Developing and Piloting Mental Health Campaigns in Trailblazer Schools

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EXECUTIVE SUMMARY

In England it was estimated that 1 in 8 (13%) 5 to 19 year olds in 2017 were living with a diagnosable mental health disorder, which typically persist into adulthood. The Green Paper (2017) on Transforming Children and Young People's Mental Health Provision focused on piloting early intervention and prevention approaches in the context of schools and colleges. A key aspect of this preventative approach is the rollout of the 'Trailblazer' programme which, by taking a 'whole school approach' (WSA) to mental health, embeds clinicians into schools and colleges to improve mental health awareness and treatment of mild to moderate mental health disorders, including providing help to school staff, signposting and delivery of focused evidence-based interventions.

Supported by the NHS England's Northern England Clinical Networks (NECN), there are currently eight Trailblazer sites funded across over three separate waves in the North East and North Cumbria (NENC), with successive annual waves expected. There were three NENC sites awarded in the first wave and formed the focus of our study as they were further along their WSA journey: Newcastle and Gateshead; South Tyneside; and Northumberland. To support the NENC Trailblazer sites, NECN commissioned this research to produce an accessible resource for localities to develop and/or enhance and evaluate their mental health awareness raising and anti-stigma campaigns. To achieve this aim, we engaged staff from localities and the NECN in a co-production process with the following objectives:

- Conduct a scoping literature review to identify components of effective mental health awareness raising and anti-stigma campaigns in schools, including methods that localities can use to evaluate their campaigns
- Informed by the findings of the scoping review, to co-produce (using one-to-one interviews, co-production meetings and interactive group workshops) the mode, form and information content of an accessible resource informed by the lived experience and expertise of staff from the three localities and NECN

The scoping review identified seven completed and five in-process studies of UK-based school-wide interventions targeting children and young people published from 2015 to June 2020. Mental health literacy interventions utilising a range of structured educational interventions demonstrated positive results. Empathy-based approaches and interventions capitalising on peer support also appear to have promise. Interventions primarily focused on children, and omitted other members of the staff school community, including parents/guardians and stakeholders from the wider community. Critically, the scoping review identified a lack of studies evaluating the impact on behaviour (at the school level) and school culture.

The findings of the scoping review informed in-depth qualitative work that engaged 27 people in semi-structured interviews or interactive group workshops, with representation from all three localities. Guided by the analytical heuristic of micro, meso and macro system levels of analysis, qualitative data demonstrated a pressing need for top-down guidance, support and incentives from the Government to embed mental health and wellbeing as a core business activity of compulsory and further education. Mental health provision was often viewed as a 'luxury' with traditional academic attainment prioritised in schools, despite evidence showing how one is necessary for the other. Bottom-up learning to inform campaigns where lived experiences of teachers, parents and children/young people need to be heard and valued was also identified as a core theme. The 'recovery curriculum' (in response to the COVID-19 pandemic) was considered to be an opportunity for the Government to learn about what schools have been doing to address mental health and wellbeing as part of the core business of schools.

A WSA embedded with an over-arching whole community approach (WCA) was proposed by participants, where everyday mental health and wellbeing practices are embedded into communities and schools as the business of all stakeholders such as schools, public and private organisations, including voluntary services, parents/guardians and children/young people. This would necessitate buy-in and involvement from all community stakeholders, with everyone adopting the same practices and talking the same "language" about mental health and wellbeing, and critically taking responsibility for funding, implementation, monitoring and evaluation of a WCA. Further, the concept of a trauma-informed approach, use of restorative related practice, and shifting practices to an empathy-based approach were considered optimal for addressing existing and preventing trauma-related conditions and adverse childhood experience in both children and staff. Finally, participants emphasised that a positive mental health and wellbeing culture in a WSA could in part be achieved by introducing relatively simple environmental changes at little financial cost, for example a "buddy bus stop" system in school yard at breaktimes.

The scoping review and qualitative findings, along with expert recommendations on resources and evaluation strategies, informed the development of an accessible resource, which is broken down into four parts to inform campaign design and evaluation. **Part 1** of the resource describes its structure and content, including how this resource is complementary, and distinctive, from existing guides on WSAs to mental health and wellbeing. **Part 2** focuses on the rationale for, and components of, a WSA as described by our participants. **Part 3** focuses on the organisation, mode, form and content of campaigns. The value and principles of co-production and the need for diversity and involvement of all stakeholders in this activity (learning from the bottom-up) are extolled to inform the selection and design of campaign activities and content, with support from senior management to implement their recommendations. **Part 4** focuses on planning and implementing a robust mixed methods evaluation of campaigns.

1. BACKGROUND

In England it is estimated that 1 in 8 young people (13%) aged between 5 and 19 years are living with a diagnosable mental health disorder [1]. Research has shown that 50% of mental health disorders are present by the age of 14 [2], increasing to 75% by the age of 18 [3]. Critically, these mental health problems in adolescence typically persist into adulthood [4]. Despite these figures there is a disparity between prevalence and treatment access. As many as 70% of young people who experience significant mental health difficulties do not receive appropriate interventions at a sufficiently early stage, with young people exhibiting the poorest mental health service access of any age group [3]. Tackling mental health issues earlier increases a young person's chances of leading a healthy and productive future [5]. Following the disruption, closures, and social distancing measures introduced due to the COVID-19 pandemic, it is important to consider their impact on children's and young people's mental health and wellbeing, which has been shown to have exacerbated their mental health/wellbeing, in particular during the initial national lockdown [6-10].

The school is a pivotal setting for young people to achieve positive mental health and emotional wellbeing [11]. NHS England's Northern England Clinical Networks (NECN) is responsible for supporting the Government's Green Paper on Transforming Children and Young People's Mental Health Provision [12]. The Green Paper focuses on piloting early intervention and prevention approaches in the context of schools and colleges. There are currently eight Trailblazer sites funded in three separate waves across the North East and North Cumbria, with successive annual waves expected. Taking a 'whole school' approach, the Trailblazer sites embed newly trained clinicians (Education Mental Health Practitioner, EMHP) and supervisors into schools and colleges to improve mental health awareness and treatment of mild to moderate mental health issues, as well as providing help to school staff, and appropriate signposting and delivery of focused evidence-based interventions. The Trailblazer programme will run for 12 years.

Each site will incentivise every school and college to identify a designated Senior Lead for Mental Health to form a Mental Health Support Team and supervise the approach to mental health and wellbeing. One site will trial a 4-week waiting time for access to specialist NHS children and young people's mental health services.

To support the North East Trailblazer sites, NECN is keen to support the development mental health campaigns (an intervention that aims to change attitudes, behaviours/cultural norms) that promotes mental health awareness and reduces mental health stigma in educational settings. Each locality has been assessed by NHS England to have, with varying degrees of robustness, their own mental health stigma campaigns [13]. NECN is keen to strengthen the robustness of these local campaigns by developing a set of key principles, which demonstrate the components that lead to effective mental health campaigns. NECN is particularly interested in campaigns that

increase people's understanding of the three spheres of physical, psychological/emotional, and social wellbeing. This theoretical position is relevant considering the national drivers of the integration of health and social care (and public health) and aspiring to achieve parity of esteem for mental and physical health [14].

In order to develop the set of key principles, we engaged members of the NECN and staff in the Trailblazer sites in a co-production process. Co-production is a specific value-driven approach to decision making, where there is an equal partnership between service providers and users, which is mutually advantageous [15], involves collaborative working, making full use of their respective knowledge, resources and contributions, to achieve better outcomes or improved efficiency [16].

1.1 Aim and Objectives

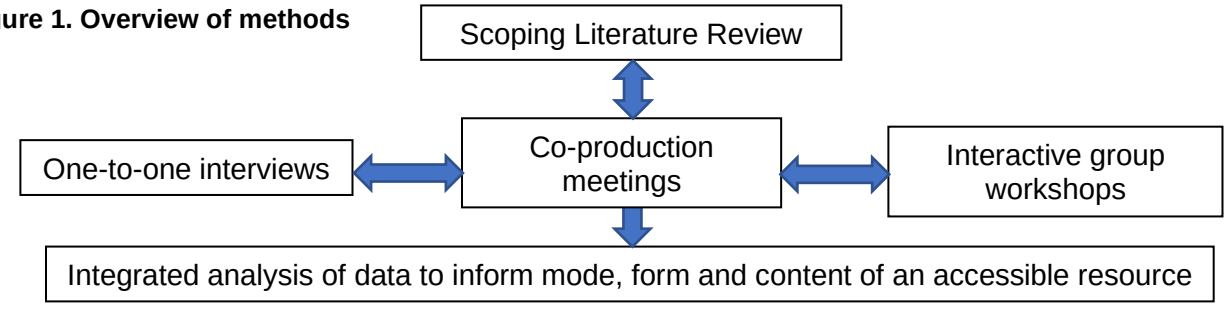
The overarching aim was to produce an accessible resource for localities to use, which includes the best available evidence to develop and/or enhance and evaluate their mental health awareness raising and anti-stigma campaigns. This aim will be achieved by engage staff from localities and the clinical networks in a co-production to process with the following objectives:

- Conduct a scoping literature review to identify components of effective mental health awareness raising and anti-stigma campaigns in schools, including methods that localities can use to evaluate their campaigns
- Informed by the findings of the scoping review, to co-produce the mode, form and information content of an accessible resource informed by the lived experience and expertise of staff from localities and the clinical networks

2. METHODS

A diagrammatic summary of the methods is shown in Figure 1. A favourable ethical opinion for the interviews / workshops was obtained from School of Health and Life Sciences Research Ethics Sub-committee at Teesside University (Application no: 239/19) on the 6th May 2020 (Appendix 1). Data collection was undertaken during March 2020 to July 2020. Due to restrictions in place to combat COVID-19, all data collection and project team meetings were conducted remotely using video-conferencing software.

Figure 1. Overview of methods



2.1 Ways of Working – Co-Production Principles and Processes

At the outset of the project, a meeting of the co-production team (authors of this report) was convened to discuss ways of working, and to agree on roles and responsibilities. Initial collaborative discussions took place regarding the criteria for the scoping review, the strategy for recruitment, and topic guides for the interviews and workshops.

2.2 Scoping Literature Review

With reference to published guidance [17,18], a scoping review protocol was developed by the project team, which was registered with the Centre for Open Science [19]. The review was guided by the following co-produced scoping review question that reflected the Population, Concept and Context of interest:

> *For children and young people aged 4 to 19 years, what are the active ingredients of effective school-wide[1] anti-stigma / mental health awareness campaigns delivered within UK educational settings?*

Peer-reviewed primary quantitative or qualitative (or mixed methods) research studies conducted in the UK, including grey literature (non-peer reviewed papers that report on descriptions of intervention design processes, content, and outcomes from local evaluations) were eligible for inclusion.

Search strategy: Exploratory searches linked to the scoping review question were used to develop a sensitive and specific search strategy using combinations of keywords and controlled vocabulary (e.g. MeSH headings). The final developed search strategy (Appendix 2) was applied to 6 bibliographic databases: Embase, MEDLINE, PsycINFO, ASSIA, CINAHL and Web of Science. Hand-searching of reference lists and citation searching of included studies was also undertaken. Only literature published between 2015 and June 2020 was included to maximise temporal relevancy with the current policy and culture of UK-based educational settings. A time-limited email request was also sent to regional and national stakeholders to identify published and unpublished grey literature that fulfilled the scoping review criteria. Government and organisational websites (local and national) were also searched for relevant studies using relevant search terms (mental health campaigns, schools, mental health and children and young people).

Study selection: Two reviewers (LS and IG) independently screened the titles and abstracts of material identified by the search strategy for inclusion. The same two reviewers working independently then evaluated full-text versions of articles retained at stage 1 using a study selection form. Disagreements at each stage were resolved via discussion, or where no agreement could be reached, a third reviewer (DF) adjudicated on the final decision.

[1] *At a minimum include all staff or children/students from one, or more year groups in a participating school*

Data extraction: A bespoke data extraction form was used to extract relevant data from studies included in the scoping review (Appendix 3). A focus was placed on describing the interventions (e.g. using the TIDieR framework [20]), and extracting data on active ingredients of interventions in terms of intervention features (e.g. duration, intensity, mode of delivery, involvement of stakeholders in design/development) and content (e.g. theory-linked behaviour change techniques using the latest version of the taxonomy [21]; frameworks/theories/models underpinning interventions); and outcomes (for example, changes in knowledge/awareness/attitudes; changes in physical, psychological/emotional and social wellbeing; changes in behaviour; and economic outcomes such as cost-effectiveness, return on investment), including details of engagement and evaluation strategies, and psychometric properties of outcome measures.

Data Synthesis: Due to methodological heterogeneity between studies, a narrative approach was used to synthesise the findings of included studies, which was informed by themes arising from discussions within the review team. A promise ratio assessment [22-24] was used to identify features/content associated with campaign effectiveness for outcomes within included studies. In order to calculate a promise ratio, interventions were grouped into three 'promise' categories relating to changes in outcomes (statistically significant within- or between-group): very promising (statistically significant between-group improvements in outcomes in favour of the intervention group); quite promising (intervention groups with statistically significant within-group improvements in outcomes, or improvements greater than those in a comparator group); and non-promising (no statistically significant improvements in outcomes either within or between groups). Very/quite promising interventions for each outcome that included an active ingredient were summed and divided by the number of non-promising interventions with the same active ingredient. Active ingredients identified in at least twice as many very/quite promising, compared with non-promising interventions (promise ratio of ≥2) were designated as promising active ingredients.

2.3. Qualitative Work

It was originally intended to engage only with NHS England Northern England Clinical Networks and Trailblazer staff; however, many of these staff were employed by Public Health England, who were re-tasked with combatting COVID-19 during this project. Therefore, we extended the invitation to teaching staff and relevant charitable organisations to engage in the co-production process (as part of the project team or participation in an interview or interactive group workshop).

Design. This qualitative study was designed with reference to the Consolidated Criteria for Reporting Qualitative Research (COREQ; [25]) to explore the preferences, views and perspectives of Trailblazer staff, public health professionals, and individuals from local authority, teaching, and charity sectors, on the mode, form and content of an accessible resource to inform the design and

evaluation of ‘whole-school’ mental health awareness raising and anti-stigma campaigns (or optimising and evaluating their existing campaigns); and to document and describe the process of co-production.

Participants: Members of the core research team, Trailblazer Programme and Public Health England staff, teaching staff (Special Educational Needs Co-ordinators [SENCOs] and student support/pastoral teams working in a range of school settings) and charitable organisations with experience of involvement in anti-stigma campaigns/MH awareness activities across the North East and North Cumbria.

Recruitment strategy: A purposive sampling approach was used to recruit participants to capture a broad range of views and experiences. An invitation email was sent to all eligible participants using their publicly available email addresses. The email included a participant information sheet that explained the purpose of the study and other information required for potential participants to make an informed decision to take part or not. Prior to participating in co-production meetings, interviews, or workshops, written informed consent was obtained from all participants.

Data collection: Participants took part in co-production meetings, interviews, or interactive group workshops (depending on their preference and availability). Participants could cease their participation at any point before and during the workshop, without giving a reason. However, due to the interactive nature of the data collected from the discussions in co-production meetings, removing the contribution from an individual(s) was not possible as it would invalidate the value of contributions made by others. This was clearly stated on the participant information sheet as part of the consent process. All meetings and interviews/workshops were conducted via the video-conferencing software (MS Teams). Co-production meetings took place approximately every two weeks from March to July 2020, which consisted of members of the initial project team plus additional members drawn from recruitment activity.

Nine one-to-one semi-structured interviews of up to 45 mins duration were undertaken by IG with reference to an interview guide (Appendix 4), which included questions on the following topics:

- Anti-stigma campaigns/mental health awareness activities – experiences and views
- Advice on recruitment for co-production (current/future work on campaign design)
- Knowledge of local campaigns and related grey literature
- Preferences, views and perspectives on the mode, form, and content of an accessible resource for informing the design of mental health awareness / stigma reduction campaigns

Three interactive group co-production workshops (90 minutes duration, which included a comfort break) were scheduled using remote methods (MS Teams). DF served as the facilitator for all

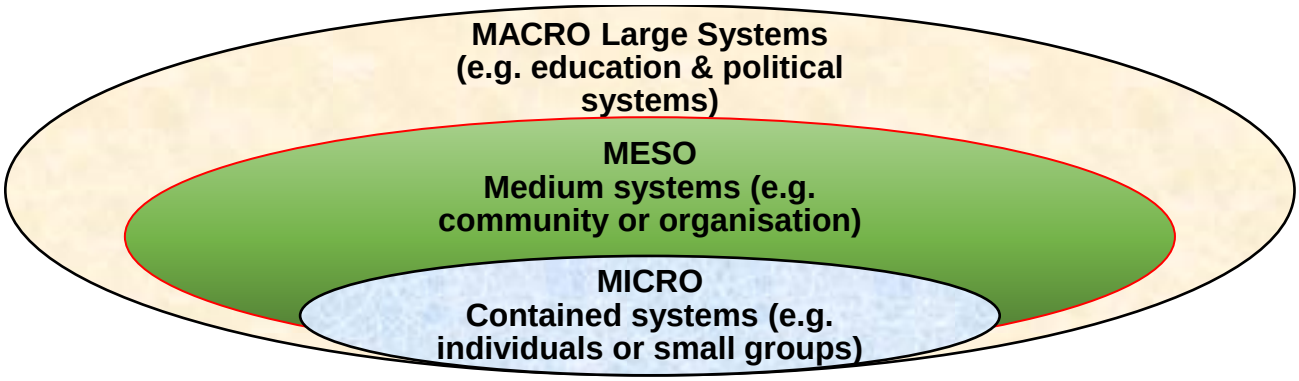
workshops, with three co-production team members (LS, IG and CD-G) contributing to the introductory sections of the workshops. Following introductions and an explanation of the ground rules, the first part of the workshop was a brief PowerPoint Presentation (Appendix 5) with an overview of the Trailblazer programme, aims of the project, the rationale for a whole school approach, including provisional findings of the scoping review and one-to-one interviews. The final component was an interactive discussion to elicit views and perspectives on how best to design the accessible resource, with reference to a topic guide:

- Thinking about the context of your own school, what would a whole school approach to mental health awareness / stigma reduction look like?
- What are the enablers to a whole school approach?
- What are barriers to a whole school approach?
- How, and what types of activities should be included?
- What should be the key messages?
- Who should be involved in evaluation and what would this look like?
- Other issues to consider?

Co-production team meetings, interviews and workshops were audio-recorded (using a Dictaphone held next to the computer speaker by a member of the research team [IG]), which were transcribed verbatim for subsequent analysis.

Data analysis: An integrative approach to data analysis was undertaken using a common coding frame across all data sets (meetings, interviews, and workshops) to allow for comparison between the different data sources. Thematic analysis [26] was applied to these data, guided by the analytical heuristic of micro, meso and macro system levels of analysis [27] and project objectives (Figure 2).

Figure 2. Micro, meso and macro system levels



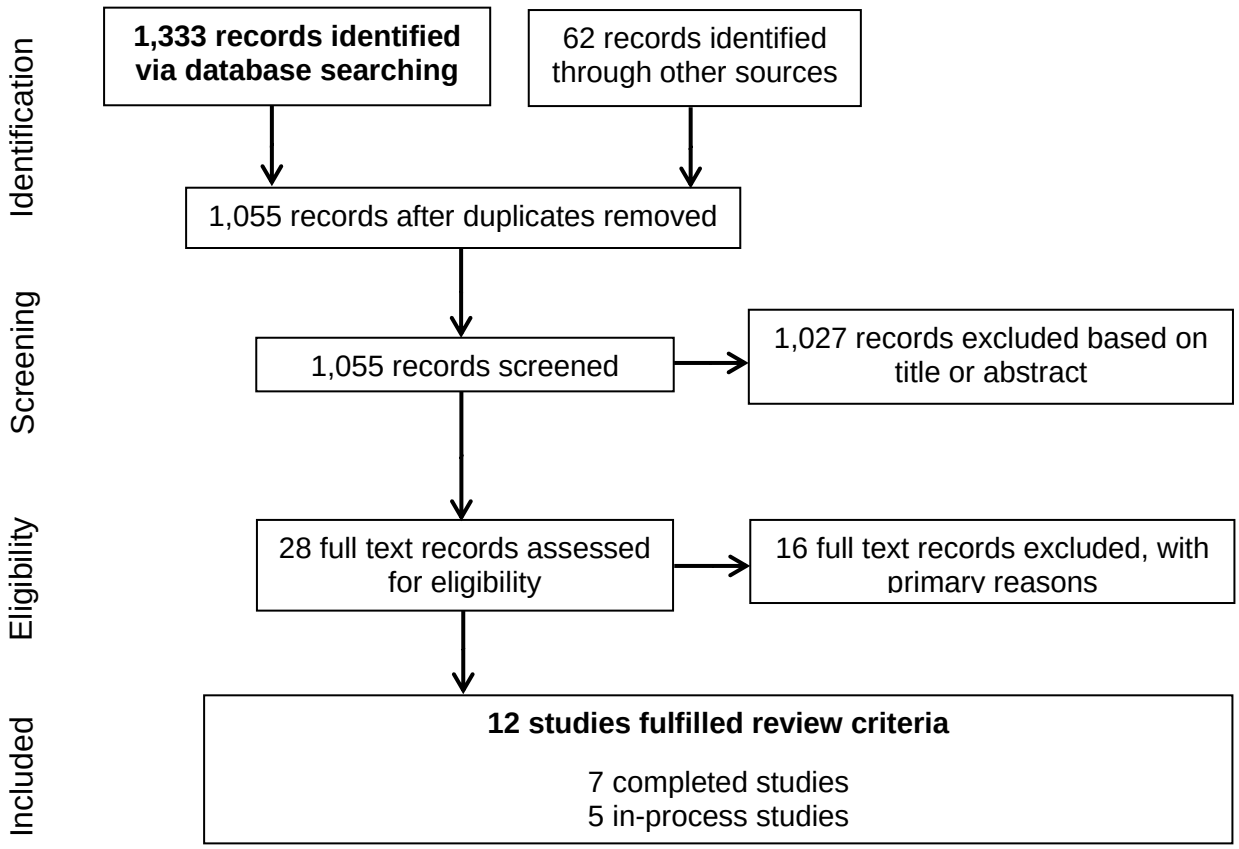
One researcher analysed the data (IG). Validation of findings was carried out in several ways during and after data collection activities. Meetings of the co-production team were held regularly to discuss emergent findings (peer debriefing), and identification of topics that would benefit from

further exploration in interviews. Preliminary findings were presented during introductions at co-production workshops and feedback was incorporated into subsequent analysis. Debriefing meetings were held after each workshop to discuss emergent themes and cross-checking with members of the co-production team. Redaction of names and places and use of labels such as ‘headteacher or ‘public health expert’ were used to protect the identity of participants. Direct quotes are used to enhance the credibility of the themes.

3. FINDINGS: SCOPING REVIEW

Overall, 1,333 records were identified in electronic databases by the search strategy (Figure 3). Contact with experts as part of the scoping review process to identify studies missed by search strategy and to identify grey literature, and discussions with experts during interviews and co-production workshops (see Section 4) identified 62 grey literature resources. In total, 7 completed studies [28-34] undertaken in the UK between 2015 and June 2020 fulfilled the review criteria. Three of the seven studies were identified from contact with experts [32-34]. A further 5 in process studies [35-39] met the scoping review inclusion criteria. One in process study was identified from contact with experts [39].

Figure 3. Flow diagram summarising the process used to identify studies



A summary of the 7 completed peer-reviewed studies [28-34] and the 5 in process studies [35-39] are presented in Tables 1 and 2 respectively. Due to the small number of completed studies identified by the scoping review and heterogeneity in their designs and delivery methods, the planned assessment of active ingredients (e.g. duration, intensity, mode of delivery, involvement of stakeholders in design/development; theory-linked behaviour change techniques; frameworks/theories/models underpinning interventions) would not provide any useful insights. A framework to assess the 'promise' of active ingredients of studies for use in a larger full systematic review is provided in Appendix 6.

3.1 Completed studies

School Space was a pragmatic cluster RCT [28] and the WISE study was a pilot RCT [29]. Uncontrolled before and after studies were undertaken to evaluate OpenMinds [30], Peer Education Project [31] and the Blues Programme [32]. Two studies evaluating the Roots of Empathy intervention employed a matched-groups (quasi-experimental) design [33-34]. The age ranges of children targeted by the interventions were different across all seven studies – ranging from 5-8 years [33]; 5-11 years [34]; 11-13 years [28]; 11-12 years [31]; 12-14 years [29]; 13-15 years [30]; and 13-19 years [32].

School Space [28] reported on a 1-day educational programme (designed by mental health service users) that aimed to reduce stigma related to mental illness and improve mental health literacy; promote wellbeing, mental health and resilience; and increase positive attitudes to help-seeking in young adolescents (aged 11-13 years). The intervention was delivered during usual classes and facilitated by 2-4 staff and led by mental health professionals (NHS mental health specialist and a teaching assistant). A minimum of one teacher from each school also facilitated the intervention. The lesson plans covered the following topics:

- Being 'normal' ~25 mins
- Stress and anxiety ~60 mins
- Depression ~20 mins
- Psychosis ~45 mins
- Stigma and myths ~10 mins
- Contact session ~20 mins
- The history of mental illness ~20 mins
- The mental health scale and me ~25 mins
- Different ways of thinking; thoughts, feelings, and behaviours ~20 mins
- Drama workshop ~60 mins
- Going over the day ~10 mins

Schools randomised to the contact condition also received a "contact module" delivered by an expert by experience (recruited primarily from an Early Intervention in Psychosis Service), who initially did not disclose their personal experience with mental health conditions, which was subsequently 'revealed' after working in the class during the first half (morning) of the intervention. The education only condition reported significant improvements at 2-weeks follow-up in attitudinal and knowledge-based stigma, mental health literacy, emotional wellbeing and resilience. Attitudes to help seeking did not improve in either study condition. Attitudinal and knowledge-based stigma improved in both conditions at 2-weeks follow-up with no significant effect of condition. Indeed,

counter to the social contact hypothesis [40], children in education and contact condition did not report improved mental health literacy, emotional wellbeing or resilience.

The Wellness in Secondary Education [WISE] study [29] focused on providing school staff (8-9 per school) with training on Mental Health First Aid (MHFA) to enable them to provide peer support to anyone appearing distressed or at risk of developing a common mental health condition and psychosis. Up to 20 staff in each school also received youth MHFA training. The rationale being that this would put teachers in a better place to support their students (whilst simultaneously improving their own mental health too) as well as raising the profile of mental health in their respective schools. WISE was feasible (assessed by observations of 13 training sessions, 14 staff focus groups and 6 staff interviews) and self-reported mental health knowledge, attitudes confidence in helping others, and awareness regarding their own mental health increased (12 month follow-up) in staff receiving MHFA training. The peer-support service provided by trained staff was viewed as positive, although salient barriers were identified such as concerns about confidentiality and a preference for accessing support from existing networks. An embedded process evaluation of the WISE study is currently underway [35].

OpenMinds [30] targeted young people aged 13 to 15 years who received two OpenMinds workshops over 2–3 weeks, delivered by medical students. The training received by university students consisted of:

- Crash Course - six to eight sessions on child and adolescent mental health topics including depressive disorders, anxiety disorders, psychosis, eating disorders, substance misuse and self-harm. Each session facilitated by a psychiatrist or clinical psychologist, followed by group activity to design the content of sessions to deliver with school students
- Classroom Training – one to three sessions (facilitated by experienced educators) focused on teaching skills for delivery of workshops to school students
- Workshops (45-50 mins) are designed by pairs of university students on topics that schools select from the Crash Course, which are reviewed by The OpenMinds facilitators in collaboration with mental health professionals to ensure content is appropriate
- After the workshops, university students attend a further meeting provide feedback and to recruit new OpenMinds facilitators for the future

Workshops were then delivered by pairs of university students to a class of school students (with a teacher present). After the intervention, significant improvements in knowledge and attitudes were reported for university students and school children. Social distance improved only in the university sample and helping attitudes increased only in school children. University students' perceived teaching efficacy improved but their interest in pursuing psychiatry as a career. Over 70% of school students 'enjoyed' the workshops and were positive about being taught by university students.

The Peer Education Project (PEP, [31]) developed by the Mental Health Foundation was co-produced with children (years 7 to 12) informed by a literature review on mental health education for children to develop a 40-minute x 5 session PEP syllabus (Mental Health Awareness; Myths, Facts & Stigma; Staying Well; Getting Help; and Helping Others). Peer educators were drawn from the school's 6th Form who received two-days training from the MHF and partner organisations to deliver the PEP syllabus to Year 7 children supported by school staff. Peer educators reported improved key skills, but no other changes between pre- and post-measures were statistically significant. Year 7 children reported improved scores on key terms, key skills, readiness to help others and emotional difficulties, but a worsening perception of the school climate.

The Blues Programme was evaluated by Action for Children [32] on mental health outcomes for young people. To be eligible for the programme children had to report 'elevated depressive symptoms' assessed by a score of ≥20 on the Center for Epidemiologic Studies Depression Scale (CES-D) [41]. Delivered by an independent Action for Children trainer, the Blues Programme consists of 6 sessions of cognitive-behavioural group work (no other specific details of the programme delivery were reported). The report describes mixed methods outcomes before and after implementation of the Blues Programme in 10 sites across the UK, with 5,253 participating young people aged 13-19 years. Out of the participating young people, 72.8% reported a reduction in CES-D score, 2.9% remained static, and 17.2% reported an increase on the CES-D. On the how are you feeling questionnaire, completed at the end of the programme, the majority reported improvements (80% increased confidence; 76% increased self-esteem; 75% better engaged with learning; 73% improved relationships with friends and family; and 72% of young people reported improved relationships in school). Qualitative data identified (i) a positive impact on thinking and problem-solving/coping, (ii) young people reported using as least one programme technique in their daily lives; and (iii) the value of mood screening via the CES-D (enabled schools to recognise young people who had not previously been identified as experiencing difficulties, and raising staff awareness of mental health).

Given that the evaluations of OpenMinds, PEP and The Blues Programme all utilised uncontrolled before and after study designs, no inferences can made about the effectiveness of these interventions for improving mental health-related outcomes.

The remaining two completed studies evaluated the ***Roots of Empathy (ROE)*** intervention using a matched groups design in Scotland [33,34]. ROE consists of 9 themes delivered across the school year and promotes the development of more caring and less aggressive behaviours while also increasing pupils' knowledge of infant development. The baby is central to the delivery of the ROE Programme and is considered the 'teacher'. The instructor guides the class to notice and become

aware of the baby's development, the relationship with their parent and subsequent attachment. The first evaluation of ROE was conducted by North Lanarkshire Psychological Service [33] and the second was conducted by The University of Glasgow on behalf of Action for Children [34] targeting children aged 5-8 years and 5-11 years respectively. Empathy increased in the ROE groups compared with controls in both studies, although studies utilised different methods of assessing empathy. The ROE groups in both studies compared with controls also reported decreased aggression and increased prosocial behaviour. The North Lanarkshire evaluation [33] also reported a greater recognition of emotions and understanding of infant development in the ROE group compared with controls. The University of Glasgow evaluation also reported that the ROE intervention may be more effective in male than female children [34].

Table 1. Summary of completed studies included in the scoping review

Study Details	Aims/Objectives	Study Sample	Active Ingredients	Evaluation Strategy	Key Findings
Chisholm et al (2016) [28] School Space Pragmatic cluster RCT 2-week follow-up (plus 6-month follow-up in n=2 schools)	To reduce stigma related to mental illness and improve mental health literacy; promote wellbeing in young adolescents, including mental health and resilience; more positive attitudes to help-seeking. Hypothesised that contact, in addition to education, is more effective than education alone in reducing stigma, improving mental health literacy, and promoting wellbeing in young adolescents	6 secondary schools in Birmingham. 769 participants provided data at baseline. Of these, 112 were absent for the intervention day or were lost to follow-up; 657 participants aged 11–13 years participated.	1-day educational programme in each school led by mental health professional staff. School Space was designed with mental health service users (based on the work of the authors). Schools randomised to the contact condition also received a “contact module" delivered by an expert by experience, who worked with young people for a morning before revealing their diagnosis. A 20-min session followed by a group discussion of mental illness with the volunteer, who then worked with the class for the afternoon.	Primary outcome was students’ attitudinal stigma of mental illness (Reported and Intended Behaviour Scale). Secondary outcomes were knowledge-based stigma (Mental Health Knowledge Schedule); mental health literacy (responses to vignettes); emotional wellbeing (Strengths & Difficulties Questionnaire); resilience (Resilience Scale); help-seeking attitudes (single item)	At 2-weeks follow-up, attitudinal stigma improved in both conditions with no significant effect of condition (education versus education plus contact). The education only condition reported reduced attitudinal and knowledge-based stigma, and improved mental health literacy, emotional wellbeing and resilience. Contact was found to reduce the impact of the intervention for several outcomes. Caution is advised before employing intergroup contact with younger student groups.
Kidger et al (2016) [29] WISE study Pilot cluster randomised controlled trial 12-month follow-up	Assess the feasibility and acceptability of the Wellness in Secondary Education (WISE) intervention*, and explore the justification for evaluating the intervention in a full cluster RCT. * putting teachers in a better place to support students (improving their own mental health too) and raising the profile of mental health in the schools.	6 mainstream non-fee-paying secondary schools in England. 1,024 staff and 2,616 students participated; 3 schools received the intervention, and 3 received usual practice. 438 staff (43.5%) and 1,862 (56.3%) students (years 8 & 9) completed questionnaires at baseline & 1 year later	In the intervention schools: (i) 8-9 staff received two full days of Mental Health First Aid (MHFA) training, delivered by a registered independent trainer, and became staff peer supporters (ii) Youth MHFA training (2-days) was offered to up to 20 staff in each school by an external independent trainer. The intervention targets ‘common mental disorders’ (depression, anxiety) and psychosis.	Feasibility of the WIDE study was assessed by observations of 13 training sessions, 14 staff focus groups and 6 staff interviews were completed.	MHFA training was considered relevant for schools, and school staff gained in knowledge, confidence in helping others, and awareness regarding their own mental health (pre- and post-questionnaire after MHFA training). Peer-support services established in all intervention schools were reported to be helpful; e.g. through listening, signposting to other services - and raising the profile of mental health at school level. Barriers included lack of knowledge about the service, concerns about

Study Details	Aims/Objectives	Study Sample	Active Ingredients	Evaluation Strategy	Key Findings
					confidentiality and a preference for accessing support from existing networks.
Patalay et al (2017) [30] OpenMinds Before and after study	Aimed to collect preliminary evidence on whether OpenMinds is an efficacious and acceptable programme, in both the university student facilitators and the school students receiving the workshops.	3 state schools 234 school students aged 13 to 15 years who received the intervention, delivered by 40 medical students who had completed pre- and post-outcome assessments	OpenMinds comprises of three sequential components organised by a team of 'OpenMinds facilitators' for university students: • the Crash Course (range of topics) • Classroom Training (focused on teaching skills) • Workshops designed by university students (based on topics selected by participating schools) School students receive two OpenMinds workshops over 2–3 weeks, delivered by university medical students, generally during the personal, social and health education (PSHE) classes	Primary outcome was university student mental health literacy: • disorder identification and helping attitudes – knowledge questions based on vignettes • asking for help themselves (if facing the difficulties described in vignettes) and confidence in ability to help the person in the vignettes • Social distance (would they participate in different activities with the person in the vignettes) • Non-stigmatising attitudes (questionnaire) and knowledge of common mental health disorders (MCQs) School children were assessed on changes in non-stigmatising attitudes, helping attitudes, knowledge and social distance (adapted from the measures used for university students)	University and school student participation in OpenMinds was associated with significant improvements in 3 of 4 mental health literacy elements Knowledge & attitudes improved in both samples - social distance improved only in the university sample & knowledge of helping behaviours increased in the school sample University students' perceived teaching efficacy improved (single item 6-point scale) but no change in pursuing psychiatry in their career (1-10 scale). Acceptability was high; over 70% of the school students agreed that they enjoyed the workshops and liked being taught by a university student.

Study Details	Aims/Objectives	Study Sample	Active Ingredients	Evaluation Strategy	Key Findings
Eisentstein et al (2019) [31] Peer Education Project (PEP) Before and after study	Aimed to assess impact on student emotional and behavioural difficulties; perception of school climate; confidence to talk about mental health; knowledge of available information and resources; readiness to support others; knowledge of key terms related to mental health; and confidence in key skills related to management of mental health.	7 secondary schools in London and South East England, and the Channel Islands. 45 peer educators, and 455 student trainees who returned both pre- & post-evaluation questionnaires.	PEP is designed to support young people to develop the skills and knowledge needed to safeguard their mental health, and that of their peers. PEP was developed by the Mental Health Foundation and was co-produced with children (years 7 to 12) informed by a literature review on mental health education for children. PEP is a 5 x 40-minute session syllabus, covering Mental Health Awareness; Myths, Facts & Stigma; Staying Well; Getting Help; and Helping Others. Peer educators (6th form students) receive 2 days of training from the PEP staff team, to deliver in pairs the PEP syllabus to Year 7 children, supported by school staff. Children received a workbook with worksheets and information about mental health.	Pre- and post-questionnaires to assess changes in emotional and behavioural difficulties (Me & My School Questionnaire), school climate in terms of perceived quality of relationships and support within schools (School Climate Survey) Questionnaires from a previous evaluation of a mental health pilot in Schools was used to assess changes in key skills; key terms; confidence to talk about mental health; knowledge of information & resources; and readiness to support others	Peer educators reported improved key skills, but no other changes between pre- and post-measures were statistically significant Year 7 children reported improved scores on key terms, key skills, readiness to help others and emotional difficulties, but a worsening perception of the school climate 60% of year 7 children reported it was helpful to learn from peer educators instead of their usual teacher; 30% stated that it did not make a difference. 6% reported it was not helpful.
Action for Children (2017) [32] The Blues Programme Mixed methods before and after study	To improve mental health outcomes for young people aged 13-19-years with elevated depressive symptoms (≥20 on CES-D)**	In the 3-year period 2017-2020 in the UK: - Programme delivered in 149 schools (10 areas of the UK) - 37 Action for Children staff were trained	6-session cognitive-behavioural group work programme for adolescents with elevated depressive symptoms (developed at Oregon Research Institute by Professor Paul Rohde et al) Not funded by Health Services (Royal Mail)	Center for Epidemiologic Studies Depression Scale (CES-D) scale assessed before and after the programme (approximately 10 weeks later) CES-D has 0-60 range, with 0 indicating no depressive symptoms and 60 indicating major	CES-D scale: Mean baseline score was 31.2; mean post-delivery score was 23.3 72.8% showed a reduction in CES-D score, 2.9% remained static, and 17.2% an increase on CES-D. Results not available for 7.1%

Study Details	Aims/Objectives	Study Sample	Active Ingredients	Evaluation Strategy	Key Findings
		- 9,869 (out of 28,714 screened) identified as suitable for the programme - 6,763 young people were enrolled, and 5,253 completed the programme (4,849 completed the full programme; 404 completed a minimum of 4 sessions).		depression. A score of 16 or above indicates a heightened risk of developing depression. ** A score of 20 or above was needed to be eligible for the programme *How are you feeling now*?' questionnaire which is completed on exit from the programme. End of programme focus groups 45 students from 5 schools across the UK	*How are you feeling now questionnaire?* -80% reported increased confidence -76% reported increased self-esteem -75% better engaged with learning -73% improved relationships with friends and family -72% of young people reported improved relationships in school Qualitative data identified a positive impact on thinking and problem-solving/coping and young people reported using as least one programme technique in their daily lives. Mood screening via the CES-D enabled schools to recognise young people who had not previously been identified as experiencing difficulties; assisted in raising staff awareness of the issue of mental health Cost of delivering the Blues Programme to each individual participant was £380 based on a large-scale delivery with support from the Royal Mail An RCT is currently underway
North Lanarkshire Psychological Service [33]	To establish the impact of Roots of Empathy (ROE) Programme on empathy,	17 primary schools, primary 1 to primary 7	The programme is delivered by a trained ROE instructor and consists of 9 Themes delivered	Child & teacher assessment of:	Cognitive empathy (distinction between oneself and another) and Emotional Empathy

Study Details	Aims/Objectives	Study Sample	Active Ingredients	Evaluation Strategy	Key Findings
Roots of Empathy Quasi-experimental (matched groups) design	prosocial behaviour, anger management/aggression, class climate, knowledge of infant development and recognition of emotions	(19 classes) across North Lanarkshire 17 matched control schools (18 classes) in terms of deprivation level, free school meals and clothing grant data	across the school year. Each theme consists of a family visit, in which a mother and baby visit the class, and a visit before and after the family visit, in which the instructor reinforces the teachings from 10 the family visits. ROE promotes the development of more caring and less aggressive behaviours while also increasing pupils' knowledge of infant development. The baby is central to the delivery of the ROE Programme and is considered the 'teacher'. The instructor guides the class to notice and become aware of the baby's development, the relationship with their parent and subsequent attachment.	• Empathy (Thinking & Feeling Question', children only) • Prosocial Behaviour (Altruism Drawing Measure [children]; Strengths & Difficulties Question' [SDQ, Teachers]) • Aggression (Child Anger Management Scale, SDQ – Total Difficulties [Teachers]) • Wellbeing (Stirling Children's Wellbeing Scale) • Class Climate (My Class Inventory) • Knowledge of Infant Development • Recognition of Infant Emotions	(Feeling with another) increased in the ROE group compared with controls Prosocial behaviour increased in ROE group and decreased in control group (Teacher assessed) Aggression: ROE group decreased in Inhibition (turning emotion inward) compared with controls Knowledge of Infant Development: ROE group had a greater understanding of infant development ROE group had a greater recognition of emotions
University of Glasgow [34] Roots of Empathy Quasi-experimental (matched groups) design	To examine the extent to which the Roots of Empathy (ROE) intervention in Scotland works to reduce levels of aggression with 5-8 year old children and how changes in empathy mediate this relationship	Children aged 5-8 years (N=695) in schools from 5 local authority areas - Glasgow, Highland, South Lanarkshire, West Dunbartonshire, West Lothian	Roots of Empathy is a classroom-based programme that aims to reduce levels of aggression within schoolchildren, while increasing their social and emotional competence and helping develop their empathy	Assessed children's empathy (affective, cognitive), aggression & prosocial behaviour Interviewed a sub-sample of children using Kids Empathic Development Scale) to measure empathy (affective, cognitive & behavioural)	Compared with the controls, children in the ROE group reported increased affective empathy (but not cognitive empathy), decreased aggression and increased prosocial behaviour ROE may be more effective for boys than for girls, on average.

3.2 In process studies

The Wellness in Secondary Education [WISE] study [29] described in Table 1 is currently being evaluated further in a cluster randomised controlled trial [35] involving 25 secondary schools to establish the effectiveness of the intervention (mental health support and training available to secondary school teachers through delivery of the training package Mental Health First Aid [MHFA] and a staff peer support service). The embedded process evaluation is adopting a mixed methods approach using range of quantitative and qualitative assessments, including interviews and focus groups with staff, year 10 children and other stakeholders for eight schools (4 assigned to the intervention and 4 to the comparator groups) to explore acceptability and sustainability.

The ***Approaches for Wellbeing and Mental Health Literacy: Research in Education (AWARE)*** intervention [36] and ***INSPIRE (INterventions in Schools for Promoting Wellbeing: Research in Education)*** [37] are being conducted by the same team as part of a wider programme of research. A cluster RCT of ***AWARE*** [36] is currently underway to establish the effectiveness and cost-effectiveness of two interventions (i) ***Youth Aware of Mental Health (YAM)*** and (ii) Mental Health and High School Curriculum Guide (The Guide) compared with usual school-based provision for improving mental health and wellbeing of year 9 pupils in England.

YAM consists of 5 interactive sessions, delivered across 5 consecutive weeks (compared to the original 5-hour programme across 3 weeks), structured around 6 main themes: (1) what is mental health?; (2) self-help advice; (3) stress and crisis; (4) depression and suicidal thoughts; (5) helping a friend in need; and (6) who can I ask for advice? Sessions are delivered by instructors (who have completed a 5-day workshop delivered by YAM developers and collaborators). Children also receive learning materials and tailored booklets related to the 6 main themes, which include details of local support services. Role play is a central activity, focused on three main themes: awareness about choices; depression and suicidal thoughts and feelings; and how to manage stress and crisis situations

The Guide consists of six modules: (1) stigma of mental illness, (2) understanding the relationship between mental health and mental illness, (3) understanding specific mental illnesses, (4) adolescents' experiences of mental illness, (5) seeking help and finding support, and (6) the importance of positive mental health. The Guide in this study will be delivered by school staff (who receive 1-day of training by the Anna Freud National Centre for Children and Families) to children across six 1-hour lessons.

The primary outcome for YAM and The Guide will be depressive symptoms (Short Mood and Feelings Questionnaire) and help-seeking (General Help-Seeking Questionnaire) respectively measured at baseline, 3–6 months and 9–12 months follow-up. Secondary outcomes will include

changes in positive wellbeing, behavioural difficulties, support from school staff, stigma-related knowledge, attitudes and behaviours, and mental health first aid. A process and implementation evaluation, as well as an economic evaluation will also be undertaken.

The INSPIRE [37] intervention is currently being tested in a cluster RCT to establish the effectiveness of three intervention components in 40 primary (years 4 and 5) and 16 secondary (years 7 and 8) schools with six classes each schools in England, developed by a panel of experts (psychologists, researchers, the Programme Director of Mental Health and Wellbeing Schools and a Headteacher Quality Assurance Panel and a pilot study)

1. Mindfulness Practices consists of breathing exercises and other activities focussed on self-awareness of sensations, emotions and thoughts. Staff deliver mindfulness for 5 mins each day during classes at a time of the staff member's choosing for up to 12 months.

2. Relaxation exercises focus on deep breathing and progressive muscle relaxation. Staff deliver relaxation exercises (alternating each week between deep breathing and muscle relaxation) for 5 mins each day during classes at a time of the staff member's choosing for up to 12 months.

3. Strategies for Safety and Wellbeing (SSW) originated from teaching practical approaches to personal safety, known as 'Protective Behaviours'. SWS consists of an 8-week (40 min) lesson plans: (1) It is safe to talk about mental health; (2) You are never too young to talk mental health (primary schools) / We all have mental health (secondary schools); (3) What is safety?; (4) Early warning signs – noticing our bodies; (5) Early warning signs – noticing our feelings and thoughts; (6) Developing our safety networks; (7) Safe friendships; and (8) Safe ways of managing emotions.

Staff assigned to each intervention arm attended a half day training course (focused on experiential exercises [mindfulness and relaxation] or covering the psychoeducational content [SWS] delivered by the Anna Freud National Centre for Children and Families). The primary outcome measures for Mindfulness Practices and Relaxation are internalising difficulties (Short Mood and Feelings Questionnaire). For SSW the primary outcome is intended help-seeking (General Help-Seeking Questionnaire). The trial will also include a range of secondary outcomes assessed in children, that will include staff (those who deliver the interventions) assessment of mental health literacy. An economic evaluation, implementation and process monitoring assessments will also be undertaken.

The cluster RCT of ***The Guide Cymru*** [38] aims to evaluate the effectiveness of this intervention for improving the mental health literacy of 13 to 14 year old school children, including reducing

stigma to others and to the self, and levels of good mental health behaviours and help-seeking for mental health problems. Similar to the in process AWARE trial [36] the Guide Cymru is based on an adapted version of the Mental Health and High School Curriculum Guide (developed in Canada) for the Welsh culture and context. The primary (mental health literacy) and secondary outcomes (quality of life and psychological adjustment) will be assessed at 12- and 14-weeks follow-up, with a required sample size of 13,000 year 9 school children

The Resilience Revolution [39] is described as a whole community system change approach to the town of Blackpool, which aims to provide people with 'the right support at the right time and in the right place. A resilience promoting environment will be developed to target all 10-16 year olds (Year 5) school children by embedding the Academic Resilience Approach (https://www.boingboing.org.uk/academic-resilience-approach/), which is a whole-school approach, in Blackpool's schools and local community. Specific tailored support will be provided to looked after children, young people who self-harm and those in transition from primary to secondary school. Schools' pastoral care will also be developed through training, supervision and communities of practice to help embed a bespoke approach developed by the partnership - Resilient Therapy (further details at: https://www.boingboing.org.uk/wp-content/uploads/2010/10/Resilience-Framework-children-and-young-people-2015.pdf) into everyday practice. Details of the evaluation strategy could not be located at the time of writing, although this is a live project, with outputs and impact assessments to be added over time to the Resilience Revolution resources page (https://www.boingboing.org.uk/resilience/resilience-revolution-resources/).

An RCT of the Blues Programme [32] is also currently underway, although no details are available.

Table 2. Summary of incomplete studies included in the scoping review

Study Details	Aims/Objectives	Study Sample	Active Ingredients	Evaluation Strategy
Evans et al 2018 [35] WISE Cluster RCT / integrated process evaluation	The primary aim of the Wellbeing in Secondary Education (WISE) intervention is to improve the mental health and wellbeing of teachers through provision of a peer support service and training in supporting students.	The study sample comprises secondary schools across the two study sites of England and Wales. Twenty-four schools were required to ensure statistical power, but 25 were recruited to mitigate against the risk of drop-out.	The WISE project is a cluster randomised controlled trial (RCT) of an intervention to improve the mental health support and training available to secondary school teachers through delivery of the training package Mental Health First Aid (MHFA) and a staff peer support service. The intervention's theory of change is informed by social support theory. Social support offers problem-focused coping strategies and emotion-focused supportive strategies, both of which can have a positive impact on physical and mental health	The embedded process evaluation adopts a mixed methods approach Teacher & student questionnaires; audit of school policies & interventions; attendance records for intervention training; observations of intervention training; post-training course fidelity checklist; training evaluation forms; peer supporter logs & feedback sessions. Interviews with funding organisation representatives, trainers, head-teachers and peer support service users. Focus groups with peer supporters and recipients of MHFA for Schools & Colleges training, teachers not in receipt of MHFA training and Year 10 students
Hayes et al 2019 [36] AWARE Cluster RCT	Approaches for Wellbeing and Mental Health Literacy: Research in Education (AWARE) aims to establish the effectiveness and cost-effectiveness of two interventions (i) Youth Aware of Mental Health (YAM) and (ii) Mental Health and High School Curriculum Guide (The Guide) compared with usual school-based provision for improving mental health and wellbeing of year 9 pupils in England	The overall sample size is 135 schools (45 schools per intervention arm; each with 60 year 9 children) of which 45 control schools will serve as comparators for both interventions.	YAM was developed in the USA, and aims to enhance awareness via discussions on risk, protective factors and knowledge around mental health. Delivered across 5 consecutive weeks structured around 6 themes: (1) what is mental health?; (2) self-help advice; (3) stress and crisis; (4) depression & suicidal thoughts; (5) helping a friend in need; (6) who can I ask for advice? The Guide, developed in Canada, aims to increase awareness of mental disorders and their treatments, as well as increasing understanding of how to obtain and maintain mental health, reduce stigma and improve help-seeking efficacy. It is delivered across six 1-hour lessons: (1) stigma of mental illness, (2) understanding the relationship between mental health and mental illness, (3) understanding specific mental illnesses, (4) adolescents' experiences of	Primary outcome for YAM is depressive symptoms (Short Mood and Feelings Questionnaire); and The Guide it is help-seeking (General Help-Seeking Questionnaire) measured at baseline, 3–6 months and 9–12 months follow-up. Secondary outcomes: changes in positive wellbeing, behavioural difficulties, support from school staff, stigma-related knowledge, attitudes and behaviours, & mental health first aid

Study Details	Aims/Objectives	Study Sample	Active Ingredients	Evaluation Strategy
			mental illness, (5) seeking help and finding support, and (6) the importance of positive mental health	There will also be process and implementation evaluation, and economic evaluation
Hayes et al 2019 [37] INSPIRE Cluster RCT	INSPIRE (INterventions in Schools for Promoting Wellbeing: Research in Education) includes three intervention conditions (Mindfulness Practices, Relaxation Exercises and Strategies for Safety and Wellbeing [SSW]) This trial aims to establish whether the interventions are more effective than usual school-based provision in reducing internalising difficulties in young people (Mindfulness Practices), reducing internalising difficulties in young people (Relaxation), and increasing intended help-seeking behaviour among young people around mental health (SSW)	The study aims to recruit 56 schools per arm (40 primary and 16 secondary schools with six classes each). Primary schools (year 4 and 5 children) Secondary schools (year 7 and 8 children)	Mindfulness practices - breathing exercises and other activities focussed on self-awareness of sensations, emotions and thoughts (5 mins per day in class time) Relaxation exercises - focus on deep breathing and progressive muscle relaxation (5 mins per day in class time) Staff delivering each intervention will attend a half day training course delivered by the Anna Freud National Centre for Children and Families SSW originated from teaching practical approaches to personal safety, known as 'Protective Behaviours' (PB). SWS consists of an 8-week (40 min) lesson plans: (1) It is safe to talk about mental health; (2) You are never too young to talk mental health (primary schools)/We all have mental health (secondary schools); (3) What is safety?; (4) Early warning signs – noticing our bodies; (5) Early warning signs – noticing our feelings and thoughts; (6) Developing our safety networks; (7) Safe friendships; and (8) Safe ways of managing emotions.	The primary outcome measures for Mindfulness Practices and Relaxation, are internalising difficulties (Short Mood and Feelings Questionnaire (SMFQ). For SSW the primary outcome is intended help-seeking (General Help-Seeking Questionnaire, GHSQ). Secondary outcomes: Mental health first aid; Paediatric Quality of Life; Positive wellbeing; Stigma; Behavioural problems; Support from school staff. Participating school staff (nominated by the school) will complete measures on mental health literacy. Outcome assessment will be completed at baseline and 3–6 and 9–12 months post intervention. Economic evaluation, implementation & process monitoring measures will also be collected.
Simkiss et al 2020 [38] The Guide Cymru Cluster RCT	Aims to evaluate the effectiveness of The Guide Cymru for increasing mental health literacy, including reduced stigma to others and to the self, and levels of good mental health behaviours	All 205 secondary schools in Wales will be invited to participate (30,000 Y9 pupils). Schools will be randomised to either The Guide Cymru or to wait-list	"The Guide Cymru" is an adaptation of The Guide designed for 13 to 14 year olds and for the Welsh culture and context, which consists of 6 modules; Understanding Mental Health and Mental Illness, Seeking help and the importance of positive mental health	Mental health literacy (Knowledge and Attitudes to Mental Health scale) and quality of life (Pediatric Quality of life inventory), and psychological adjustment (Strengths and Difficulties Questionnaire) will be assessed at baseline (pre-intervention), 12

Study Details	Aims/Objectives	Study Sample	Active Ingredients	Evaluation Strategy
	and help-seeking for mental health problems	control to receive The Guide Cymru 12 weeks later	The Guide Cymru includes a two-day training course for up to 3 teachers (termed the Go-To Educator) per school that covers the materials in The Guide Cymru and learning resources. Teachers then deliver The Guide Cymru over an 8–10 week period.	weeks (after the active group has received The Guide Cymru), and 24 weeks follow-up (after the wait-list control has received The Guide Cymru).
The University of Brighton's Centre of Resilience for Social Justice, Boingboing, Blackpool Council, Blackpool HeadStart [39] Resilience Revolution	The Resilience Revolution aims for a sustainable, whole-system change to the town of Blackpool, transforming systems to give people the right support at the right time and in the right place.	A resilience promoting environment targets 10 to 16-year olds, plus Academic Resilience Approach programme offered to all year 5 students in all Blackpool's schools.	The Resilience Revolution will: • provide purposeful opportunities for any member of the community, particularly those affected by disadvantage, to co-lead a grass roots social movement • mobilise the town towards supporting every young person's resilience • provide a resilience-promoting environment for all 10-16-year olds, by embedding the Academic Resilience Approach • provide a community development approach and young people's hub to embed a resilience approach • improving schools' pastoral care through training, supervision, and communities of practice to help embed Resilient Therapy into everyday practice • Developing and providing Video Interaction Guidance training and supervision Tailored support for priority target groups: • Our Children (looked-after children) – support includes personal resilience-building, Friend for Life and a digital mentoring community • Young people who self-harm – support includes systems remodelling, daily group resilience sessions in hospitals, and development of PSHE curricula • young people in transition from primary to secondary school – support includes team support from Resilience Coaches across Years 6 and 7	This is a live project, outputs and impact assessment will be added over time to the Resilience Revolution resources page.[2]

[2] https://www.boingboing.org.uk/resilience/resilience-revolution-resources/

3.3 Other Grey Literature

Experts (members of the co-production team, participants in interviews and workshops, including other project stakeholders) recommended a wide variety of resources for inclusion in an accessible resource for localities to use best available evidence to develop and/or enhance and evaluate their mental health awareness raising and anti-stigma campaigns. These resources were accessed in October 2020 and summarised in Section 4.6.

4. FINDINGS: QUALITATIVE WORK

4.1 Participants

In total, nine people agreed to participate in one-to-one semi-structured interviews. Three interactive group workshops were attended by a total of 18 participants with representation from all three localities (Newcastle and Gateshead; South Tyneside; and Northumberland). A summary of the participant roles is summarised in Table 3.

Table 3. Summary of the people who participated in the qualitative work

	Co-production meetings*	1-2-1 Interviews	Workshop 1	Workshop 2	Workshop 3
Academic Researchers	4		3	2	3
Parent Representative	1		1	1	1
Public Health Staff	4	2	1	4	
Teaching staff (including SEND)		2			
Commissioner	1	1	1		
Charity worker	1	1			1
School mental health intervention worker		2			
Educational Psychologist		1			
	Totals	9	6	7	5

Note:
* These figures do not represent totals
All three workshops were facilitated by DF (not included in numbers for the workshops as he did not provide any views during the discussions).

4.2 Macro Level of Analysis

Participants stated a pressing need for top-down guidance, support and incentives from the Government and the Office for Standards in Education, Children's Services and Skills (Ofsted) to embed mental health and wellbeing as a core business activity of compulsory and further education (Table 4, quotation 1). Several participants emphasised that the focus of schools was invariably on academic achievement (and other Ofsted criteria) with a lack of incentives to address mental health/wellbeing of staff and children/young people. This was a particularly problematic issue for engaging schools in mental health campaigns who were struggling to address Ofsted mandated improvements related to delivery of the core curriculum or other issues. Several participants also commented that there was little room in the curriculum for mental health and wellbeing (Table 4, quotation 2); indeed, one participant commented that mental health was considered a luxury (Table 4, quotation 3). In relation to this, the variation between schools in their delivery of mental health campaigns was also recognised. On the one hand there was also a perception that “Schools might say they understand how to promote good mental health but are

just ticking boxes" (I7, Mental health intervention practitioner), whereas on the other hand, examples were given of schools that had successfully rolled whole school mental health campaigns.

There were differential perceptions on the mechanism for implementing campaigns. Teachers and mental health intervention practitioners emphasised a need for top-down guidance and support from the Government to embed mental health and wellbeing as the core business of education. Conversely, public health practitioners and commissioners highlighted a need for a bottom-up learning to inform campaigns where lived experiences of teachers, parents and children/young people need to be heard and valued. The 'recovery curriculum' (in response to the COVID-19 pandemic) was considered by a range of participants to be an opportunity for the Government to learn about what schools have been doing to address mental health and wellbeing as part of the core business of schools (Table 4, quotation 4). It was suggested this learning could inform criteria used by Ofsted inspectors; for example, what are you doing to support the mental health of children and staff at your school? (Table 4, quotation 5) which is currently addressed in more general terms within parts of the current Education Inspection Framework (EIF)[3] published in 2019 [42]. However, mental health was typically thought not to be a priority in such inspections.

Learning from the bottom up was considered crucial. Public health workers and commissioners suggested gathering information from teachers, parents and students about their lived experiences and using data that schools already have in databases. This indicated a need for a two-way flow of information between policy/decision makers and people working "on the ground" so that information from all those involved is valued equally. It was suggested that this would contribute to a shift in power dynamics needed to enable a co-produced approach (Table 4, quotation 6).

Table 4. Themes at the macro-level of analysis

Theme	Description	Exemplar quotes
Top-down guidance and support from the Government	Ofsted quality criteria to embed mental health and wellbeing as core business activity of compulsory and further education	Q1*: "teachers are judged [by Ofsted] on books, maths and English, nothing to do with the mental health of kids"* (I8, Headteacher, Primary School). Q2*: "there is too much content [in curriculum] and too little time…Learning for fun and to feel good is lost*" (I7 Mental Health Intervention Practitioner) Q3*: "mental health is a luxury"* (I7 Mental Health Intervention Practitioner)

[3] The Education Inspection Framework (EIF) criteria is used by Ofsted inspectors. In the section on Behaviour and Attitudes criteria the focus is on whether the environment positively supports relationships among learners and staff, specifically bullying, peer on peer abuse and discrimination (p.10); in the Personal Development section there are criteria on how the curriculum and providers help students develop their character, resilience, independence and "know how to keep physically and mentally healthy" (p.11).

Learning from the bottom-up with expert input including lived experiences	Gathering input from all involved provides opportunities for the Government and policy/decision makers to learn about mental health campaigns happening in schools and what is needed e.g. responses to Covid-19 to address mental health, the application of the 'recovery curriculum'	Q4*: "COVID has grabbed us by the shoulders and shaken everybody up….even for the most traditional, disciplinarian teachers they- they're starting, you know, when we look at recovery curriculums, it's a huge opportunity to raise that profile of, you know, [mental health]"* (Public Health Worker, CW2) Q5*: "Within those kind of Ofsted schemes if there was some way of monitoring that and making that a compulsory part of what they have to achieve then that might kind of increase people's, you know, the people who hold the purse strings and make the decisions in schools, m- to make mental health a little higher up on their agenda (*Researcher, CW2) Q6: "*taking off lanyards [during co-production] so levelling that playing field so that power dynamic shifts…it's that osmosis of expertise and knowledge. It's the only point we will get that whole school approach*" (Commissioner, CW1)

4.3 Meso Level of Analysis

A dominant theme that emerged at this level of analysis was that a whole school approach (WSA) was insufficient to generate the cultural paradigm shift required for mental health and wellbeing to be better understood and effectively addressed in schools. A WSA embedded with an over-arching whole community approach (WCA) was proposed, where every day mental health and wellbeing practices are embedded into communities and schools as the business of all stakeholders such as schools, public and private organisations, including voluntary services, parents/guardians and children/young people (Table 5, quotation 1). This would necessitate buy-in and involvement from all community stakeholders, with everyone adopting the same practices and talking the same "language" about mental health and wellbeing (Table 5, quotations 2 and 3), and critically taking responsibility for funding, implementation, monitoring and evaluation of a WCA. Therefore, the rationale as to why children's' and young peoples' mental health has value for everybody needs to be disseminated community wide. The principal rationale provided for a WCA was that children's/young people's experience of a WSA would cross the boundaries of the 'school gate' where campaigns would target parents, non-teaching staff and other adults in contact with children in the community (e.g. youth workers, lollipop people, bus drivers, shopkeepers). This would recognise unused resources and influences in the community and serve to prevent interactions with the wider community from compromising the culture of the school that is supportive of children/young peoples' mental health and wellbeing. (Table 5, quotation 4).

A WSA embedded within a WCA raised implications for partnership working both within and between schools in a community. Participants discussed the variability in perceptions of responsibility about addressing mental health between schools, and the different extent to which schools are actively engaged in promoting good mental health and wellbeing. Strong

communication between schools and other stakeholders was considered essential, and to facilitate this participants' suggested sharing school data systems across organisations to better understand a child's situation, and ensuring campaigns were sustainable with consistent key messages delivered by organisations so that they "stuck". A shift from schools operating as independent entities to a partnership model with a shared vision and strategy was needed with an emphasis on a co-ordinated multi-disciplinary partnership working involving educational psychologists, school nurses, SEND, local authorities, commissioning groups and schools was needed to effectively deliver campaigns (Table 5, quotations 5, 6 and 7).

Several participants provided a compelling rationale for partnership working between schools. It may take several years for tangible impacts of WSA mental health campaigns to appear, and in many cases may not fully manifest until after a child has transitioned to another school (a maturational effect). For example, whole-school interventions delivered in primary schools may have a more tangible impact on children's mental health and wellbeing (resulting in improved scholastic and other outcomes) when they reach junior or secondary school (Table 5, quotation 8).

4.3.1 Additional core components of a WSA

Participants universally agreed that a trauma-informed WSA was optimal for addressing mental health and wellbeing of staff and children/young people (Table 5, quotation 9). Largely the result of meso-level themes, and recognition that schools were predominately operated within a business model, participants acknowledged key challenges for schools aspiring to adopt a WSA mental health and wellbeing campaign; specifically a lack of guidance from peer-reviewed evidence on how to optimally implement a WSA and the positive impact it may have on staff and children (Table 5, quotations 10 and 11); However, participants provided examples of a WSA being applied in the UK. This was considered important for schools to draw upon as exemplars to demonstrate to schools that it is possible to implement this approach with demonstrable benefits for mental health and wellbeing, and that we can learn from, and build upon their experiences to support local implementation of a WSA. Examples of grey literature on completed and in process evaluations of WSAs to mental health and wellbeing, and other resources were shared with the research team (see Section 4.6).

The concept of a trauma-informed approach and use of restorative related practice[4] emerged as an important prerequisite for a WSA, and was considered optimal for addressing existing and preventing trauma-related conditions and adverse childhood experience in both children and staff

[4] components of trauma-focused programmes have been categorised as: (a) individual and group-based approaches, (b) classroom-based approaches, and (c) school-wide approaches, with empirical evidence [43]. Restorative practice (RP) is a behaviour management method that aims to help students develop conflict resolution and aggression management skills [44].

(Table 5, quotations 12, 13 and 14). A need for updated guidance for schools on what constitutes trauma to address perceptions that it is not exclusively related to diagnosed behavioural conditions such as ADHD was suggested (Table 5, quotations 3 and 14), as well as a shift from managing children with archaic disciplinary practices to an empathy-based approach. One participant provided an example of a school where a teacher who raised their voice to children would be considered as gross misconduct (Table 5, quotation 15). A further important component of trauma-informed WSA was for all members of the school community (irrespective of role from senior management to the receptionist) with direct and indirect contact with children and young people to receive the same level of training (Table 5, quotation 16). This was considered essential to achieve a critical mass of buy-in required for a true WSA, and high adherence to campaign messages and maximising the proportion of interactions between staff and children being supportive of mental health and wellbeing. However, it was acknowledged this poses a significant challenge, and that buy-in from senior management is critical (Table 5, quotation 17). Adoption of a trauma-informed WSA also raised implications for selection of teaching staff at the point of entry to teaching (e.g. PGCE) and staff selection/recruitment and training of staff from across the entire school (see micro-level of analysis and content of campaigns – Sections 4.4 and 4.5 respectively), with an emphasis on appointing staff with appropriate interpersonal skills, attitudes and lived experience of mental health and wellbeing (Table 5, quotations 18, 19 and 20).

De-medicalising mental health and wellbeing was raised as a further important component of an effective WSA to mental health and wellbeing. Participants asserted that mental health and wellbeing is predominately viewed through the lens of medical model and the almost exclusive remit of healthcare/NHS commissioners. An important message to communicate across the school was that access to mental health services should not be the default solution; it is about “access to the right person at the right time” (Table 5, quotation 21). This needed to shift towards a community model of mental health and wellbeing with an emphasis on normalisation and the wider ‘non-medical’ determinants of mental health and mental wellbeing (and the difference between them), including how to coping positively with challenging situations to foster resilience and avoidance of escalating distress to medical services (Table 5, quotation 22). The message that mental health and physical health are inter-linked was also considered to be important by participants.

Commissioners and teachers recognised the need for service providers to invest in establishing trust and building relationships with schools (staff and children/students) and service providers, especially in schools that were not prioritising mental health due to financial, Ofsted-related or cultural reasons (Table 5, quotations 23 and 24). Suggestions included service providers requesting permission to access SENCO Network meetings and school visits to initiate a rapport with co-production teams (see Micro level of analysis – Section 4.4, Table 6) and provide them with information about their services and an opportunity to scrutinise them with reference to their needs.

This was important to establish credibility of the services being offered to schools who often receive an overwhelming amount of information about mental health campaigns and service providers (Table 5, quotation 25). This would facilitate schools to make informed decisions about which services providers they wish to commission to best meet the needs of their school (Table 5, quotation 26).

Table 5. Themes at the meso-level of analysis

Primary Theme	Descriptions	Exemplar quotes
A Whole School Approach embedded within a Whole Community Approach	Mental health and wellbeing are the business of all stakeholders in a community	Q1: "*We need to create a community model which is a whole encompassing model and- and by using non medicalised people to deliver emotional resilience and mental health up,-skilling in the generalised format is something that will really make a shift change and grow confidence in teachers and wider community (*Charity Worker, CW3) Q2:*"…but real, again evidence based [mental health] programmes [need to be] embedded into erm, into the curriculum and into the everyday so that they can start to understand how to process things and how to build their resilience and how to cope when they are worried or anxious* (Commissioner, CW1) Q3: "*I think something is about changing the language of how those children are perceived because a lot of those children who we would consider have had awful experiences in their lives are seen by primary mental health and CYPS through the lens of ADHD and that sort of realm of diagnosis…you need to share that, the new terminologies…because I do think kids are being diagnosed possibly in the past incorrectly who have had significant trauma"* (Public health Worker, CW2) Q4: "*What we need to be looking at is not just a whole school approach but a whole community approach… Because actually that that could really help to booster the whole school approach if children and young people, particularly those more difficult to reach young people who might not engage with school as such, but if they they're hearing the same messages at the places where they are comfortable, where they do have really positive relationships, then we might see a really huge improvement as a result of that* (Commissioner, CW2)
Co-ordinated Partnership working between Schools in a community	Stronger links between commissioners and schools (e.g. shared understanding of language) and multi-disciplinary and multi-agency partnership working within the community. Impact of campaigns recognised beyond primary into secondary schools	Q5: *"One of the points that [name] mentioned was about that strong connection with the school…they have to be able to trust you to be able to know that [commissioners] appreciate the challenges…I think what will enable a whole school approach is having that tight relationship with the school* (Public Health Worker, CW2). *Q6: "When we looked at the senior mental health leads in schools role, we bought together people from ed psychology, school nursing, education staff, SEND have been really helpful… You need a variety of people around the table to make sure it's delivered in a coordinated way otherwise…you just have everybody going off and doing their own thing in schools"* (I4, Local Authority Public Health Manager) *Q7: "In [place name] I don't think we've got a joined up approach to promoting mental health campaigns….so different teams will be doing different things. Your enquiry has*

		prompted us to think about how we do this more consistently or how we liaise…and how we join up more consistently" (I3, Educational Psychologist) Q8: "*Creating a really mentally healthy primary school will potentially benefit the middle or the secondary schools that those children go onto and may not be obvious- an obvious benefit to the primary school in the first instance*" (Public Health Worker, CW2)
Additional Core components of a Whole School Approach	Recognition that WSA is the optimal approach, but lack of accessible guidance on how it can be implemented	*Q9: "a trauma informed approach in school goes hand in hand with anything that you would ever attempt to do with mental health in school. You know, they're completely interlinked so the evidence is there for the trauma informed schools… the impact on the staff alone would be phenomenal but the knock on impact on mental health would just be huge"* (CW3, Parent) Q10: *"in health we talk in one way and in education they talk in a completely different language.. that [guidance] document hadn't been written"* (Public Health Worker, CW2) *Q11: "There haven't been any concrete impact evaluations [of campaigns] or looking at whether the message has spread… we haven't got a way of looking at how far that reach was or the impact of it"* (I3, Educational Psychologist)
	Trauma-informed with a focus on empathy as opposed to discipline	*Q12: "…the exemplary trauma informed school in the country. Is [name]…They are truly trauma informed, probably the only in the country…because it is every single person in the school from the caretaker to the receptionist to the dinner nannies on board"* (Parent, CW1) *Q13: "What we've learnt from trauma informed schools and a trauma informed environment the most securely attached neurotypical, absolutely settled safe child can- No harm can be done by them being treated and interacted with in a trauma informed way".* (CW2, parent) Q14: *"they would need some sort of guidance as to what it was that would be offered when you talk about trauma. We need to share that language and not just hold in a professional context where it's just a new buzz word rather than, you know, it was ADHD and all that sort of language, and now we're talking about trauma, so they'd need to understand what we were talking about* (Public Health Worker, CW2) Q15: "*A School [name redacted] has on job description for every member of staff that it is gross misconduct to raise their voice to children*" (CW1, Parent)
	All staff (irrespective of role) have the same level of training. All staff buy into positive mental health promotion and understand why it is important for everyone involved	Q16: "*So the main thing about a whole school approach is if your caretaker and your receptionist, your telephonist, they have to have the same level as training as the head teacher, the senior leadership team, the school counsellor, everyone, every single person who is going to look at that child, interact with them verbally, non-verbally has to have the same level of training but also to completely get the culture of it because it's a huge culture change*" (WP – Parent) *Q17: "need the buy in of everyone….it starts with the senior leadership and they can deal with the rest that need it"* (CW1, Parent)
	Selection of staff at point of recruitment is	Q18: *"You should only able allowed to work in a school if you are a genuinely kind person and smile freely, because kids need that security all the time" ….[some school staff] are*

	crucial, including parental involvement in the process	*determined to change things…but their flames can be put out by people that maybe haven't been touched by it [mental health]…and can't empathise with it"* (CW1, Parent) Q19: *"[teachers'] personality demonstrates what their approach to mental health might be…their ability to engage someone who needed poor mental health support might be variable"* (I9, Deputy Head, Secondary School) Q20: "*Selection at entry to teaching important – there can be an attitude to having knowledge that the students don't have - some teachers are there for the power kick*" (Provider, CW3)
	De-medicalising mental health and wellbeing. Access to medical services is not the only solution	Q21: *"I think that people see mental health as, I will refer you to CAHM and they will give you this golden nugget thing and make you better. And for the vast majority with mental health disorder that is never going to happen, so why are we telling people that? It's about getting people to a place where they are able to effectively engage at the right service, at the right time with the biggest impact."* (Charity Worker, CW3) Q22: *"…we need to be able to nip things in the bud not over medicalise or identify as a significant mental health matter, and if it can be managed on that front of is infinitely the best way than getting involved in any sort of services where they may be overly scrutinised, should I say, and overly assessed, when that isn't necessary"* (Commissioner, CW2)
	Service providers building relationships with schools	Q23: *"So I think that's one thing for me is when we start to look at a whole school approach, it's not just an inward facing, it's identifying how we can work with schools to enable them to be more open and more engaging with those people or those services or those interventions that want to come in"* (CW3, Charity Worker) *Q24: "We're working with five schools in the Jewish community, which is sort of slower progress, because it's been a year of relationship building and trust building. but we've made some really positive progress in some Jewish schools in the area where we've delivered some staff training when they've not really had mental health awareness training before…so for us this is a real* *Q25: The mental health arena is crowded…teaching staff are absolutely overwhelmed by what's being sent to them…schools can be a bit confused about where they're coming from"* (I4, Local Authority Public Health Manager) Q26: *"I think if you had a few rubber stamped people or organisations that you could talk to for further information on specific things, then I think that would cover things and then it would be up to the school to decide have they were going to implement it in their own setting"* (I9, Deputy Headteacher)

4.4 Micro Level of Analysis

A clear message that several of these participants emphasised was that a positive mental health and wellbeing culture in a WSA could in part be achieved by introducing relatively simple environmental changes could embed mental health and wellbeing awareness within routine practices and activities across the school at little financial cost (Table 6, quotations 1 and 2), for example a "buddy bus stop" system in school yard at breaktimes.

Further to the assertions regarding a need for a bottom-up approach (see Macro level of analysis, Section 4.2,Table 4) a range of participants expressed views that more value and importance should be placed on the views of people with lived experience (in particular those on the front line, such as children/young people and teachers) and engaging them in meaningful co-production activity (Table 6, quotations 4 and 5). It was further emphasised that providers must listen to and implement the views of children/young people to avoid disillusionment with co-production and dis-engagement from campaign messages (Table 6, quotation 5). Parents/guardians were also considered as essential component of co-production activity, who should be upskilled and empowered to engage in co-production/decision making around mental health in schools to capitalise on their expertise (Table 6, quotation 6)

Participants identified a need for support and training on mental health and wellbeing for teachers and other school staff. There was a recognition that all school staff would not have the same level of understanding and confidence to engage with mental health issues due to a range of factors such different personalities and experiences, workloads and subject interests of teachers; which would have a concomitant impact on consistency of implementing whole-school mental health and wellbeing campaigns (Table 6, quotations 7, 8 and 9).

In order to increase the capability and capacity of teaching staff to address mental health and wellbeing issues, participants emphasised a need for an empathic approach to the challenges faced by teaching staff and being responsive to their personal mental health and wellbeing support needs, in order to develop their awareness, skills and confidence with issues around mental health and wellbeing. This should include access to flexible training on how to address their own mental health needs and practical training on how to embed positive mental health practices into their teaching that adds value without increasing workloads (Table 6, quotation 10).

Staff modelling normalised attitudes to mental health and adaptive coping to stressful situation was highlighted as a critically important component of a WSA at the micro level of analysis, which can also help to break down barriers between students and teachers by using lived experience. One example provided was a teacher disclosing to students that public speaking was a stressful experience and engaging with it (rather than avoiding it) helps to develop resilience in response to stress (Table 6, quotation 11).

Table 6. Themes at the micro-level of analysis

Primary Theme	Descriptions	Exemplar quotes
Small adjustments to the environment can have a big impact	Making environmental changes to foster a culture of mental health and wellbeing • Providing safe spaces to support wellbeing e.g. Mindfulness area • Buddy Bus stop – a buddy system in schoolyard at breaktimes • Worry tree – children hang their worries to let go of them	Q1: *"We've got a mindfulness area…they'll ask to go to. They know it's there and they know they can access it…we let children choose if they want to go there if they want a break, they can ask for a chill out pass…"* (I8, Headteacher, Primary School) Q2: *"..you know how that peer support and just a really simple easy tool, now that's the Buddy Bus Stop and if you feel sad or if you need any help or if you're feeling a certain way you can go there and someone will come and talk to you"* (Commissioner, CW1)
Bottom-up approach to design and delivery of a WSA mental health campaign (informed by co-production activity)	Lived experience to inform decision making. People on front line e.g. children / young people and teachers involved in co-production and decision making. Senior management support to ensure outputs from co-production are implemented	*Q4: "It doesn't matter, all of the academic work, yes, it is vital, but it means absolutely nothing, and it cannot be translated if you're not bringing lived experience into it. It's just an absolute non-starter"* (CW1, Parent) *Q5: "On paper the young people were consulted and in reality they were ignored…so you must, must listen to what young people say and act on it…young people can become very disillusioned…the next time they are asked for youth participation they will say no"* (I5, Counsellor)
Involvement of parents / guardians	It was suggested that parents, as well as other adults in contact with children in the community, should be upskilled and empowered to be involved in co-production/decision making around mental health in schools and by doing so capitalise on their expertise.	*Q6: "…The skills that we [parents] can professionally bring to a table can sometimes be more than the professionals around us…you are accessing information and experience that you don't have, you might not have round the table anyway"* (CW1, Parent)
Support and training on mental health and wellbeing for teachers and other school staff	While teachers felt that all staff should receive training in mental health, it was felt expectations for all teachers to provide mental health support were too high, and that there should be more understanding that not all teachers are prepared and may lack time to develop skills. Mental health support for teachers and other school staff Understanding what it is like for teaching staff – their situations and being	*Q7: "We've sort of got an assumption that everyone knows what [mental health] is and that everyone is confident about it"* (I8, Head Teacher, Primary School) *Q8: "With regards to mental health…there needs to be an understanding that not all teachers are going to be able to respond and implement that information in the same way. And that won't be due to a lack of care…. you've just got a variety of people, personality, skills and expertise…we've all got mental health and we're all human beings"* (I9, Deputy Headteacher, Secondary School) *Q9: "…this idea of being full time teaching a class and doing this work on top is a big ask. And I think personality types, some are more suited to it than others…it has to be somebody who have a commitment and want to do that, I don't think it's something you can say to a staff team you must do this… for me it needs to be people who feel comfortable and wants to do it otherwise what's the point?"* (I5, School Counsellor)

	responsive to their mental health needs, provision of support and training available e.g. adults' resilience programme On-line training that can accessed on a flexible basis Training addressing empathy e.g. parents/teachers/students understanding each other's situations.	*Q10: "Training should include the basics, an idiots' guide and needs to add value for overstretched schools/teachers e.g. include strategies that they can share with pupils*. (I8, Headteacher, Primary School)
Staff modelling normalised attitudes to mental health and positive coping	Staff explicitly modelling good mental health and coping strategies, including awareness they can model maladaptive coping in response to stress. This can help to break down barriers between students and teachers using lived experience.	Q11: "*One of my teachers said to an assembly full of kids, "I really struggle with public speaking, but this is why I do it anyway and this is how I do that." And that was massive because that was huge modelling and it was really, it was a turning point for some of those kids because, you know, it was about saying, they're not indestructible but this is what they do to get over it*" (CW2, Public Health Practitioner)

4.5 Mode, Form and Content of Campaigns

Participants provided a range of suggestions for what to include in accessible resource on the mode of delivery, form, and content of mental health campaigns as part of a WSA (embedded within a whole community approach). These are described along with exemplar quotes and suggestions from participants in Table 7.

Table 7. Themes related to organisation, Mode, Form and Content of Campaigns

Theme	Description	Exemplar quotes	Participant suggestions
Mode and Form of Campaigns	Simplify campaigns – do not need many resources. Exemplars of existing WSAs to mental health to demonstrate that is it possible, and to learn from their experience Different needs of school settings and individuals (pupils, teachers) involved need to be recognised and personalised in order for campaigns to be meaningful Iterative and informed by existing ideas - build on what is already being done locally and nationally Draw on work done by charitable organisations such as Mind Different needs of school settings and individuals (pupils, teachers) involved	*"It does not have to be the next big thing…we can use ideas we know already work and…learn from past lessons"* (CW1, Commissioner) *"a lot of this has been done potentially before…so rather than reinventing the wheel, use with pride what's available regionally and nationally"* (CW2, Public Health Worker).	Resources recommended by experts Models of collaborative working shared between schools and settings. Information on previous successful campaigns / activities should be accessible to all - this information is often not known about or difficult to access as it is often not publicly available

	need to be recognised and personalised, in order for campaigns to be meaningful and impactful. Ready-made, accessible teaching resources for those who may not otherwise be engaged. Showcase campaigns with local celebrities, e.g. local radio to generate interest/kudos		
Content of Campaigns	• Context appropriate • Input from young people essential – all participants raised this. Must listen to input or may deter from engaging in future research. • Visually appealing for young people, age appropriate. • Different methods of reaching young people need to be used in addition to settings-based campaigns • Adjustable, open teaching material to suit age/intersections e.g. sexuality, race, gender/school context/ resources available to teachers. • Use of video clips and exposure to life experience to promote attitude change • Practical activities can help pupils open up about their mental health. • Pupils need clear understanding of what good mental health is, how the brain works and what happens to it with mental ill *health* to destigmatise. • Training using life experience and self-reflection e.g. video clips of situations where they see own behaviour • Use of strategies such as overlearning, giving young people choices/control, confidence building for staff and pupils. • Primary school kids engage well with puppets/props for explanations and secondary school kids "learning something cool" (I6) e.g. animation.	*"We [commissioners] go in with the problem statement and then [the health ambassadors] do that problem solving around that…the way the mental health ambassadors work is that shared power and that shared decision making between us and them"* (I1, Public Health Worker) *"my advice…is sit down with your students and ask them what they want…mind, I'll put an addition to that, er you can't just listen to young people and not act on that"* (I5, School Counsellor, Secondary School) *"What might not seem like an issue to an adult can feel very significant to a child/young person"* (I7, Mental Health Worker)	Health ambassadors model where young people are trained to solve health problems given to them by commissioners by asking other young people what they want and need. Campaign launch party held at known suicide site chosen by young people – local narrative more meaningful Brighter colours, abstract design, relatable mental health language non-clinical, non-traditional and practical activities to capture interest. Peer to peer campaigns in combination with campaigns in schools Schools need to be supported to develop their own ethos and approach to mental health rather than a one size fits all approach of larger campaigns Clear, consistent whole school messages
Organisation and delivery of campaigns	Strong multi-agency communication Consistency and longevity so messages stick Need a broader campaign to educate everyone about what healthy wellbeing looks like, that is owned by everyone i.e. co-produced with all stakeholders	*"…it is that same broader campaign on educating ourselves and others about what- what that means, what that will look like, what healthy wellbeing looks like…So, the cultural change has to be not only owned by a school, it has to be broadly*	Look towards successful campaigns in other domains e.g. breastfeeding and dental health campaigns (in Northumberland that were informed by and engaged everybody in the community and

		owned by all people in the community" (CW2, Public Health Worker)	changed behaviours as a result.
Physical environment	Simple, uncostly adjustments to setting can make huge difference to young people in help seeking. • Providing safe spaces to support wellbeing e.g. Mindfulness area • Buddy Bus stop – a buddy system in schoolyard at breaktimes • Worry tree – where children hang their worries to let go of them	*Provision of chill out/mindfulness areas to reduce stress at breaktimes* (CW3 -Charity Worker). *Waiting room seats placed back to back increased attendance at local service* (I6, Campaign Design Consultant) *School detention room next to counsellors' office deterred young people* (I5, School Counsellor)	Conduct co-production work with staff and students/children

4.6 Recommendations from participants on resources to support WSA mental health campaigns

Examples of schools that have successfully implemented trauma-informed WSAs to mental health and wellbeing were considered important to demonstrate to schools that such an approach is possible. Two examples provided by participants in the co-production activity are presented in Table 8.

Table 8. Examples of trauma-informed schools in the UK

Headlands School, Penarth, South Wales [45] Website: https://www.headlandsschool.org.uk/	From their website: "Expectations are everything" Headlands is an independent day and residential special school that provides high quality education and care to children and young people aged 7 to 19 years. Our therapeutic model of education and residential care is based on the principles of Dyadic Developmental Practice (DDP) and has been developed by the staff at Headlands residential homes and school. The model is designed for children and young people who have experienced early developmental trauma and those young people with a diagnosis of Autistic Spectrum Conditions. Our model holds the child at the centre of our thinking and is structured to meet the complex needs of all the children and young people we work with.
Colebourne Primary school, Birmingham [46] Website: http://www.hazwebs.co.uk/colebourne/	From their website: We value each individual child and work with parents, the community and beyond to offer diverse experiences and support for pupils and families in a caring and safe environment. We develop children to be confident, life-long learners and compassionate, respectful members of their community and the world.

Several participants recommended resources that were already available to support the design of mental health campaigns, for example "so rather than reinventing the wheel, use with pride what's available regionally and nationally" (CW2 Public Health Worker). Tables 9 and 10 provide a brief

overview of the publicly available resources, which will be used to signpost schools to sources of complementary information presented in the accessible resource.

Consistent with our findings at the meso-level of analysis, the Thrive Framework provides guidance on developing a whole school approach embedded within a whole community approach to mental health and wellbeing. The other resources from Northumberland County provide useful advice and guidance on the development of whole school approach. These resources are summarised in Table 9.

Table 9. Resources to support the design and implementation of WSA mental health and wellbeing

The THRIVE framework for system change [47]	Provides a set of principles for mental health support for children, young people, and families. The Framework is needs-led, so mental health needs are defined by children, young people and families alongside professionals through shared decision making. Needs are not based on severity, diagnosis, or health care pathways. It has been extensively implemented across England and used as a basis for service transformation plans in many child and adolescent mental health services. Helped to develop shared language and vision of campaigns in Northumberland. The THRIVE framework is for all children and young people aged 0–25 within a specified locality; and any professionals who seek to promote mental health awareness and help children and young people with mental health and wellbeing needs or those at risk of mental health difficulties (whether staff in educational settings, social care, voluntary or health sectors or others) The Framework conceptualises the mental health and wellbeing needs of children, young people and families into five needs-based groupings: 1. Those whose current need is support in maintaining mental wellbeing through effective prevention and promotion strategies 2. Those who need advice and signposting 3. Those who need more extensive and specialised goals-based help 4. Those who need focused goals-based input 5. Those who have not benefitted from or are unable to use help, but are of such a risk that they are still in contact with services
Northumberland County Council Whole School Approaches to Promoting Emotional Health and Wellbeing Good Practice Guide [48] Northumberland Promoting Emotional health and Wellbeing School Checklist, Northumberland County Council [49]	Provides guidance, information and examples of current practice on implementing a whole school approach to good mental health. It is based on eight key principles which underpin a whole school approach in the government guidance “Promoting Children and Young People’ Emotional Health and Wellbeing” [50]**. The guide provides suggestions on ways for schools to develop practice and systems to support whole school principles. The schools represented are from the primary, first, middle, secondary, high and special schools in Northumberland. This and the corresponding checklist on their emotional and wellbeing provision can be used as a self-assessment of activities they are carrying out in adopting a whole school approach to mental health. ** Describes how Ofsted criteria can be linked to components of a WSA to mental health and wellbeing
National Children’s Bureau A whole-school framework for emotional wellbeing and	Brings together research evidence and provides practical support by setting out additional information and resources. It is intended to support all schools to create sustainable and manageable responses to the emotional wellbeing and mental health needs of both students and staff.

mental health – supporting resources for school leaders [51] A whole school framework for emotional wellbeing and mental health – A self-assessment and improvement tool for school leaders [52]	There are four key areas that schools can monitor which, underpinned by staff capacity and taking a whole school approach, can contribute to improving a school's climate and ethos: • Pupil engagement • Parent/carer engagement • Developing social and emotional skills of pupils • Improved provision of targeted help with mental health difficulties Proposes a four-stage approach to wellbeing and mental health: 1. Deciding to act and identifying what is in place already 2. Getting a shared understanding and commitment to change and development 3. Building relationships and developing practices 4. Implementation and evaluation
Time to Change – Children and Young People's Campaign [53]	Anti-stigma campaign run by Mind and Rethink Mental Illness to improve the knowledge, attitudes and behaviour of young people and families around mental health. The website includes resources which any secondary school can use to run their own Time to Change Campaign

A need for off-the-shelf resources for teachers to provide practical activities to help children 'open up' about their mental health, and training for teachers was emphasised by participants. Their recommendations of existing resources to support these areas is presented in Table 10.

Table 10. Resources for teaching staff

The Mental Health and High School Curriculum Guide [54]	Evidence-based mental health curriculum resource that has been demonstrated to improve both teachers' and students' (ages 13 to 15 years) mental health literacy through usual teacher education and application in the classroom in a variety of program evaluations and research studies in Canada and elsewhere. Additional resources on this website are available to support the guide and improve students and educators' understanding of mental health and mental disorders. Adapted versions of this guide are currently being evaluated in the AWARE trial [29] and The Guide Cymru [31] described further in the scoping review – Table 2 (in process studies)
Positive Behavioural Support Training (PBS) and the RAID approach [55]	Training course based on a positive behavioural support (PBS) to working with challenging behaviour. RAID® (Reinforce Appropriate, Implode Disruptive) is a leading positive psychology approach for tackling challenging behaviour at source approach centres on inclusion, increased quality of life, participation and emphasis on valued social roles with stakeholder participation and feedback. While there are assessments and interventions in place to monitor, change and manage behaviour preventive strategies are at the forefront. Use of "red and green behaviour" to side-step value judgements and define behaviour. Emphasis on staff proactively encouraging adaptive behaviours and analysing challenging behaviour to know how to respond.
The ROAR Response to Mental Health in Primary Schools [56]	The ROAR model (R – recognise the signs and symptoms, O – ask open questions – try to spot the big thought, A - access support, services and self-care R- build resilience) responds to the top five CPD priorities identified by primary schools across Liverpool; Emotional difficulties, Behavioral difficulties, Parental mental distress, Anxiety and Neurodevelopmental conditions. Training course designed for a whole school approach to mental health. A designated member of staff receiving this training will be:

	• Equipped to respond to specific mental health needs within your school. • Provided with lesson plans (KS1 and one for KS2) to build awareness around mental health and resilience that can be delivered to each class by member of staff. • Given resources to deliver a 2-hour CPD session within your school setting to give the whole school staff a general understanding of child mental health and introduce them to the ROAR model. • Given resources to deliver a children's mental health awareness session for parents within your school setting.
Writing for mental health [57]	Intervention to support mental wellbeing through writing and other activities to express feelings (Can't Talk, Write toolkits) Web resource developed by Action for Children in collaboration with the Royal Mail and The Prince's Trust. Downloadable workbooks are full of activities to get young people writing. The young person's version (11-18 years) has 10 activities. Each one encourages a different style of writing. The facilitators' toolkit is for adults to use with young people. It's divided into 10 sessions – each with an accompanying activity. The activities help young people to express their emotions, either alone or in a group.
Northumberland Education e-courier [58]	Northumberland Education website providing links to a large number resources for schools on mental health-related topics

4.7 Evaluation of Campaigns

There was a consensus that evaluating impact of campaigns on knowledge and attitudes (mental health literacy) was useful, although campaigns would benefit from evaluating their impact on wellbeing (e.g. WEMWBS), and critically on actual behaviour (staff and children/young people) and culture of schools. Several impact measures were suggested, many of which could utilise routinely collected data:

- attendance rates (staff and children/young people)
- staff retention / turnover
- use of disciplinary measures
- academic achievement
- quality of relationships between parents/guardians and schools
- benefits in cost terms (return on investment)
- narratives of children/young people, school staff and parents/guardians

Changes in routinely collected data by Ofsted and local school inspectors was suggested, for example using information they gather together with Trailblazer outcomes to form a source of data for use in evaluation activity, which would be longitudinal and utilise mixed methods to understand, what, how and why campaigns work:

> " *[Trailblazers are] government funded for 12 years to be evaluated and look at the outcomes for children, we're tracking children from whatever age they engage with, you*

know, if you're talking about a five years, so by the time they're 18 we should have seen an improvement. What's the connection with Ofsted who are inspecting the schools to measure this? You know, is it running parallel or is it any national discussion on how these trailblazers would tie into that because surely it would be it would be a clear incentive for a school to engage with this model?" (Public Health Worker, CW2)

It was considered important that assessments need to capture lived experiences, including the perceptions and feelings of staff and young people. In order to maximise engagement in evaluation of campaigns, rewards for participation should be considered. Moreover, evaluations should the reflect the priorities and preferences of the staff and children/young people. In this regard, consistent with the view that design of campaigns should capitalise on the benefits on co-production activities, and this approach was recommended as the optimal approach to evaluation of campaigns.

The need to explore the long-term cumulative impact of WSA mental health and wellbeing campaigns was noted. It may take several years for tangible impacts of campaigns to appear, and in many cases may not to manifest until a child has transitioned to another school. For example, whole-school interventions delivered in primary schools may have a more tangible impact on children when they reach junior or secondary school. This maturational impact of whole-school interventions adds further weight to the suggestion for schools in a community to work in partnership (see Meso level of analysis), not just for evaluative purposes across a child's educational journey, but also to ensure consistency in approach and maximising the 'maturational' impact of a WSA to mental health and wellbeing, culminating at the point young people leave education.

One participant suggested that schools could utilise regional surveys (for example, the Northumberland Health and Wellbeing survey) to monitor impact of introducing WSA approaches to mental health and wellbeing on individual or clusters of schools.

5. DISCUSSION AND DEVELOPMENT OF AN ACCESSIBLE RESOURCE

The scoping review identified seven completed and five in-process studies of UK-based school-wide interventions targeting children and young people published in the last 5 years (2015 to June 2020). This informed in-depth qualitative work that engaged 27 people in semi-structured interviews or interactive group workshops, with representation from all three localities (Newcastle and Gateshead; South Tyneside; and Northumberland).

5.1 Discussion on evidence identified in the scoping review

Four of the seven completed studies focused on structured educational 'class-room' based approaches designed to impact on knowledge and attitudes, and intentional behaviours related to the concept of mental health literacy and resilience [28,30,31,32]. There is no definitive definition of mental health literacy, although it has been described to consist of four components: understanding of positive mental health, knowledge of mental health disorders and treatment options, tackling stigma, and enhancing help-seeking self-efficacy [59]. This may in part account for the diverse range of self-reported methods used to assess mental health literacy outcomes. Whilst classroom-based education delivered to students, designed to improve their mental health awareness, knowledge, and attitudes demonstrate positive self-reported outcomes, there is limited evidence that they are driving actual changes in school culture / behaviour of staff and children over the long-term.

The majority (6 out of 7) of completed studies focused exclusively on improving outcomes in school children. Only one study focused specifically on the mental health and wellbeing of teaching staff, however, other studies also included teaching staff as participants. There is compelling rationale, informed by evidence, that interventions targeting teaching staff has benefits not only for the mental health and wellbeing of teaching staff who are at high-risk of mental health disorders [60], but also children's mental health and wellbeing as they are subsequently better placed to support children and young people with mental health issues [61]. Schools also benefit from fewer adverse occupational outcomes such as absenteeism [62].

The only completed study that focused on staff mental health and wellbeing was the WISE study [29]. This study demonstrated the feasibility of providing selected staff with training on Mental Health First Aid (MHFA) to enable them to provide peer support, and setting up of a peer-support service provided by trained staff. The on-going embedded process evaluation of the WISE study will provide useful insights into how best to implement peer-support services in schools [35].

The remaining two completed studies reported on evaluations of the Roots of Empathy intervention, which as opposed to being focused on mental health literacy or stigma reduction, was underpinned by attachment theory to promote the development of more caring and less aggressive

behaviours using infant development and relationships with its parents. Both evaluations reported improved scores on measures of empathy, aggression and prosocial behaviour [33,34], which suggests that empathy-based interventions may have promise for improving the school climate and culture (and is consistent with a trauma-informed approach as recommended by participants in our study). Therefore, as opposed to placing a focus on reducing stigmatising attitudes and behaviours, it may be more appropriate to focus on enhancing empathy and prosocial behaviours as part of 'pro-mental health' campaigns.

Involvement of people with lived experience of mental health conditions in delivery of interventions to school children was explicit in one study, School Space [28], but did not report any additional impact of a facilitator who acknowledged lived experience of mental health disorders.

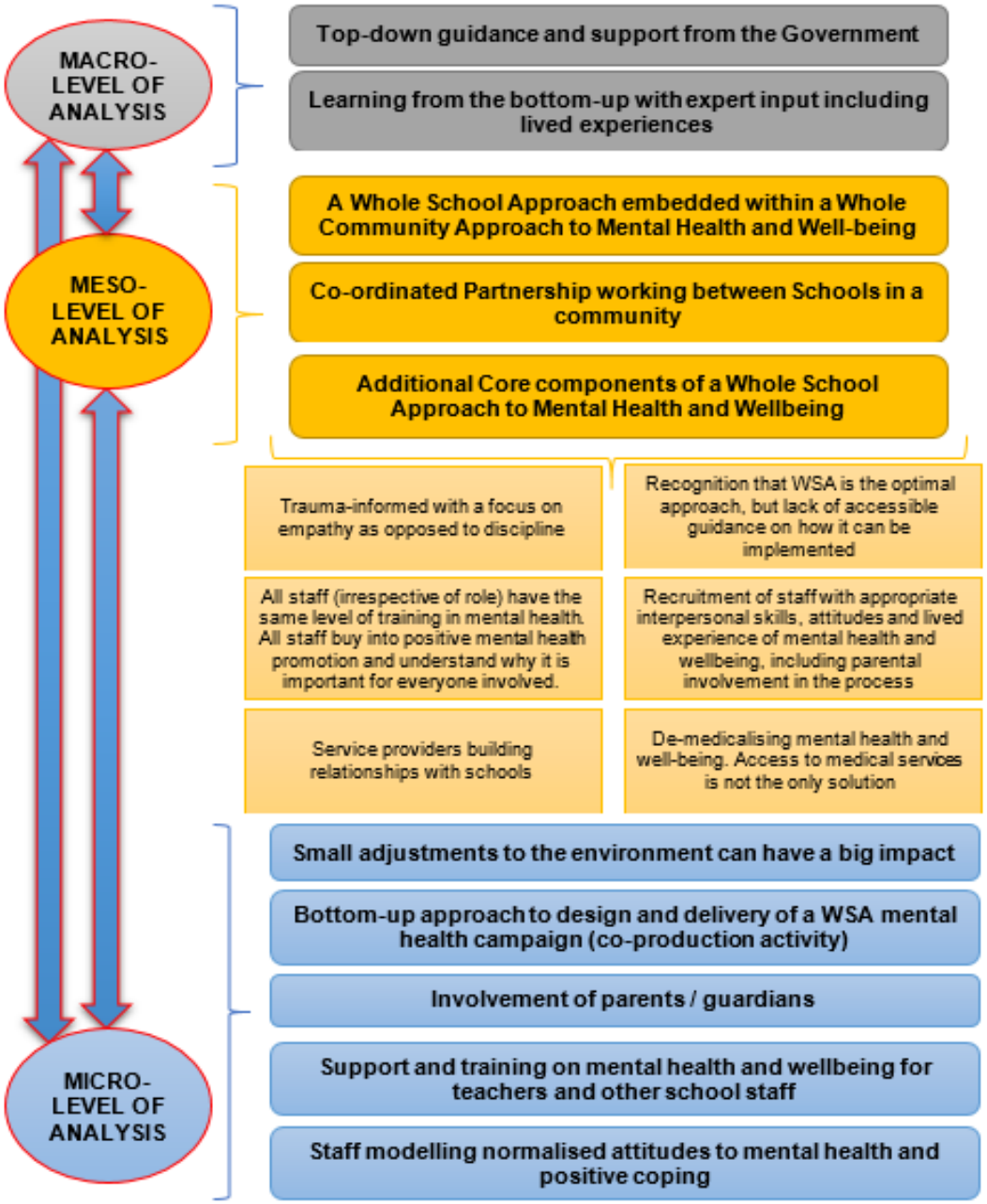
The Blues Programme [32] is notable as it employed screening of participants for eligibility to participate using the Center for Epidemiologic Studies Depression Scale (CES-D), which according to the authors of this study had important advantages - enabling schools to recognise young people who had not previously been identified as experiencing difficulties, as well as raising staff awareness of the issue of mental health across the school.

In conclusion, mental health literacy interventions utilising a range of structured educational interventions have demonstrated positive results. None of the studies focused exclusively on stigma-reduction, with three studies [28,30,31,36] aiming to improve mental health literacy and reduce stigma. Empathy-based approaches and interventions capitalising on peer support also appear to have promise, but more research is needed on interventions that also target school staff. Critically, there is a distinct lack of studies evaluating the impact on behaviour (at the school level) and school culture. The interventions primarily focused on children, and omitted other members of the staff and school community, including parents/guardians and stakeholders from the wider community. Moreover, there is dearth of interventions that address all the components of a WSA described by participants in interviews and workshops (Section 4.3, Table 5). One in-process study, Resilience Revolution [32] appears to be consistent with philosophy of a whole school approach embedded within a whole community approach, although at the time of writing no formal evaluation of this intervention was available.

5.2 Overview of Accessible Resource Development

Informed by their lived experience and expertise of participants enabled rich narrative thematic data to be generated at the macro, meso and micro level of analysis. The findings of the scoping review, and qualitative data summarised in Figure 4, along with the expert recommendations on resources (Section 4.6, Tables 9 and 10) and evaluation strategies (Section 4.7) informed the development of an accessible resource to inform campaign design and evaluation.

Figure 4. Graphical summary of themes derived from qualitative work



Part 1: What is covered by this resource?

The first part of the resource describes its structure and content. Learning from what had been used already emerged strongly as a recommendation from the participants. Therefore, we describe (and refer to) how the information presented is complementary, and distinctive from existing guides on WSAs to mental health and wellbeing.

In contrast to the other existing resources, it is informed primarily by an integrative analysis of qualitative data (guided by the analytical heuristic of micro, meso and macro system levels of analysis) collected from Trailblazer Programme and Public Health England staff, teaching staff (Special Educational Needs Co-ordinators [SENCOs] and student support/pastoral teams working in a range of school settings) and charitable organisations with expertise and lived experience of

involvement in anti-stigma campaigns/mental health awareness activities across the North East and North Cumbria. Themes at the micro-level of analysis are also a unique contribution to what is already available, including specific guidance on content of campaigns and evaluation strategies.

Part one also addresses macro-level themes by providing advice on how Government Policy, and in particular how Ofsted criteria, maps onto improving mental health in schools by providing salient examples, and signposting readers to existing Resources to support the design and implementation of WSA mental health and wellbeing (Section 4.6, Table 9).

Part 2: What does a WSA to mental health and wellbeing look like?

The second part focuses on the rationale for, and components of, a WSA as described by our participants, focusing primarily on the meso level themes (Section 4.3, Table 5). At this level of analysis, participants universally agreed that a trauma-informed WSA and use of restorative related practice is optimal for addressing mental health and wellbeing of staff and children/young people. Research on traumatic life experiences has revealed how healthy development can be derailed and brain architecture altered, by excessive or prolonged activation of the body's stress response [63], with The National Survey of Children Exposed to Violence reporting that 60% of children surveyed had been exposed to some form of trauma, either in or out of school [64]. When children experience stress and adversity, schools are a critically important setting in which to intervene and foster their resilience [65], providing a unique environment to prevent and counter the negative impacts of trauma [63].

Therefore, regardless of the cause of the trauma, those working with children can benefit from a deeper understanding of how trauma affects development, and which interventions can be effective [43]. Many school-based programmes have potential to benefit children with an elevated risk for academic difficulties and mental health disorders, although questions remain as to which are effective and sustainable [65]. The concept of a trauma-informed approach has emerged as an important prerequisite for a whole school approach (WSA), and the components of trauma-focused programmes have been categorised as: (a) individual and group-based approaches; (b) classroom-based approaches; and (c) school-wide approaches, with empirical evidence favouring individual and group-based approaches. However, classroom-based and school-wide programmes may be better positioned for integration, access to services, and sustainability [65].

Restorative practice (RP) is a behaviour management method that aims to help students develop conflict resolution and aggression management skills [44]. Evidence in support of RP has been shown in both behavioural measures of success; such as reduced rates of fixed-term and permanent exclusion or increases in attendance, and also through sociocultural measures of

success; such as transferability into the community context, or organisational change across the whole institution. Schools may sustain RP through an ongoing process of promoting expertise and understanding of RP in their staff base, training, modelling, and supervision. Taking a WSA has been shown to be central to embedding RP [66].

With reference to the above, a brief overview of the value of adopting trauma-informed approach is included in the accessible resource, along with exemplars of two schools (Section 4.6, Table 8) that have successfully implemented a trauma-informed WSA to demonstrate the feasibility of implementing such an approach.

Part 3: What types of things should be included in a campaign?

The third part focuses on the organisation, mode, form and content of campaigns with reference to the information presented in Section 4.5 (Table 7) and training resources for teaching staff in Section 4.6 (Table 10). Consistent with our findings, the value and principles of co-production and the need for diversity and involvement of all stakeholders in this activity (learning from the bottom-up - Section 4, Tables 4 and 6) are extolled to inform the selection and design of campaign activities and content, with support from senior management to implement their recommendations. This should also address other key themes identified at the micro-level of analysis (Section 4.4, Table 6) including signposting to resources for teaching staff in Section 4.6 (Table 10).

Part 4: How do I test whether the intervention has worked as intended?

Focuses on planning and implementing a robust mixed methods evaluation of campaigns with reference to the findings presented in Section 4.7.

5.3 Limitations and Further Research

The concepts of trauma-informed and restorative practice approaches were not included as specific search terms in the search strategy for the scoping review. Subsequent full-scale systematic reviews should include trauma as inclusion criteria and develop concomitant search terms to identify studies evaluating these approaches. The onset of the Covid-19 pandemic inhibited the co-production process due to the requirement for remote working. Furthermore, many of these staff were re-tasked with combatting COVID-19 during this project. Consequently, the sample may not be representative of NHS England NECN and Trailblazer staff. Nevertheless, this presented an opportunity to extend participation to teaching staff and relevant charitable organisations, and their expertise and lived experience provided added value to the project.

Robust theory- and evidence-based guidance on implementation of a WSA to mental health is lacking in the peer-reviewed literature. In this regard, participants in the project suggested conducting in-depth research to explore and understand the environmental and culture changes

needed to achieve a WSA as part of WCA. Further research is required to understand the interaction between core elements of a trauma-informed approach, teaching pedagogy, and organisational factors that support the embedding, use, and transferability of school-wide approaches [63]. There is a pressing need to develop a deeper "bottom-up" understanding of the components and mechanisms that underlie WSAs to gain insight into their implementation challenges and enablers using appropriate methods such as Realist Evaluation methods. A greater use of parents'/guardians' expertise was emphasised by participants; specifically, acknowledging them as experts by experience and compensating them for their time and input. Engagement with parents/guardians is planned for the next phase of this work.

A key thread running through suggestions for further research was that COVID-19 has presented an opportunity for schools to appraise and change their mental health and wellbeing profiles. Future research would benefit from exploring these changes to inform WSA mental health and wellbeing campaigns. In this regard, there is a pressing need to further develop the guide to include the views and perspectives of children/young people and parents/guardians, including other school staff and other stakeholders such as community organisations.

A whole school approach embedded within a whole community approach warrants an examination of alternative funding mechanisms beyond health, for example integrated and collaborative commissioning, which reflects the themes identified at the macro level (the need for a bottom up approach drawing on lived experience and embracing co-production):

> *"This means that in the future, local stakeholders will be involved in an equal and meaningful way in commissioning and all the resources of a community, including but not confined to public funding, will be deployed to tackle the community's challenges. People will be trusted to co-design the services they use. Rather than being seen as a place of distinct policy priorities — health or crime or educational underachievement - a community will be seen as a 'system' of interconnected parts, each of which impacts the others"* [67] p106.

5.4 Conclusions

We co-produced an accessible resource to enhance and evaluate mental health awareness raising and anti-stigma campaigns, informed by research evidence and the expertise and lived experience of 27 staff with representation from a diverse range of roles across all three localities. The resource will require updating as new evidence emerges, and receipt of feedback from schools on its utility for supporting campaign enhancement and development. Mental health provision in schools is inherently complex, and more research is required to identify the contexts, mechanisms and resources needed to generate a cultural shift towards prioritising the wide-spread implementation of WSA to mental health and wellbeing, which address the needs of staff and children, parents/guardians as part of a whole community approach.

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Appendix 1. Email confirming ethical approval

Re: 239/19 – 'Developing and Piloting Mental Health Campaigns in Trailblazer Schools'

Harrison, Samantha
Wed 06/05/2020 09:09
To: Flynn, Darren; SOHSC-Ethics

Reply all

You replied on 07/06/2020 09:23.

Dear Darren,

I can confirm that the following study is approved and can proceed as soon as you receive this email (which can be used as evidence of approval)

Application no: 239/19 – Developing and Piloting Mental Health Campaigns in Trailblazer Schools.
Chief Investigator: Dr D Flynn

Kind regards,
Dr Samantha Harrison
Sub-chair (Allied Health Professions and Public Health), School of Health and Life Sciences Research Ethics Sub-committee

Appendix 2. Scoping Review Search Strategy

Domain		Search Terms (Title/Abstract)	Controlled Vocabulary					
			Web of Science	Embase (Emtree)	MEDLINE (MeSH)	PsycINFO (Thesaurus of Psychological Index Terms)	ASSIA (Thesaurus)	CINAHL (Subject Headings)
Population	Children and young people, aged 4 to 19	child* OR adolescen* OR teen* OR youth* OR "young person" OR "young people" OR student OR "young adult" OR juvenile	N/A	Adolescent/ OR Child/ OR School Child/ OR Infant/ OR Student/ OR Young Adult/ OR High School Student/ OR Middle School Student/	Adolescent/ OR Child/ OR Infant/ OR Young Adult/ OR Students/	N/A	INSUBJECT.EXACT("Infants") OR MAINSUBJECT.EXACT("Children") OR MAINSUBJECT.EXACT("Young People") MAINSUBJECT.EXACT("Adolescents") OR MAINSUBJECT.EXACT("Students")	(MH "Child") OR (MH "Adolescence") OR (MH "Infant") OR (MH "Students, High School") OR (MH "Students, Elementary") OR (MH "Students, Middle School") OR (MH "Young Adult")
Intervention	Anti-stigma programmes ; mental health awareness raising programmes	"anti*stigma" OR "mental health literacy" OR "mental health education" OR "mental health awareness" OR "anti*discrimination" OR "educational program*" OR "mental health first aid" OR "mental health campaign" OR "mental health inequalit*"	N/A	Stigma/ OR Social Stigma/ OR School Health Service/ OR Health Promotion/ OR Early Intervention/ OR Social Discrimination/ OR School Stress/ OR School Health Education/ OR Health Literacy	School Health Services/ OR Health Promotion/ OR Early Intervention, Educational/ OR Discrimination, Psychological/ OR Social Stigma/ OR Stereotyping/ OR Health Literacy/ OR Health Education/	Adolescent Attitudes/ OR Mental Health Stigma/OR Self-Stigma/ OR Stigma OR Stereotyped Attitudes/ OR Health Literacy/ OR Early Intervention/ OR School Based Intervention/	MAINSUBJECT.EXACT("Stigmatization") OR MAINSUBJECT.EXACT("Destigmatization") OR MAINSUBJECT.EXACT("Early Intervention Programme") OR MAINSUBJECT.EXACT("Intervention") OR MAINSUBJECT.EXACT("Interventions") OR MAINSUBJECT.EXACT("Psychological Intervention") OR MAINSUBJECT.EXACT("Psychosocial Intervention") OR MAINSUBJECT.EXACT("Social Interventions") OR MAINSUBJECT.EXACT("Health Literacy") OR MAINSUBJECT.EXACT("Mental Health Promotion")	(MH "School Health Education") OR (MH "Early Intervention") OR (MH "Early Childhood Intervention") OR (MH "Health Literacy")
Context	All UK schools (primary and secondary), sixth forms, colleges	"primary school" OR "infant school" OR "junior school" OR "secondary school" OR "first school" OR "middle school" OR "high school" OR "sixth*form" OR "college" OR "comprehensive school" OR "grammar school"	N/A	School/ OR High School/ OR Primary School/ OR Middle School/	Schools/	Elementary Schools/ OR High Schools/ OR Middle Schools/ OR Schools/	MAINSUBJECT.EXACT("Middle Schools") OR MAINSUBJECT.EXACT("Public Schools") OR MAINSUBJECT.EXACT("Grammar Schools") OR MAINSUBJECT.EXACT("High Schools") OR MAINSUBJECT.EXACT("Elementary Schools")	(MH "Schools") OR (MH "Schools, Middle") OR (MH "Schools, Secondary")

Appendix 3. Scoping Review: Data Extraction Form

Reference				**Design**				**Intervention**			**Outcomes**		**Notes**
Author(s)	*Year*	*Title*	*Journal*	*Aims*	*Study Design*	*Setting*	*Sample Size*	*Intervention Description*	*Target Mental Health Domains*	*Target Factors in School*	*What was effective?*	*What was not effective?*	

Appendix 4. Interview Guide

These are initial questions for key stakeholders across three Trailblazer sites who have been involved with anti-stigma campaigns/MH awareness activities.

Anti-stigma campaigns/mental health awareness activities – experiences and views

- How have campaigns been developed and set up in school and college settings in your site?
- Has there been any co-production to develop the campaigns or activities?
- What do campaigns look like in school and college settings? (Where, what, who, outcomes, effectiveness, impact)
- Do they address MH stigma? Do they address intersections associated with MH stigma e.g. disability, poverty, obesity, LGBTQ, race, etc?
- How are campaigns made accessible? To whom? Key principles…
- What has worked best/needs improvement
- What has made a difference (impact)? Has the impact been measured/how?
- What makes a successful anti-stigma campaign/mental health awareness raising activity?
- Have any of the campaigns been evaluated? How was this carried out – methods, what worked, outcomes.
- What do we need to know about setting up anti-stigma campaigns/awareness raising activities? Are there any gaps in knowledge?

Recruitment

- How can we best engage members of NECN/Trailblazer sites in co-producing this work?
- How can we best engage parents/guardians/carers, teachers and students in a co-productive process? What are their needs? What support do they require?
- Key contacts involved in campaigns and activities within schools at Trailblazer sites e.g. mental health staff champions, health ambassadors (students) in schools or co-ordinator

Literature

- Unpublished documentation or literature regarding campaigns (what, where, how accessed)
- Where to find info/documentation about how campaigns were developed, decisions made, how they were co-produced
- Knowledge of any other campaigns nationally

Outputs - Preferences, views and perspectives on the mode, form and content of an accessible resource

- Which products/resources are being used in campaigns or activities (e.g. websites, apps, events, animations etc)? What do they look like? Views of these.
- What product /resource is most useful and/or works best? Why? How is it / could it be measured?
- Are the products/resources accessible? Key points of accessibility

Appendix 5. Workshop Slides

Developing and Piloting Mental Health Campaigns in Trailblazer Schools

Chief investigator: Dr Darren Flynn, Associate Professor and Practitioner Health Psychologist, Teesside University

Co-Investigators: Dr Stephanie Scott, Senior Research Fellow, Newcastle University; Dr Rashmi Bhardwaj-Gosling, Senior Lecturer, Sunderland University; Clare Devanney-Glynn, Northern England Clinical Networks (NECN) Voice of Children and Young People; Gavin Rathmell, Trailblazer Lead for Gateshead/Newcastle; Julie Daneshyar, Health and Wellbeing Programme Manager, Public Health England North East

Researchers: Dr Isabel Gordon (Sunderland University), Liam Spencer (Newcastle University)

Partners: NHS England Northern England Clinical Networks, Trailblazer site staff and staff, students and parents in co-located schools in the North East and North Cumbria (Northumberland, Newcastle/Gateshead and South Tyneside); Public Health England North East; Fuse, The Centre for Translational Research in Public Health

Overview

- **Introductions and ground rules** (Darren / all)
  - Mute microphones if you are not speaking. OK to record the session, any questions before we start?
- **Overview of Trailblazer Program** (Darren)
- **Aims of this project - Developing and Piloting Mental Health Campaigns in Trailblazer Schools** (Darren)
- **Summary of scoping literature review** (Liam)
- **A Whole School Approach is the optimal approach, and it is happening in the UK** (Clare)
- **Summary of Interviews** (Isabel)
- **Comfort break**
- **Main part of the session: Interactive discussion – mode, form and content of an accessible resource to inform**
  - the design and evaluation of mental health awareness raising and anti-stigma campaigns
  - or optimising and evaluating existing campaigns

Brief overview of Trailblazer Programme

- NHS England's Northern England Clinical Networks (NECN) is responsible for supporting the Government's Green Paper on Transforming Children and Young People's Mental Health Provision.
  - Green Paper focuses on piloting earlier intervention and prevention approaches in and linked to schools and colleges.
- To date, 5 Trailblazer sites funded across the North East and North Cumbria, with successive annual waves expected:
  - 3 Wave 1 Trailblazer sites secured in 2018/19 (Northumberland, Newcastle/Gateshead and South Tyneside)
- Taking a **'whole school' approach**, the Trailblazer sites **embed clinicians into schools and colleges** to improve mental health awareness and mild to moderate provision, as well as appropriate signposting, for students, parents and staff. The Trailblazer programme will run for 12 years.
- **Each site will:**
  - Incentivise every school and college to identify a Designated Senior Lead for Mental Health to oversee the approach to mental health and wellbeing
  - Fund Mental Health Support Teams, supervised to provide specific extra capacity for early intervention and ongoing help, providing interventions to support those with mild to moderate needs and supporting the promotion of good mental health and wellbeing
  - One site will trial a 4-week waiting time for access to specialist NHS children and young people's mental health services

Aim of this project - Developing and Piloting Mental Health Campaigns in Trailblazer Schools

- Develop a **prototype** accessible resource to inform the **design and evaluation** of mental health awareness raising and anti-stigma campaigns (or optimising and evaluating existing campaigns)

- Whole school approach (an activity or input that is school-wide and/or part of the curriculum)
- Campaigns (intervention targeting specific groups, that aims to change attitudes and behaviours)

Three phases:

1. Rapid scoping review of the published literature
2. Interviews with professionals (public health and schools)
3. Co-production workshops

Rapid scoping review question:

For children and young people, what are the active ingredients of effective school-wide anti-stigma / mental health awareness campaigns delivered within UK educational settings?

- 4 completed studies met the inclusion criteria
  - UK-based study
  - Published in past 5 years

- A further 4 studies are in process (protocol only – results pending publication)

School Space
Chisholm et al 2016

Study Details	Key Components/Active Ingredients
• A pragmatic cluster randomised controlled trial at n=6 secondary schools in Birmingham. • Aimed to test the hypothesis that contact, in addition to education, is more effective than education alone in reducing stigma, improving mental health literacy, and promoting well-being in young adolescents. • In total, 769 participants provided data at baseline. Of these, 112 were absent for the intervention day or were lost to follow-up; 657 participants aged 11–13 years took part in the trial.	• The intervention aimed to reduce stigma related to mental illness and improve mental health literacy; promote wellbeing in young adolescents, including mental health and resilience; more positive attitudes to help-seeking. • It was designed with current and past users of mental health services and there was a **"contact module" involving education about mental illness delivered by volunteers with experience of mental illness**, who worked with young people for a morning before revealing their diagnosis. • A 20 min session then allowed group discussion of mental illness with the volunteer, who then worked with the class for the afternoon.

Peer Education Project (PEP)
Eisenstein et al 2019

Study Details	Key Components/Active Ingredients
• An evaluation with pre- and post-questionnaires at n=7 secondary schools in London and South East England, and the Channel Islands. • Aimed to assess impact on student emotional and behavioural difficulties; perception of school climate; confidence to talk about mental health; knowledge of available information and resources; readiness to support others; knowledge of key terms related to mental health; and confidence in key skills related to management of mental health. • n=45 peer educators and n=455 student trainees returned pre- and post- questionnaires.	• PEP is designed to supporting young people to develop the skills and knowledge needed to safeguard their mental health, and that of their peers. • Peer Education Project (PEP) is a five 40-minute session syllabus, covering Mental Health Awareness; Myths, Facts and Stigma; Staying Well; Getting Help; and Helping Others. • **PEP first trains peer educators to deliver the syllabus over two days**. Peer educators then deliver the education sessions in pairs to Year 7, supported by school staff. Students receive a workbook with worksheets and information about mental health.

OpenMinds
Patalay et al 2017

Study Details	Key Components/Active Ingredients
• A pre- and post-intervention design to assess the efficacy of the OpenMinds programme delivered in n=3 schools in London. • Aimed to collect preliminary evidence on whether OpenMinds is an efficacious and acceptable programme, in both the university student facilitators and the school students receiving the workshops. • n=335 school students aged 13 to 15 years received the intervention, delivered by n=55 medical students.	• The main outcome of interest was mental health literacy, comprising the elements of knowledge, non-stigmatising attitudes, helping attitudes and **social distance**. • **School students received two OpenMinds workshops over 2–3 weeks, delivered by medical students.** The programme involves a structured programme of education and training for university medical students, who then deliver workshops in secondary schools.

WISE study
Kidger et al 2016

Study Details	Key Components/Active Ingredients
• A pilot cluster randomised controlled trial in n=6 mainstream non-fee paying secondary schools in England. • Aimed to assess the feasibility and acceptability of the Wellness in Secondary Education (WISE) intervention, and explore the justification for evaluating the intervention in a full cluster randomised controlled trial (RCT). • In total n=1024 staff, n=2616 students participated; n=3 schools received the intervention, and n=3 schools received usual practice.	• The intervention aims to provides **school staff with a strategy for providing initial help to anyone appearing distressed or at risk of developing a mental health problem**. Therefore putting teachers in a better place to support students (improving their own mental health too) and raising the profile of mental health in the schools. • In the intervention schools: i) **staff received two full days of Mental Health First Aid (MHFA) training**, delivered by a registered independent trainer and became staff peer supporters; and ii) youth MHFA training was offered to up to 20 staff in each school, again by an external independent trainer. • The intervention targets 'common mental disorders' (depression, anxiety) and psychosis.

Summary of findings from the scoping review

- Campaigns/interventions in the UK **do not take a 'whole-school' approach to mental health**
- Campaigns and interventions focus primarily on reported changes in knowledge and attitudes, rather than actual changes in behaviour
- Class-based education delivered to students, designed to improve their mental health awareness, knowledge, attitudes does help, but this is **not enough** to change behaviour
- Studies typically have a short follow-up period, which makes prevents any long-term shifts in school culture and behaviour to be evaluated
- **Studies in other countries (for example, the USA) have focused more on whole-school approaches, which may be useful to us, but we must be mindful of the different contexts and cultures**
- **There are examples of WSA in the UK, but no published evaluations. Clare will provide some examples**

A Whole School Approach is the optimal approach, and it is happening in the UK

Summary of Interviews: *professionals working in schools and public health*

Organisation and delivery of campaigns	*You need a variety of people around the table to make sure it's delivered in a coordinated way otherwise…you just have everybody going off and doing their own thing in schools" (Local Authority Public Health Manager)* *"There haven't been any concrete impact evaluations [of campaigns] or looking at whether the message has spread…we haven't got a way of looking at how far that reach was or the impact of it" (Senior Educational Psychologist)*
Content of campaigns	*"My advice…is sit down with your students and ask them what they want…mind, I'll put an addition to that, er you can't just listen to young people and not act on that" (School Counsellor, secondary school)* *"What might not seem like an issue to an adult can feel very significant to a child/young person" (Mental health intervention practitioner)*
Setting factors	*Some people said they wanted to be seen [for mental health problems] in school, some said they definitely didn't…there is no one place fits all, so it came round to the idea of giving young people choice" (Campaigns design consultant)* *"We've got a mindfulness area…they'll ask to go to. They know it's there, they know they can access it…we let children choose if they want to go there if they want a break, they can ask for a chill out pass…" (Headteacher, primary school)*
Wider contextual backdrop	*"There is too much content [in curriculum] and too little time…Learning for fun and to feel good is lost" (Mental health intervention practitioner)* *"Teachers are judged [by Ofsted] on books, maths and English, nothing to do with the mental health of kids" (Headteacher, primary school).*
Differing (capacities for and perceptions of) mental health provision	*"Schools might say they understand how to promote good mental health but are just ticking boxes"(Mental health intervention practitioner)* *"[teachers'] personality demonstrates what their approach to mental health might be…support might be variable" (Deputy Head, secondary school)*
Support for teachers	*There is a value to sharing information with all [teaching] staff because at a very basic level it is one of their responsibilities" (Deputy Head)* *"We've sort of got an assumption that everyone knows what [mental health] is and that everyone is confident about it" (Headteacher, primary school)*
Engagement of schools and young people	*"Mental health can be seen as a luxury" (Mental health intervention practitioner)* *"The mental health arena is crowded…teaching staff are absolutely overwhelmed by what's being sent to them…[and] schools can be a bit confused about where they're coming from" (Local Authority Public Health Manager)*

Over to you!

Participant Workshop Template

Developing and piloting mental health campaigns in Trailblazer schools

Developing an alpha prototype of an accessible resource to inform the design and evaluation of mental health awareness raising and anti-stigma campaigns (or optimising and evaluating existing campaigns)

Whole school approach (an activity or input that is school-wide and/or part of the curriculum)

Campaigns (intervention targeting specific groups, that aims to change attitudes and behaviours)

Definitions of mental health and mental well-being from Mind (2020):

Good mental health = being generally able to think, feel and react in the ways that you need and want to live your life

Mental well-being describes your **mental state** – how you are feeling and how well you can cope with day-to-day life. Our mental wellbeing is **dynamic**. It can change from moment to moment, day to day, month to month or year to year. If you have good mental wellbeing you are able to:

- feel relatively **confident** in yourself and have positive **self-esteem**
- feel and express a range of emotions
- build and maintain **good relationships** with others
- feel engaged with the world around you
- live and work productively
- **cope** with the stresses of daily life
- adapt and manage in times of change and uncertainty

Some issues to consider in the discussions

1. Thinking about the context of your own school, what would a whole school approach to mental health awareness / stigma reduction look like?
2. What are the enablers to a whole school approach?
3. What are barriers to a whole school approach?
4. How, and what types of activities should be included?
5. What should be the key messages?
6. Who should be involved in evaluation and what would this look like?

Other issues to consider?

Appendix 6. Active Ingredients Assessment Table

Intervention Feature	Study 1	Study 2	Study 3	Study 4	Study 5	Study 6	Study 7	Study 8	Study 9	Study 10	Study 11	Study 12	Study 13	Study 14	Study 15	**Totals**
Overall N (% loss to follow-up)																
Region of UK • England • Scotland • Wales • NI																
Type of school (state/private/faith)																
Target population • Children / young people • Teaching staff • Both children/young people and teaching staff																
Gender distribution of children/young people • Males **(n/%)** • Females **(n/%)**																
Age range / year group of children/young people • 4-9 • 10-16 • Over 16																
Outcomes assessed • Knowledge / awareness of mental health • Attitudes towards mental health • Stigmatising attitudes • Mental health symptoms / diagnoses • Mental wellbeing • Behaviour (e.g. attendance)																
Intervention includes peer-mentor/support																
Intervention underpinned by framework/theory/ model of behaviour																
Mode of delivery • 1-2-1 sessions only • 1-2-1 sessions and group sessions • Group sessions only • On-line / social media																
Type of interventionist • Teacher • Non-teacher affiliated to school • Non-teacher independent of school																
Training of interventionists • Appropriately qualified interventionist • Contact with people with lived experience of mental health conditions																
Involvement of stakeholders in design/development																

Intensity (no contacts over intervention period)																
Duration of intervention/weeks																
Behaviour Change Techniques 1.1 Goal setting (behaviour) 1.2 Problem solving 1.3 Goal setting (outcome) 1.4 Action planning 1.5 Review behaviour goal(s) 1.6 Discrepancy between current behaviour and goal 1.7 Review outcome goal(s) 1.8 Behavioural contract 1.9 Commitment 2.1 Monitoring of behaviour by others without feedback 2.2 Feedback on behaviour 2.3 Self-monitoring of behaviour 2.4 Self-monitoring of outcome(s) of behaviour 2.5 Monitoring outcome(s) of behaviour by others without feedback 2.6 Biofeedback 2.7 Feedback on outcome(s) of behaviour 3.1 Social support (unspecified) 3.2 Social support (practical) 3.3 Social support (emotional) 4.1 Instruction on how to perform a behaviour 4.2 Information about antecedents 4.3 Re-attribution 4.4 Behavioural experiments 5.1 Information about health consequences 5.2 Salience of consequences 5.3 Information about social and environmental consequences 5.4 Monitoring of emotional consequences 5.5 Anticipated regret 5.6 Information about emotional consequences 6.1 Demonstration of the behaviour 6.2 Social comparison 6.3 Information about others' approval 7.1 Prompts/cues 7.2 Cue signalling reward 7.3 Reduce prompts/cues 7.4 Remove access to the reward 7.5 Remove aversive stimulus 7.6 Satiation 7.7 Exposure 7.8 Associative learning 8.1 Behavioural practice/ rehearsal 8.2 Behaviour substitution 8.3 Habit formation 8.4 Habit reversal																

8.5 Overcorrection																
8.6 Generalisation of a target behaviour																
8.7 Graded tasks																
9.1 Credible source																
9.2 Pros and cons																
9.3 Comparative imagining of future outcomes																
10.1 Material incentive (behaviour)																
10.2 Material reward (behaviour)																
10.3 Non-specific reward																
10.4 Social reward																
10.5 Social incentive																
10.6 Non-specific incentive																
10.7 Self-incentive																
10.8 Incentive (outcome)																
10.9 Self-reward																
10.10 Reward (outcome)																
10.11 Future punishment																
11.1 Pharmacological support																
11.2 Reduce negative emotions																
11.3 Conserving mental resources																
11.4 Paradoxical instructions																
12.1 Restructuring the physical environment																
12.2 Restructuring the social environment																
12.3 Avoidance/reducing exposure to cues for the behaviour																
12.4 Distraction																
12.5 Adding objects to the environment																
12.6 Body changes																
13.1 Identification of self as role model																
13.2 Framing/reframing																
13.3 Incompatible beliefs																
13.4 Valued self-identity																
13.5 Identity associated with changed behaviour																
14.1 Behaviour cost																
14.2 Punishment																
14.3 Remove reward																
14.4 Reward approximation																
14.5 Rewarding completion																
14.6 Situation-specific reward																
14.7 Reward incompatible behaviour																
14.8 Reward alternative behaviour																
14.9 Reduce reward frequency																
14.10 Remove punishment																
15.1 Verbal persuasion about capability																
15.2 Mental rehearsal of successful performance																
15.3 Focus on past success																
15.4 Self-talk																
16.1 Imaginary punishment																
16.2 Imaginary reward																
16.3 Vicarious consequences																