Guided self help: a feasible and acceptable way for high schools

to promote emotional wellbeing in students?

Using schools to promote young people's emotional wellbeing makes perfect sense – from a health perspective. Emotional wellbeing is a building block of mental health, and the mental health of young people is a growing public health concern (Wahlbeck and Taipale 2006).

Few would dispute the interdependence of academic achievement and positive mental health. However, there may be a gap between the expectations placed on a school by policy makers, and what it can feasibly deliver. A school's response to its obligations to support student emotional wellbeing may ultimately be driven by pragmatic issues of capacity and enthusiasm (e.g. see Humphrey et al. 2010).

For high schools that are looking for a feasible and acceptable emotional support strategy, guided self help (GSH) might offer a solution. GSH is a method of delivering low intensity mental health care, and has been useful in primary health care contexts (Lovell et al. 2006). It involves a systematic approach to clarifying the problem, setting a realistic goal, and working towards it in small steps. Most of the therapeutic work is done by the recipient on their own, in between appointments with a practitioner -not necessarily a therapist- who provides guidance, support and encouragement.

To find out whether GSH could be useful for schools, a project was developed to pilot a GSH model that had been adapted to provide emotional support in a high school context. It was set up and operated in three urban UK high schools during 2006-7 (Kendal et al, 2011; Kendal et al, in press).

The project offered students GSH for emotional difficulties including anxiety, low mood, self esteem, and relationship problems. Any student could self-refer for individual, face-to-face appointments of 15-30 minutes, in which they were supported to clarify and systematically work towards goals, using behavioural and cognitive techniques. Through extended conversations with school personnel, it was established that the pastoral teams of non-teaching staff were willing and able to take on the role of practitioner. They received brief training (maximum 4 hours), a project manual, regular and frequent supervision, and ad hoc telephone support from an experienced mental health nurse. A clear process of risk assessment and referral was incorporated into the model and supported by the school nurse in each school.

Appointments took place discretely in school breaks or after school. Various communication routes for self referral were created (e.g. post-boxes, e-mail, mobile phone, direct approach). High value

was placed on the privacy of students who used the project. The purpose, access routes and rules of confidentiality were advertised in school assemblies, staff meetings, and on posters and flyers.

Findings

Twenty one students used the project, which was a smaller number than anticipated. Students asked for help with a wide range of problems including difficulties engaging with lessons, aggression, family worries, panic attacks and self harm.

Interviews with students and staff explored their views on the project. Students seemed to value the confidentiality and privacy that self referral offered, but many staff thought it excluded less able students. The short appointments were difficult for some staff and students to get used to, although most agreed that short appointments were a realistic option within a crowded school day. Students and staff liked the structured approach and practical strategies. They also approved of the recruitment of pastoral and support staff to deliver the project- students trusted them, and other staff were confident in their skills.

Most students who used the project said they had benefitted, as illustrated by this reflection from a KS3 student:

> *Before all this … I didn't know who to talk to… I was in a fight every day. But now I'm like in a fight every month or something like that.*

Students were supportive of the project, whether or not they had used it. The pastoral staff who delivered the project tended to say that it complemented existing pastoral provision, but most reported that it was not sustainable unless they had protected time. This raised the issue of managerial support, which varied between schools. The school ethos was an important influence: the project fared best in schools where the management was confident that it was needed, and where the school openly advertised support and resources for students who might have problems.

Recommendations

The GSH model may be a relatively low impact model for schools, and could complement stretched pastoral systems. It is highly structured and requires the active engagement of participants, and so has potential to filter out those with transient problems that they simply wish to offload. Support from health practitioners can be minimal. With adequate structures in place, students could access safe, effective and appropriate help, on their terms, and acquire skills for sustainable emotional self management.

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