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Guided self-help: is it relevant to emotional wellbeing promotion in high schools?

A few years ago, SHEU published an article about a research study I conducted in three high schools in the UK (Kendal, 2011). The aim was to find out whether there was a way to use 'guided self-help' in schools, to help promote students' emotional wellbeing. Guided self-help (also known as supported self-help) combines support or guidance from a practitioner (a person with appropriate skills but not necessarily a mental health expert), techniques and principles of cognitive behaviour therapy (CBT), and evidence-based, self-help resources such as books and websites. There is an abundance of self-help and self-improvement literature freely available but the quality of these texts is variable. In recent years however, the body of evidence around self-help has been growing and evidence-based self-help now sits within mainstream mental health services. I developed this study because I had been impressed by the effectiveness of guided self-help during my clinical practice as a mental health nurse, and thought it might have something to offer in a high school setting; but since then, self-help has become a core therapy in the UK-wide Improving Access to Psychological Therapies (IAPT) programme (Cooper, 2013).

This research study was conducted during 2006-7. I provided a set of high quality, carefully selected self-help resources to use with students, on topics such as how to manage anger, panic or low mood; and delivered brief training and ongoing supervision in guided self-help for some teaching support staff in the three schools. These wonderful staff offered students a discreet and confidential service via a system of self-referral and brief, guided self-help interventions lasting 15-30 minutes each. The role of the staff was to help students with engagement, clarifying the problem, setting and working towards goals, and motivation. We learned that the pupils found the service valuable- particularly the fact that it was discreet; but despite the model of short appointments, staff needed protected time to deliver it, which was not always feasible.

In this article, I will reflect on the policy context, accumulating evidence and recent developments around promoting mental health and emotional wellbeing in UK schools.

The scale of the problem : young people's mental health

The reported prevalence of mental disorders in young people in the UK is 10% for 11-16 year olds (Green et al., 2005), but this is likely to be an underestimate because young people encounter many difficulties when attempting to access help (Kendal, 2014). More recently, US data have indicated higher prevalence of 14-32% (Merikangas, 2010), and global data suggest an equivalent prevalence worldwide (World Health Organization (WHO), 2015). Mental health problems in early life have been linked with lifelong disadvantage, including poor mental and physical health throughout adulthood, and reduced life chances overall (Richards et al., 2009); yet many young people are in circumstances that make them vulnerable to mental health problems. UK public health data suggest that one in 10 students in secondary education feel unhappy, one in three feels low every week, just under a quarter report that they have been bullied and more than a third are frightened of being bullied (National Institute for Health and Care Excellence (NICE), 2009). Prevalence and reoccurrence rates of domestic

abuse affecting young people are high (Fox et al., 2014; Sousa et al., 2011). Being a young carer or in local authority care, having a learning disability or a parent in prison and living in poverty are all risk factors for mental health problems in young people (Jones at al., 2013; NHS England, 2015; Richards et al., 2009).

Within current UK policy, much of the responsibility for supporting the emotional wellbeing of young people rests with schools (NHS England, 2015). Although specialist child and adolescent mental health services (CAMHS) can have strong and effective relationships with local schools, these services are oriented towards meeting clinically-recognised needs. Some pupils with challenging problems that do not fit this profile may be ineligible for CAMHS services, which can create a problem for schools seeking specialist support for them.

For example, self-harm amongst students is a particularly stressful issue for teachers to manage (Berger et al., 2014a, Berger et al., 2014b). The prevalence of self-harm in young people is uncertain, partly because it can be a hidden problem, but also because of differences in how self-harm is defined. Behaviours that are a concern for teachers can include getting bodily piercings, poor eating habits, sexual activity, using mind-altering substances and having a general appetite for risk taking, but they are open to interpretation as a normal, even a healthy part of adolescent development (Claes, 2005). The immediate and long-term implications of self-harm are an anxiety-provoking and emotive topic for school staff, especially those who have pastoral responsibilities but limited specialist knowledge or training to draw on (Cunningham, 2014). Of course, there are many other worries and concerns to preoccupy young people. Therefore, the problem of how to help schools to support and promote pupils' emotional wellbeing remains important, and needs to be addressed.

Policy context

Between 2007 and 2014 most UK statutory children's services were located within a Department of 'Children, Schools and Families' consistent with the principles and values of Every Child Matters (ECM). ECM was an integrated government strategy from 2003 developed partly in response to the failure of multiple agencies to prevent the death of Victoria Climbié in 2000. In the same spirit, the 2004 Children Act introduced legislative frameworks aimed at better coordination of children's services. In this context, schools were encouraged to achieve Healthy Schools Awards, which were based on success in four areas: Personal, Social and Health Education, Healthy Eating, Physical Activity and Emotional Health and Well-being. Thus, during this period there were strong incentives for schools to develop holistic, universal, whole school strategies for health promotion, and an appetite for supporting related research and innovation.

Universal interventions in schools are often classroom based but can also apply to the whole school community. However, strategies for preventing problems and promoting health and wellbeing can have an intrinsic disadvantage if their funding relies on evidence of effectiveness. Hence, when the independent social research agency Natcen reviewed the evidence around Healthy Schools, it was found that while schools themselves felt the initiative was helpful and relevant to their overall aims, the impact on individual pupils was difficult to measure (Natcen, 2011). This is not the kind of powerful evidence required to attract ongoing funding. To convince funding agencies that illness has been prevented, or general health has been enhanced, we often need large, longitudinal, population studies, which in themselves require substantial financial backing.

Targeted health and wellbeing interventions are an alternative. Compared to whole school interventions, interventions for specific groups with clearly identified problems can more easily demonstrate effectiveness- and thus may be more attractive to hard-pressed funders. Targeted interventions can be faithfully implemented without adaptations, and accurately measured. They have the advantage of directing resources towards a known issue, and arguably avoid allocating them where they may not be needed; but they also risk stigmatising recipients and excluding people whose needs do not meet predetermined criteria (Weare, 2010; 2013).

The strengths and limitations of universal vs targeted interventions are illustrated by the evolution of SEAL (Social and Emotional Aspects of Learning), the national UK programme to enhance emotional wellbeing in schools

(Lendrum and Humphrey, 2012). Initially universal and designed to be adapted by schools as required, SEAL also developed targeted interventions requiring close fidelity to a model, reflecting a recognition that it was necessary to generate hard evidence of effectiveness. These insights are now major considerations influencing intervention and programme design (Weare, 2010; Lendrum and Humphrey, 2012; Weare and Nind, 2011).

Following a change of government in 2010, the Department of Children, Schools and Families was dismantled and statutory children's services were delivered through separate government departments. Policy for the health and wellbeing of children and young people in school now sits with the Department for Education, and tends to favour targeted approaches. Current educational policy highlights school responsibilities towards groups rightly identified as vulnerable, including new statutory guidance on looked-after children, safeguarding children and young people, special educational / health needs and children with disabilities (Department for Education, 2015).

Therefore, irrespective of an individual teacher's skill set, there is an expectation of a skilled response when students talk to them about self-harm, substance abuse, exploitation, bullying, suicidality, symptoms of serious mental illness and other complex issues that could challenge mental health experts. Schools may have access to specialist advice from a school nurse skilled in mental health care, local children's services, or pastoral teams, but despite this, many school staff may feel under-equipped for this aspect of their role (Fitzgerald et al., 2011; Weare and Nind, 2011). A compounding issue for schools is the difficulty in accessing statutory support for pupils since local CAMHS may only accept referrals from schools if the pupil's presentation meets their referral criteria. A practical consequence of difficulties accessing statutory services is that a child, who needs a place of safety, may need to remain on school premises with a member of staff until late into the evening, if it takes that long for alternative arrangements to be worked out.

A way forward

Despite the challenges, there is an encouraging development in the form of Future in Mind (NHS England, 2015). This is a new government document that sets out a positive vision for children's mental health services that are more person centred, more integrated with other agencies, are actively engaging with the voluntary sector, privilege young people's voices, and exploit the possibilities of digital resources. The CAMHS IAPT programme has helped to make psychological services more accessible to schools (Cooper, 2013) and includes cognitive behaviour therapy (CBT)-based interventions alongside other talking treatments. Future in Mind's emphasis on the potential of digital media to improve access to emotional and mental wellbeing support in the UK, reflects global interest in the possibilities (e.g. Mental Health Foundation of New Zealand, 2015). Guided self-help can be seen in 'Stressbusters', which delivers CBT via computer and is showing promising results for young people (Smith et al., 2015). In general terms, young people may respond better than adults to computerised cognitive behaviour therapy (cCBT) (Lovell, 2015).

Since the 2012 Health and Social Care Act, there has been increased involvement of the voluntary sector in providing children's and young people's mental health services, opening up new opportunities. In some localities this has made it possible for schools to enhance their pastoral support quite creatively through educational outreach from charities that have considerable expertise in child and adolescent mental health. New technologies make it possible to support young people via appointment reminders, apps that provide encouragement or reminders to take medication, safer online environment for chat and advice, and e-therapies (Li et al., 2013; Pinto et al., 2013; D'Auria, 2014; Chen and Zhu, 2015; Hampshire et al., 2015).

Mindfulness is another approach to promoting mental health that has gained traction in schools. The aim of mindfulness is to achieve mental focus, observing one's emotions and thoughts dispassionately; and it appears to have potential as an intervention for stress (Zenner et al., 2014). CBT-based mindfulness is recommended by NICE and it is currently being introduced into UK schools through the Mindfulness in Schools programme (Kuyken et al., 2013). Evaluation of the programme has shown good levels of acceptability and feasibility - so far so good.

In contrast with the internal processes that characterize mindfulness, activism and

citizenship have been proposed as an alternative perspective on how to promote mental wellbeing in young people. Positive for Youth (HM Government, 2013), is the Government's cross party youth strategy, and highlights that young people need to be supported so that they can take up responsible roles in society. The vision is of youth whose mental health is enhanced through the development of coping skills and mental resilience. The policy has been criticized for ignoring the impact of austerity on young people (Mason, 2015). Arguably, resilience, coping and mindfulness are inappropriate strategies if they encourage individuals to endure unhelpful or unfair conditions. A research team at the University of Brighton has developed a proactive concept of resilience that goes beyond mental coping, towards positive action (Hart et al., 2007). It involves trying to make practical changes, thus reducing the risk of encouraging young people to accept circumstances that are not acceptable.

We know that young people's mental health support needs are increasing, funding for services is uncertain at best, and schools are caught in the middle, trying to deliver high quality pastoral care with limited resources. Creative solutions are needed. It is sensible to view young people as the experts in their own experience (Noorani, 2013), and capable of being involved in designing their own support systems (Farrelly, 2014). Guided self-help is therefore relevant to the development of acceptable, feasible and effective strategies. Research and experience supports the development of effective interventions by increasing our knowledge and understanding about what works. The shape of emotional support in schools is evolving, and with our help, young people will benefit.

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