions who held support roles related to special education needs, alternative or medical support.

   c. Youth MHFA Champions who held leadership roles were more likely to perceive enhanced use of evidence-based practice in mental health than Champions with non-leadership roles.

   d. Youth MHFA Champions had enhanced awareness of creating a more inclusive and mentally healthy school. Youth MHFA Champions who had higher perception of inclusive mental health practice were more likely to be from mainstream educational settings than specialist educational settings.

   e. Youth MHFA Champions had improved ability to meet challenges related to barriers, stigma and discrimination when implementing their Youth MHFA training. MHFA Champions' perception of the existence of barriers to implementing their Youth MHFA training within their educational setting did not influence their perception of making progress in implementing and embedding their Youth MHFA training as part of the school's mental health provison.

   f. Youth MHFA Champions who indicated they struggled with their own personal mental health issues, were tentatively more likely to also perceive they had good self-regulation such as developing self-help strategies and help-seeking.

(iv) Youth MHFA Champions wanted specialist supervision to be able to share, discuss and offload their increasingly stressful experiences in working with students. Also, Youth MHFA Champions wanted the training to become embedded within school staffs' regular professional skills and practices. This, they argued, would enable a systematic whole school approach to inclusive and participatory mental health policies and practices.

(v) Building upon the current evaluation, it is proposed that further longitudinal, repeated measures designed to evaluate Youth MHFA Champions' characteristics and understandings of the perceptual constructs would enable: (i) further validation of the findings from this study and (ii) evaluation of mental health provision and change over time following Youth MHFA training.

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Youth MHFA CASE STUDY

Teachers Focus Group Discussion Grid

Introduction

A. Thank you for completing the consent form and for agreeing to take part in this focus group. I very much appreciate you creating time in your busy schedules.

B. We are collaborating with Mental Health First Aid (MHFA) England on a project about school-based support for young people's mental health, connected to the MHFA training. The project is funded by MHFA England.

C. Members of this focus group have: (i) either been on the training directly, or (ii) have worked with those who attended in helping develop practice connected to the training, or by experiencing its impact in some other way.

D. The aim of this focus group is to learn about your reflections on the training and its impact in recognising and supporting young people's mental health within your school. If you were not on the training feel free to talk about the way you have experienced, or perceived, its impact through the work or planning you have been doing with colleagues, or through the effect it has had on pupils.

E. The focus group will be recorded and transcribed. At the end of the project we will be writing an anonymised report about our findings and sharing this with MHFA England along with an article to publish our findings.

F. Please try not to use names or reveal details that might identify someone. If you do by accident, then when it comes to transcribing the data we will remove the name or detail. At the end of the focus group we can think back together to make sure everyone is happy that no details might identify someone: we will agree not to feature that detail or we can agree on how it will be altered. I will note those down and ensure that this occurs. A reminder that, as it says on the information sheet, the project has been approved by UCL Institute of Education's Ethics Committee.

G. My role is to ask some questions and to support you in developing answers. There are seven questions so we need to watch time together, though part of my role is to help us be aware of this.

Does anyone have any questions before we start?

H.

MHFA Focus	Questions	Additional prompts if needed
(Context of mental health and schools)	1. Is there anything you'd like to say about the general current situation of pupils and mental health?	• How does this show itself in the daily life of the school?
Enhanced knowledge and awareness of mental health conditions.	2. Has the training enhanced your knowledge and awareness of mental health conditions and issues?	• Without using any names, can you give examples of conditions or issues that relate to the context of this school?
Improved awareness in spotting the signs and symptoms of mental ill health.	3. Has the training improved your awareness in spotting the signs and symptoms of mental ill health in pupils?	• Has it helped your capacity to distinguish between different conditions? • Again, can you give more some examples that relate to your school?
Improved awareness of preventative and protective factors to mental ill health, including reduced stigma and discrimination.	4. (i) Has the training improved your awareness of preventative and protective factors to mental ill health? (ii) Has the training assisted you in considering how stigma and discrimination connect to pupil mental health? *These were so close I've put them together.*	• Can you give me a sense of how the training has helped you be aware of what environmental conditions are associated with mental health issues in young people? • Can you give me a sense of how the training has helped you be aware of changes in brain functions

		associated with mental health issues in young people?
Improved confidence in staff providing help for young people with mental ill health and having conversations with school students about mental health.	5. Do you consider the training has had an impact on staff providing help for pupils with issues concerning mental health?	• Can you tell me more about that example? • Can you say something about the different kinds of impact the training has had in terms of staff ways of working? E.g. ALGEE
Enhanced experience of a more inclusive mentally healthy school.	6. Has the training had an impact on creating a more inclusive, mentally health school?	• Can you tell me more about that example? • Can you tell me about any planning in relation to this?
Identify barriers and what more needs to be done to support and build the MHFA initiative within the whole school.	7. What more needs to be done to support and build upon the initiative in your school?	• Can you tell me more about that example?

I. Think back with the group about any names or identifying detail, note these down and read back to the group.

J. Thank you very much for taking part. The school will be sent a copy of the report.

Institute of Education

Youth Mental Health First Aid (MHFA) for Schools: A UCL IoE Research Impact Evaluation: Teacher's Information Sheet

What is this research about?

This research is conducted by the UCL Institute of Education and is funded by Youth Mental Health First Aid Schools (MHFA). It aims to evaluate the school's training programme by asking MHFA trained teachers' views of their school's one day training programme and the impact the training may have had upon teaching and the school culture.

There are three parts to the research. **We are inviting you to take part in (ii) below: a focus group discussion in your school.**

    i.   A short pre and post training questionnaire; hard copy and online which should take no more than 15 minutes to complete.

    ii.   A one hour focus group discussion that will explore the impact of the MHFA one day training.

    iii. With the school's permission, we would also like for one MHFA trained teacher's tutor group to complete a student Mental Health Survey with approximately 20 pupils so we can understand more from the students' perspectives. This will take approximately 10 minutes and I will bring 20 copies of the survey and a stamped addressed envelope to send them to me at the Institute of Education.

What kinds of questions will be asked in the focus group discussion?

This research is not about evaluating you or your school in any way and we do not expect you to be an expert in children's mental health.

These are the seven questions that will frame the hour discussion:

    1. Is there anything you'd like to say about the general current situation of pupils and mental health?

    2. Has the training enhanced your knowledge and awareness of mental health

conditions and issues?

3. Has the training improved your awareness in spotting the signs and symptoms of mental ill health in pupils?

4. (i) Has the training improved your awareness of preventative and protective factors to mental ill health?

(ii) Has the training assisted you in considering how stigma and discrimination connect to pupil mental health?

5. Do you consider the training has had an impact on staff providing help for pupils with issues concerning mental health?

6. Has the training had an impact on creating a more inclusive, mentally health school?

7. What more needs to be done to support and build upon the initiative in your school?

What are the benefits of taking part in this research?

- This is a chance to make your voice heard, as this project will inform future MHFA training in more schools over the next two years.

- We hope that you will find the focus group discussion with colleagues interesting, enjoyable and manageable and that it will provide you with a good opportunity for you to reflect on your own practice.

Who will know about the research results?

A final project report will be produced for Mental Health First Aid (MHFA). Publications in academic and professional journals are also potential outputs. Participants can ask to be sent a copy of the final project report.

Will there be any problems for me if I take part?

The research has been subject to approval within the UCL Institute of Education's Ethics procedures and works within the British Educational Research Association's Ethical Guidelines which can be found at http://www.bera.ac.uk/.

Will anyone know you have been involved?

- All data generated through focus groups and the questionnaires will be anonymized, including through the use of pseudonyms for people, schools and places. Only our research team will have access to the un-anonymized data.

- Raw data will be handled confidentially and not shared with third parties. There are limits to confidentiality in cases where there are suspected child protection issues involved; in such cases, these will reported to the appropriate authorities.

Do you have to take part?

If you decide to take part in the focus group you will be given a consent form to complete and sign prior to involvement. You have the right to refuse participation and the right to withdraw yourself and your data from the research at any time up until the report writing stage (January 2018). You will not be required to give a reason for withdrawal.

Want to know more?

If you have any questions about the research, please contact the project manager, Dr. Guy Roberts-Holmes, Institute of Education, at g.roberts-holmes@ucl.ac.uk.

Institute of Education

Youth Mental Health First Aid (MHFA) for Schools: A UCL IoE Research Impact Evaluation

Consent Form for Teachers

Thank you for agreeing to take part in the project. Please sign this form to indicate that you understand the following and to give your consent:

- The researcher will be abiding by the ethical guidelines of the British Educational Research Association and the UCL Institute of Education.
- Your participation is entirely voluntary and you are free to refuse to answer any question or stop the interview at any time.
- Your interview will be kept entirely confidential. Your name and any identifying features will be changed to ensure your anonymity as far as possible. Excerpts from the interview may be used in the writing up of the research project in a final report and in academic publications by the research team.
- The interview will be recorded and transcribed, and data will be kept securely on a password protected network.

Signed:

Date:

If you have any further questions at all about this research please contact Dr. Guy Roberts-Holmes g.roberts-holmes@ucl.ac.uk

Institute of Education

UCL

Pupil Mental Health Survey

We work at the Institute of Education in London and we are really pleased to be working with your school on a project about mental health and wellbeing. The research is funded by Mental Health First Aid (MHFA).   We want to find out more about how your school has supported pupil's experiences of mental health and wellbeing. The answers will be stored safely and we will not let anyone know your name or what you have said. We may use some of the answers to help write a report to develop more mental health work in schools.

So, before you begin do you understand what the project is about? If ok, please circle YES

If you want to do this questionnaire, then please circle   YES

Please note you can choose NOT to do this survey and that is fine.

And please remember if you want to talk about anything to do with mental health and wellbeing, then please tell your teacher.

Before you begin we just need to know a little bit about you:

Gender   Girl   Boy

Age

   1.
In the box below please **tell us about anything to do with mental health that you have learnt in your school recently.** For example, in assembly or lessons your teachers may have talked about mental health conditions and issues that pupils can experience. Have any of the following been talked about:

The kinds of mental health issues pupils can sometimes have?

Some of the early signs that show a pupil might be encountering mental health difficulties?

Who to talk to if you are worried about yourself or someone else and where to go for more information about mental health issues?

Please feel free to write about these and **anything else you have learnt in school** about mental health.

2.

Sometimes pupils may feel happy and confident in talking about mental health and sometimes they may feel embarrassed and awkward. In this box please tell us **how pupils feel talking about mental health issues** to teachers and other pupils in your school.

3.

In your experience, **how good are teachers at your school in listening** to pupils about mental health issues. For example do teachers **ask** pupils about their mental health and do teachers **listen** to pupils who talk about their mental health and do teachers give **advice** to pupils who ask about mental health?

4.

What things does your school do **well** in looking after pupil's mental health?

5.

What things could your school do **better** to help pupils mental health and wellbeing?

6.

Is there **anything else** you want to say about how your mental health is looked after in your school?

What do you learn on a Youth MHFA course?

Youth MHFA provides school staff and frontline professionals working with young people the skills and confidence to spot common signs and triggers of mental health issues, as well as the knowledge and confidence to help. Through a mix of presentations, discussions and activities, the course covers these key topics:

* What is mental health?

* Depression and anxiety

* Suicide and psychosis

* Self harm and eating disorders

Within each section there is clear focus on the issues faced by young people today, including bullying/cyber bullying and substance misuse.

The Youth MHFA One Day course has been designed specifically with schools and colleges in mind and fits perfectly into inset days and busy timetables.

Completing the Youth MHFA One Day course designates an individual as a Youth MHFA Champion. A Youth MHFA Champion is skilled in understanding how to spot the signs and symptoms of mental health issues in young people and will have the confidence to guide the young person to a place of support.

To find out more about the Youth MHFA in Schools programme visit:
https://mhfaengland.org/mhfa-centre/programmes/national-schools-programme/