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ORIGINAL RESEARCH

'Stress Control Schools': training PSE teachers to deliver a CBT-based intervention for common mental health problems

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Abstract

Demand currently greatly outweighs supply in teenage mental health, with statutory services and the third sector struggling to cope with the number of referrals. There is increasing interest in the possibility of using schools to provide mental health interventions. This pilot study looked at the feasibility of developing a version of an existing evidence-based transdiagnostic large-class didactic approach widely used in NHS adult services – 'Stress Control' – for use with teenagers as a universal early intervention/prevention approach taught by teachers within the Personal and Social Education (PSE) curriculum in a high school in a highly deprived area. PSE teachers were trained, over five hours, to deliver each of the eight sessions in single weekly periods. Measures of anxiety and depression (RCADS) and wellbeing (WEMBWS) were administered at pre- and post-intervention and at 9-month follow-up. Results suggest that teachers reported few problems in delivering the approach, seen as relevant by pupils and showed significant reduction in anxiety and depression and significant gains in wellbeing at post-intervention. These gains were maintained at 9-month follow-up. There appears to be potential in this model. One of its strengths appears to be the positive collaboration between the psychologist, teachers and pupils, which resulted in changes being made to the original model. Limitations of the study and suggestions for future research are given.

Key learning aims

(1) To learn if an evidence-based adult psychoeducational approach can be adapted to meet the needs of teenage pupils in a school in a deprived neighbourhood.
(2) To learn if teachers, with no training in mental health, can deliver this approach.
(3) To test the viability of the approach with an aim of creating a sustainable intervention.

Keywords: CBT self-help; cost effectiveness; early intervention; low-intensity; psychoeducation; youth mental health

Introduction

With around one in four children and young people meeting criteria for a mental health condition at any one time in the UK, there is growing concern about the gap between supply and demand in children and young people's services (Faulconbridge *et al.*, 2017). National Health Service Child and Adolescent Mental Health Services (CAMHS) are under growing pressure. Prior to the

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coronavirus pandemic, 35% of Scottish young people referred were waiting more than 18 weeks for assessment (NHS: National Services Scotland, Information Services Division, 2019) with CAMHS, across the UK, attracting rising numbers of referrals and increasing thresholds for acceptance (Frith, 2016). The situation, post-Covid, remains the same (Public Health Scotland, 2023). Under-funded services, perhaps partially due to pressure to achieve waiting list targets, rejected 22.7% of referrals without face-to-face assessment (Future Care Capital, 2023).

One way to reduce demand is to intervene earlier. Interventions focusing on the most common, and highly co-morbid, teenage complaints of anxiety and depression would be particularly useful (Kessler *et al*., 2012). Successful preventative work in child and adolescent settings could, apart from the relief of individual distress, help remove pressure from hard-pressed CAMHS and, later, adult services. The Improving Access to Psychological Therapies – IAPT (now NHS Talking Therapies) adult services programme (Clark, 2018) received 1.81 million referrals in 2021–22 with 91% able to access services within six weeks (NHS Digital, 2024). While hugely impressive, it underlines the daunting task services face with so many people struggling in their daily life. This points to the need for services to deliver high-volume population-level services much further downstream to help complement, and ultimately reduce pressure on, these national programmes.

Meta-analyses of universal and targeted preventative programmes in schools, although showing relatively small effect sizes for anxiety and depression lasting to 12-month follow-up, suggest that school-based interventions have merit (e.g. Merry *et al*., 2011; Moreno-Peral *et al*., 2017; Stockings *et al*., 2016; Werner-Seidler *et al*., 2021). Both the Transforming Children and Young People's Mental Health Implementation Programme (Department of Education, 2024) and Mental Health and Wellbeing: whole school approach (Scottish Government, 2021) emphasise the importance of schools being actively involved in mental health education and provision.

In the UK, targeted brief behavioural activation for depression delivered by therapists in high school settings has reported early promise (Pass *et al*., 2018). However, the large-scale Myriad Programme, investigating the impact of mindfulness on Year 7 and Year 8 pupils (11–13 years old) delivered by teachers, reported no differences between school-based mindfulness training and normal provision of social-emotional education (Kuyken *et al*., 2022). This echoes an Australian trial, where pupils were taught mindfulness by an external facilitator, which similarly reported disappointing results (Johnston *et al*., 2017). An additional concern, noted by Foulkes *et al*. (2024), is the possibility for iatrogenic harm caused by some school mental health interventions.

'Stress Control' is a well-established cognitive behavioural (CBT) psychoeducational approach delivered in didactic 'classroom' format for adults with common mental health problems (White, 2000). It consists of six, 90-minute didactic class sessions, offering information about the common problems centred on anxiety and depression, and trains those attending in 'skills' to tackle those problems. Detailed booklets serve to help prepare individuals and to reinforce the information learned in the sessions. A crucial feature of Stress Control is that there is a ban on any form of personal disclosure during the sessions. It promotes the idea of 'turning you into your own therapist', something which may explain the continued improvement found at 1- and 2-year follow-up, e.g. Van Daele et al. (2013); White (1998). Stress Control has been shown to work well in the same class (average size 74 participants), across different levels of distress – mild, moderate and severe depression and anxiety (Burns *et al*., 2016). A recent meta-analysis, consisting of 19 studies, concluded that 'The depression and anxiety [effect sizes] were comparable though slightly lower than the pre–post treatment [effect sizes] reported in a recent meta-analysis of practice-based evidence from the IAPT programme' (Dolan *et al*., 2021; p. 18).

Previous research has suggested the importance of the non-specific role of 'normalising' in accounting for good outcomes (e.g. Kellett *et al*., 2006). While Stress Control, as a population-level intervention, would appear to be best placed operating as an early intervention approach, in reality, NHS participants typically exhibit the same levels of distress seen in individual therapy clinics (Mills *et al*., 2016). In order to operate as an early intervention or prevention strategy, it seems logical to place Stress Control in schools.

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Stress Control could be adapted and delivered in high schools as part of the Personal and Social Education (PSE) curriculum. By training PSE teachers to deliver the classes across eight single weekly periods, it may be possible to introduce a low-cost, sustainable intervention. If the class was modified to suit 15-year-olds and if it retained the apparent flexibility of the adult model, it could help:

- Those who, while currently coping, may, in the future, face problems with common mental problems (prevention);
- Those who are showing some signs of distress (early intervention);
- Those with existing significant problems but who may, due to the bottleneck at CAMHS services and the problems of sustainability often seen in Third Sector services (due to loss of grants, time-limited contracts, etc.), be unlikely to be able to access help. In this case, it would operate, pragmatically, as a 'better-than-nothing' approach;
- Those who will need more intensive help. In this case, could Stress Control, acting in a stepped-care capacity, help socialise teenagers in mental health models, perhaps increasing the chances of them accepting referrals and attending appointments and providing a foundation upon which to build the necessary more complex interventions?

It is possible that teens, having gained a greater knowledge of both mental health problems and 'skills' with which to counteract those problems, may be better able to help others in their orbit, e.g. stressed friends, siblings and parents.

Advantages to working with teachers would be:

- PSE is already embedded in the curriculum so any new intervention would not require finding time in a busy timetable.
- PSE teachers often have in-depth knowledge of their pupils, including knowledge of their mental health.
- PSE teachers, although not trained in mental health, typically have, due to often having daily exposure to dealing with them, a substantial bank of knowledge and experience of mental health issues.
- Stress Control is a psychoeducational approach. Teachers, more so than clinicians, know how to teach!
- By offering the Stress Control class as a universal intervention, i.e. delivered to all pupils in a particular year group, we have a captive population ensuring the hard-to-reach will be reached.
- As PSE teachers are 'free' as they are already employed by the Education Department, the costs of setting up and running classes are minimised. This should help overcome a common problem, i.e. sustaining interventions brought in from outside of the school.
- By teaching the whole class about 'stress' (anxiety and depression), it becomes a 'subject' and may reduce stigma among pupils who, otherwise, may not volunteer to access mental health in the school, e.g. with a counsellor.

Thus, this pilot study looked at the feasibility of:

- Successfully, practically and ethically adapting an evidence-based adult intervention to be delivered in schools.
- Using teachers to deliver the approach and, so, test the viability by making best use of existing resources with an aim of creating a sustainable intervention.

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The analysis plan aimed to assess outcome in terms of impact on anxiety, depression and wellbeing and to gather qualitative data from teachers and pupils through post-intervention focus-groups.

Method

Participants

St Pauls High School is a mainstream, state-funded senior school in a highly deprived area in Glasgow (Pollok). In order to reach as many pupils as possible (including the hard-to-reach), Stress Control was delivered to all 4th year pupils in the school. In the Scottish educational system, 4th years are around 15 years old. The whole Year consisted of 113 pupils. Five classes took part, with an average of 22 pupils in each. Ninety pupils completed pre-measures (22 being absent from school and one who did not complete measures but did take part in lessons), 85 at post and 77 at 9-month follow-up; 72 pupils completed measures at all three data points. Pupils were excluded from analyses if they completed measures at only one data point.

Using the Scottish Index of Multiple Deprivation (SIMD), 55% of pupils were in the most deprived decile (SIMD1), 42% in the second most deprived and 3% in deciles 3, 5 and 7 (Scottish Government, 2016a). Forty-nine per cent of pupils were female; 51% were male. Twelve per cent of pupils were from minority ethnic or asylum-seeking backgrounds.

Personal and Social Education

'Health and Wellbeing' is one of eight curriculum areas within the Scottish Curriculum for Excellence and is organised into six key topic areas: mental, emotional, social and physical wellbeing; planning for choices and changes; physical education, physical activity and sport; food and health; substance misuse; and relationships, sexual health and parenthood (Scottish Government, 2019). While some areas, e.g. substance abuse, are tightly organised with prepared lessons available, many others, including mental health are less well-structured. Although there were existing elements of mental health in the PSE curriculum at St Pauls, it was felt, by the teachers, that this was too little and too unsystematic to meet the perceived considerable mental needs among the pupils.

Stress Control Schools (SCS)

As with the adult version, SCS is based around slide shows. It is delivered over eight weekly single PSE periods. The first half of the teaching provides information; the second, basic CBT 'skills.' With a school period lasting 50 minutes, teaching was designed to be easily completed in 35 minutes, allowing teachers time to settle classes before beginning and to allow teachers space to focus more on areas in the lesson they felt important. Sessions, although protocol-based, allowed some flexibility to allow individual teachers to put their personal stamp on the lesson by, for example, offering the opportunity to carry out short relaxation exercises or using the additional time for more discussion. This was done to nurture a sense of ownership over the lessons but also to get the best out of experienced, professional teachers, allowing them to bring to life the basic templates. However, in keeping with the adult version, no discussion of personal problems was allowed. Each session contained tasks that could either be carried out in pairs, small groups or in the class as a whole, e.g. 'How would you know someone was stressed? How would it affect their thoughts, actions and body?'; 'Name some things people avoid doing or places they avoid going to due to stress'. In session 6, pupils work together, using the sleep hygiene ideas they have learned, to design a good night's sleep for 'Simon'.

The approach teaches generic skills and asks pupils to fit the skills to meet their own needs. Jargon is avoided and 'stress' is used to denote problems such as anxiety, depression, poor sleep,

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panicky feelings and poor wellbeing. We attempted to normalise these problems, i.e. that stress is normal and part of everyone's life.

The eight periods/sessions were:

What is stress?	Information about anxiety and depression – 'stress'
Controlling your body	Caffeine, exercise, 'belly [diaphragmatic] breathing'
Controlling your thoughts	'Breaking stress up' – adapted from Stress Inoculation Training (Meichenbaum, 1985) and Everyday Mindfulness
Controlling your actions	Face your fears (exposure), problem solving
Controlling panicky feelings	Breathing control. Integrating the skills
Getting a good night's sleep	Sleep hygiene
Wellbeing	'5 a day', compassion, gratitude
Controlling your future	Pulling it all together. Values. Relapse prevention

Training

Five PSE teachers volunteered to take part in the project and attended five, weekly, one-hour sessions at the end of the school day. Training was delivered by J.W. This training offered staff the opportunity to enhance their knowledge and understanding of stress control and to consider the impact that the programme would have on the young peoples' mental health and well-being. Teachers suggested changes to the intervention, particularly reducing the number of PowerPoints and increasing the opportunities to introduce discussion and group tasks. This meant that the school version became less didactic than the adult version. This was felt, by teachers, to be more consistent with current teaching approaches – perhaps best summed up in the Benjamin Franklin quote: 'Tell me and I forget. Teach me and I remember. Involve me and I learn'. All materials were made available at this point and placed in a folder in the school intranet, allowing only those PSE teachers to access them.

Materials

PowerPoints contained minimal text, high-quality images, video, e.g. 'I had a black dog' (http://www.youtube.com/watch?v = XiCrniLQGYc) and informational videos narrated in local accents. As a slide may contain only an image and no text, a 'slide-by-slide' Word file for each PowerPoint session was available to teachers offering advice about what each slide represented and suggestions for how best to teach it. The sessions were designed for 'rushed-off-their-feet' teachers, i.e. working on the assumption that, as elsewhere in the public sector, teachers rarely would have time to prepare as well as they would hope and, so, the materials were designed to be easily picked off-the-shelf and delivered with the minimum of preparation.

At the end of each lesson, pupils were given a double-sided, coloured, A4 sheet – side 1 summarised the main points of the session; side 2, the skills and homework suggestions. Flesch-Kincaid readability scores suggest these could be readily understood by an 11-year-old – 'easy' (Flesch, 1948). All relaxation and mindfulness audio tracks (voiced by J.W.) were free to download from a website to pupils' phones.

Measures

Revised Child Anxiety and Depression Scale: short version – 25 items (Ebesutani et al., 2012)

The Revised Child Anxiety and Depression Scale (RCADS) has two subscales – anxiety and depression – and an overall, total score. All items assess the frequency of symptoms and are rated on a 4-point Likert scale (never, sometimes, often, always).

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Table 1. Means and standard deviations for all outcome measures at pre-and post-intervention and 9-month follow-up along with effect sizes (Cohen's *d*)

	Pre	Post	Follow-up	Effect size pre–post	Effect size pre–follow-up
RCADS: Depression	10.14 (5.22)	7.42 (5.19)	7.7 (4.85)	0.52	0.48
RCADS: Anxiety	12.87 (7.69)	9.6 (7.52)	10.1 (6.83)	0.43	0.38
RCADS: Total	23.01 (12.26)	17.02 (11.92)	17.8 (10.75)	0.53	0.54
WEMWBS	43.3 (10.71)	46.85 (10.47)	48.64 (6.99)	0.34	0.60

Table 2. Repeated measures ANOVAs and Tukey tests on all outcome measures

		Pre–post	Pre–follow-up	Post–follow-up
RCADS: Depression	$F(2,267) = 7.79$, $p = .001$	.001	.004	.929
RCADS: Anxiety	$F(2,267) = 5.15$, $p = .006$	.009	.033	.891
RCADS: Total	$F(2,267) = 8.85$, $p = .000$	.001	.001	.993
WEMWBS	$F(2,267) = 7.26$, $p = .001$	.035	.001	.420

Warwick-Edinburgh Mental Well-being Scale – WEMWBS (Tennant et al., 2007)

The WEMWBS is a 14-item scale with five response categories (none of the time, rarely, some of the time, often, all of the time), summed to provide a single score ranging from 14 to 70. The items are all worded positively and cover both feeling and functioning aspects of mental wellbeing.

A range of qualitative measures were also used to assess perceptions of the classes. These included asking teachers and pupils of their experience delivering and participating in the sessions.

In addition, informal teacher and (separately) pupil focus groups were held within two weeks of the final session to gather information on strengths and limitations of SCS and to seek advice on improving the approach. Teachers were asked to assemble a representative cross-section of pupils rather than the more articulate, positive teenagers who might normally volunteer. The groups were conducted, separately, over the course of a single school period. Measures were completed in a PSE class before session 1, in a class after session 8 and, in a PSE class 9 months later, i.e. when pupils were now in 5th year.

Approval for the study was given by Glasgow City Council Education Department Audit Committee. Pupils were told they would be learning about stress and ways of handling it. All parents were given a letter, written by P.L., describing the project, offering the option of a phone call if they required any further information and asking parents to opt-out if they had any concerns about their child taking part. One parent requested their child did not complete the measures but allowed that child to attend the sessions. Classes began in January and, with the exception of a one week break due to a mid-term holiday, were held on a weekly basis.

Results

Data were analysed using paired *t*-tests and repeated measures ANOVAs (SPSS, version 22). Table 1 shows means and standard deviations for measures at pre, post and 9-month follow-up. Table 2 shows results from repeated measures ANOVAs on these measures.

Pupils, on average, appear to have reduced distress ratings while boosting wellbeing by post-intervention and then maintained this progress to 9-month follow-up. The large standard deviations reflect the widely differing levels of distress in the classes – from pupils who report little or no distress to those reporting very high levels of distress. Wellbeing scores start well below national averages but, by follow-up, are similar to other 15-year-olds across the country. Medium effect sizes across measures were found.

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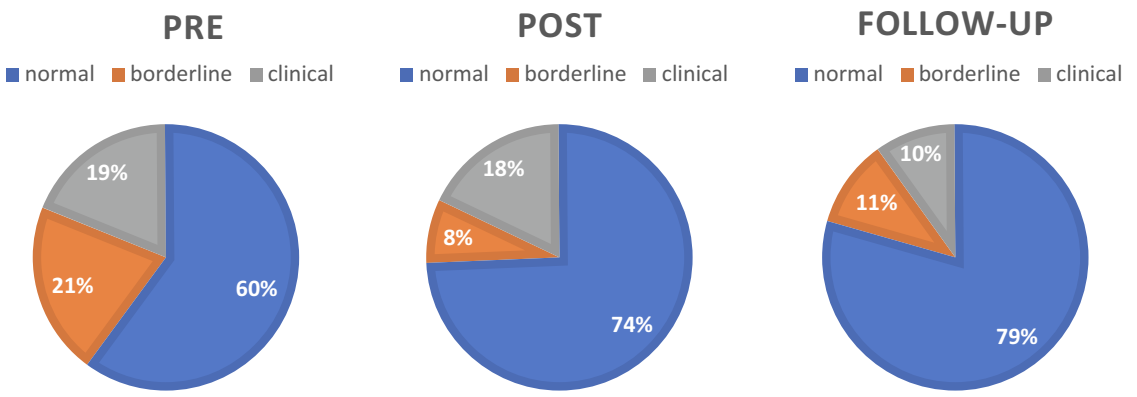


Figure 1. Percentage RCADS total score categories (normal, borderline, clinical), at pre, post and 9-month follow-up.

RCADS categories

RCADS total (anxiety+depression) score allows participants to be placed in 'normal', 'borderline' and 'clinical' categories. Figure 1 shows how pupils' status change across time.

Based on these questionnaire data, 60% of pupils are in the normal range at pre, rising to 74% at post. Most of the movement comes from pupils moving from borderline to normal with little change in those scoring in the clinical category. At follow-up, 79% of pupils are now in the normal range with those who started off in the clinical range now moving into the other two categories.

Teachers' views

The five PSE teachers who delivered classes were asked to rate, following completion of the final session, the following on 10-point scales – higher mean scores reflect a more positive rating (Table 3).

Pupils' perceptions

At both pre and post, pupils were asked to rate, using a 10-point scale, six questions. With the exception of the first question, higher scores denoted more positive ratings. Table 4 looks at pre and post responses along with values from two-tailed paired *t*-tests for the 82 pupils who completed measures at both data points. Pupils reported being significantly less stressed at post. Although pupils, at pre, were reasonably positive about learning about stress control, this dipped significantly at post. Pupils were reasonably positive about the need for schools to tackle 'stress' although less so than the teachers.

At post, pupils were asked to rate the usefulness of each of the eight sessions using a 10-point scale where '1' was 'not helpful at all' and '10', 'extremely helpful'. Mean scores were all between 5.9 ('What is stress?') and 6.4 (Getting a good night's sleep). On average, pupils (and teachers) felt the number of sessions, amount of information and the handouts were 'just about right'.

Focus groups

J.W. and P.L. met with 11 pupils who were positive about the programme but suggested further reducing the number of PowerPoint slides in order to increase the amount of time to allow more tasks and discussion. Some pupils noted that, although they were not troubled by stress, they had learned useful skills that could be used to help friends and family members. It was felt that the two-page handouts could be augmented – more detailed session workbooks ranging from 6 to 9 pages are now used – and pupils suggested the class should run immediately after the summer break

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Table 3. Teacher's perceptions of Stress Control (means and standard deviations)

Is there a need for schools to teach ways of controlling stress?	9.6 (.55)
What did you think of 'Stress Control'?	8.2 (.45)
How well-prepared were you?	8 (.71)
How confident were you teaching SC?	7.6 (.55)
Should St Paul's run this class again?	9.4 (.55)

Table 4. Pupils' ratings: means and standard deviations and paired *t*-tests (two-tailed)

	Pre	Post	*p*-value
Generally, how stressful are you?	6.2 (2)	5.3 (2.3)	.000
Generally, how happy are you with your life?	6.9 (2)	6.9 (1.9)	.653
Generally, how much control do you feel you have in your life?	6.8 (1.9)	7 (1.8)	.269
Generally, how is your self-confidence?	6 (2.5)	6 (2.5)	.952
Do you think learning about stress control will help you? (pre)/has helped you? (post)	7 (2.5)	6.2 (2.1)	.015
Do you think there is a need for schools to teach ways of controlling stress?	7.8 (2.3)	7.4 (1.9)	.125

instead of, in this study, January, to allow them more time to practise the skills before exams in April/May.

The PSE teachers' focus group was equally positive and, consistent with pupils' views, suggested fewer PowerPoints (already reduced in number following suggestions made by teachers at pre-intervention training) and more time for interaction. Teachers were keen to continue running classes.

However, this process was informal and bias effects cannot be ruled out.

Discussion

It appears that we were able to test the feasibility of adapting Stress Control for delivery by teachers in schools. Results of this uncontrolled pilot study suggest that 'Stress Control' was successfully adapted. The five teachers reported few problems preparing for, and delivering, the programme. They felt there was a need for schools to deliver such programmes; they remained positive about Stress Control and wished to continue delivering it (they are now in their third year of doing so). Pupils, similarly, felt that stress management was needed in schools and were reasonably positive about this programme.

A major strength of this intervention has been in the collaboration between a psychologist and teachers, with each able to complement the other's skills. P.L., in particular, helped to shape the programme by suggesting better ways of interpreting PowerPoints in ways a non-teacher would probably struggle to do. The general feeling was that the collaboration between an expert in mental health and experts in teaching produced a finished product better than either could have produced on their own.

Collaborating with pupils is likely to further improve the programme. While pupils did not help shape the approach before the intervention, they did produce many useful insights and suggestions at the end of the intervention. Future research will take these ideas forward.

Although based solely on questionnaire data, levels of mental health problems appeared to be high – 40% of pupils scored in the 'borderline' or 'clinical' categories of the RCADS. At post, there was little movement in the pupils scoring in the 'clinical' range but they did change by follow-up, possibly suggesting that they did use the skills they had learned after the lessons ended and so, picked up on the Stress Control idea of 'becoming your own therapist'. Without a longitudinal

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study, we are unable to say if Stress Control has any preventative effect in those who may be coping well just now but who may be at risk in the future. There remains the possibility that a targeted rather than a universal approach may be a better option. However, the advantage of keeping this as a lesson rather than a mental health intervention is the possibility it helps 'normalise' these problems – a factor found to be an important non-specific active ingredient in the adult version (Kellett *et al.*, 2006).

RCADS scores, at pre-intervention, were higher than same-age teenagers (Grades 9–10) in the US schools reported by Ebesutani *et al.* (2012). Average RCADS scores have dropped below those reported in the US sample at follow-up. WEMWBS average scores at pre (43.3) were lower than average scores of Scottish pupils aged 15, denoting poorer wellbeing (Scottish Government, 2016b). However, WEMWBS scores decrease with decreased household socio-economic status (Clarke *et al.*, 2011; Scottish Government, 2017) and it may be that the current sample's lower wellbeing and higher anxiety and depression scores may be reflective of being in one of the most deprived catchment areas in the UK. However, it appears that Stress Control was able to raise wellbeing scores closer to national average at post and maintained at follow-up.

Classes started in January and concluded in March when it might be assumed stress levels were rising in anticipation of exams starting in April. Outcomes did not reflect this. Sessions were deliberately kept flexible enough to give teachers options in the way they taught the class. From discussion, it was immediately clear that teachers felt confident enough to put their own stamp on delivery with some, for example, taking longer to do the group tasks, using time at the end of each session to have the class take part in the shorter relaxation exercises while others would use the time to engage in further discussion with their pupils. Some teachers encouraged whole class discussion while others got pupils into pairs or small groups. By not allowing discussion of personal problems, stigma was possibly reduced and allowed pupils with very different levels of distress to take what they needed out of the programme. It was noticeable that the experienced professional teachers in this study did not seem to have any great concerns about teaching about mental health. It seems reasonable to suggest that, apart from the financial savings, teachers can deliver this class more efficiently to a large number of people than, for example, someone trained in mental health, but perhaps lacking the same level of teaching skills and relationship with, and knowledge of, individual pupils, coming into the school.

We were unable to gather data on whether pupils did complete suggested tasks between sessions. It seems plausible that many hand-outs would be thrown away immediately, but we do have anecdotal evidence that hand-outs were sometimes taken home and offered to family members thought, by pupils, to be under stress. The first author was surprised, in focus group discussion, that pupils repeatedly noted that one of the strengths of the programme was in teaching them ways of using their new-found skills to help friends and family members, especially parents. This insight allowed the programme to be altered to further emphasise that Stress Control will help the individual and also help that individual to help others, thus possibly, continuing to reduce stigma.

A possible additional strength of the study is its simplicity. Teachers were trained in five hours; no specialist knowledge was required, teachers do not need to be greatly motivated to take part compared with, for example, the much more sophisticated, but unsuccessful, Mindfulness in Schools (Myriad) study which requires teachers to train in, and continue to practise, mindfulness before training in how to deliver the classes. PowerPoints are designed for 'rushed-off-their-feet' teachers, i.e. designed to be easily implemented during the busy school day. Teachers are now expected to train new teachers to take over as the original teachers go to new jobs, retire, etc. Costs are kept to a minimum as a result. The hope is that these measures will help to keep the programme sustainable.

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Limitations

This is an uncontrolled study so we must apply caution in assuming the positive outcomes are due to the impact of Stress Control. We relied on self-report measures. Parents' and teachers' reports would have been useful. More structured focus groups would have been helpful. We did not record sessions so do not know how different teachers taught the classes (although we did deliberately build flexibility into the programme). While we were not aware of any adverse effects on individual pupils, we should have monitored this. It would have been interesting to look at behavioural and academic factors – a throwaway remark by one of the PSE teachers shortly after the end of the intervention and at the start of the exam season – 'I don't think we've seen the same pre-exam meltdown this year' – a comment endorsed by others – suggests a possible focus in the future. We deliberately included simple mindfulness tasks rather than thought-challenging as we felt it may be too difficult to teach that approach in the short period of time we had available. However, given the disappointing outcomes of mindfulness approaches in schools, we may revisit this.

Future developments

Results from this uncontrolled trial suggest there is potential in this approach. There is an ongoing controlled trial taking place in another Glasgow high school where the 5th years (16-year-olds) are receiving an updated version of Stress Control delivered by PSE teachers, while 4th year pupils (15-year-olds) are acting as the no-treatment control. Many of the updates come from what we have learned in this pilot.

While, on average, significant change was found, there remain a group of pupils with high levels of anxiety and depression and low levels of wellbeing (21% remaining in the borderline or clinical categories of RCADS). Realistically, while they should be receiving help from professional therapists, e.g. CAMHS, limited resources and increasing thresholds for acceptance mean that many young people who need more than this universal version of Stress Control Schools reported here, will be unlikely to receive the level of support they require. Hence, we plan to trial 'Stress Control Plus', a revised, more intense version of a Stress Control class that is currently being tested by a CAMHS team in Scotland (NHS Lanarkshire). If successful in a CAMHS setting, this Plus adaptation will target pupils who need more than the basic universal version. It will be run by a PSE teacher trained to deliver the approach after school and, if possible, involving parents. However, caution must be applied in asking too much of teachers or to see them simply as a cheap option rather than properly investing in CAMHS and other services.

Key practice points

(1) In an uncontrolled study, we provided preliminary evidence that 'Stress Control', an adult large-class psychoeducational approach can be successfully adapted to meet the needs of school pupils in a deprived area.
(2) We trained teachers in five hours to deliver, without difficulty, the approach over eight single period PSE classes to the whole year group, thus helping to reach the 'hard-to-reach'.
(3) We found statistically significant drops in anxiety and depression and gains in wellbeing at post-intervention. These improvements were maintained at 9-month follow-up. Quantitative measures reflected these positive findings.
(4) If confirmed in future controlled research, this approach may be of benefit as an early intervention or prevention strategy as well as for those who already have high levels of distress.
(5) The results suggests that teachers and CBT therapists should collaborate in designing pragmatic, sustainable interventions.

Data availability statement. The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Author contributions. **Jim White:** Conceptualization (lead), Data curation (lead), Formal analysis (lead), Investigation (lead), Methodology (lead), Project administration (supporting), Resources (lead), Supervision (supporting), Validation (equal), Writing - original draft (lead), Writing - review & editing (lead); **Pauline Logan:** Data curation (supporting), Methodology (supporting), Project administration (lead), Supervision (lead), Writing - original draft (supporting), Writing - review & editing (supporting).

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Competing interests. Jim White is a director of Stress Control Ltd.

Ethical standards. We have abided by the Ethical Principals of Psychologists and Code of Conduct as set out by the BABCP and BPS.

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