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Initiating change locally in bullyIng and aggression through the school environment

Submission date
03/02/2014

Recruitment status
No longer recruiting

Registration date
11/03/2014

Overall study status
Completed

Last Edited
01/03/2022

Condition category
Mental and Behavioural Disorders

[X] Prospectively registered
[X] Protocol
[_] Statistical analysis plan
[X] Results
[_] Individual participant data

Plain English summary of protocol

Background and study aims
The aim of this study is to find out whether a programme of activities called INCLUSIVE is able to help secondary schools in England reduce bullying and aggression among their students. Bullying and aggression can make people more vulnerable to depression and anxiety in later life, are linked to other harmful behaviours like drug use, and can disrupt people's education. There is growing evidence that the most effective way to prevent such problems in young people is to work with schools to change the school environment relating to discipline and well-being. INCLUSIVE is based on several successful international programmes. The programme involves several elements. First, staff and students work together in an action group to improve how the school is run, ensuring students have a say. Second, school staff manage discipline differently, focusing on repairing relationships rather than just punishing bad behaviour. This is called restorative practice. Third, students are taught social and emotional skills, helping them to get on better together.

Who can participate?
Students who are about to go into year 8 (age 12/13) at the beginning of the study

What does the study involve?
Participating schools are randomly allocated to either deliver INCLUSIVE and or to not deliver INCLUSIVE. Participating students are asked to fill in a questionnaire about bullying and aggression, as well as other health topics, right at the beginning of the project, before schools even know whether they are delivering INCLUSIVE or not. These questionnaires are then repeated 24 and then 36 months later, when the students are in year 9 and then year 10, to show whether students in INCLUSIVE schools report less bullying and aggression than those in schools not delivering INCLUSIVE. Students and teaching staff are also asked questions about other issues to find out if INCLUSIVE improves student well-being and mental health and substance use and reduces teacher stress and absenteeism. The trialists also observe what happens in the schools to make sure INCLUSIVE is delivered as intended. Staff and students are interviewed to ask them whether they thought INCLUSIVE was practically possible to deliver and whether they liked it. Finally, the cost of the programme is calculated to see if any benefits it brings are really worth the money it has cost.

What are the possible benefits and risks of participating?
If successful, less bullying and aggression will be of benefit to all participants, the whole school, local communities and society in general. There may be reduction in other health risk factors (e. g. substance use) and improvements in mental health, emotional well-being and quality of life. It may reduce NHS costs (related to violence and mental health problems), and social costs including costs within the justice system. It may benefit the school by improving the school environment. There are no expected risks to participants or to schools. However, as in all interventions, there may be unexpected risks. The approach may be ineffective, and its introduction in trial schools may prevent the use of more effective techniques to reduce aggression. Some educational interventions to raise awareness of risk behaviours during adolescence have been shown to increase indulging in these behaviours. The trialists believe this is extremely unlikely in this study because our approach is based upon what is shown to be effective in previous research. Because of the above, the trialists believe that risks are minimal and that benefits justify the risks.

Where is the study run from?
The study is run from 40 schools in the south east of England

When is the study starting and how long is it expected to run for?
March 2014 to February 2018

Who is funding the study?
National Institute for Health Research (UK)

Who is the main contact?
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Contact information

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Scientific

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Additional identifiers

EudraCT/CTIS number

IRAS number

ClinicalTrials.gov number

Secondary identifying numbers
PHR 12/153/60

Study information

Scientific Title
INCLUSIVE trial: INitiating Change Locally in bUllyIng and aggression through the School EnVironment: a cluster randomised controlled trial

Acronym
INCLUSIVE

Study objectives
The aim of this study is to evaluate the effectiveness and cost-effectiveness of the INCLUSIVE intervention over three school years (two externally facilitated; one internally facilitated) using a cluster RCT design with integral process and economic evaluation to address the following research questions:
1. Is the INCLUSIVE intervention implemented over three school years more effective and cost-effective than standard practice in reducing bullying and aggression among 12-15 year olds in English secondary schools?
2. Is the INCLUSIVE intervention more effective than standard practice in improving students quality of life, well-being, psychological function and attainments, and reducing school exclusion and truancy, substance use, sexual risk, NHS use, police contacts among students, and improving staff quality of life and attendance and reducing burn-out?
3. What pre-hypothesised factors moderate and mediate the effectiveness of the INCLUSIVE intervention; including, do effects vary by socioeconomic status and sex?

Ethics approval required

Old ethics approval format

Ethics approval(s)
University College London Ethics Committee and Institute of Education Ethics Committee, amendments approved 23/03/2016, 15/10/2016, ref: 5248/001

Study design
Cluster randomised controlled trial with integral economic evaluation and process evaluation, with schools as the unit of allocation

Primary study design
Interventional

Secondary study design
Cluster randomised trial

Study setting(s)
School

Study type(s)
Prevention

Participant information sheet
Not available in web format, please use the contact details to request a patient information sheet

Health condition(s) or problem(s) studied
Anti-social behaviours in schools and their health implications

Interventions
20 schools will deliver INCLUSIVE and 20 schools will not deliver INCLUSIVE.

The intervention is intended principally to augment rather than to replace existing activities (e.g. training, curricula, etc) in intervention schools. However, it is intended to replace existing non-restorative disciplinary school policies and practices where restorative approaches are deemed by the action group to be more appropriate.

The facilitated phase provides the following inputs:
1. Annual surveys of local needs and assets (bullying, aggression, prevalence and determinants) and progress in addressing these
2. Support from an external expert education facilitator trained in facilitating INCLUSIVE
3. Social and emotional learning curriculum resources
4. Staff training in restorative practices provided by the education facilitators and comprising a short introduction and subsequent half-day for all staff (focused on introducing them to restorative practices, such as circle-time, to promote positive relationships and communication, plus enhanced three-day training course in restorative practices targeting 5-10 staff at each school, including training in formal conferencing to deal with more serious incidents via bringing together students, parents and/or staff)

These inputs will enable schools during all three years to convene an action group, which comprises (at a minimum):

1. Six students
2. Six staff, including at least one senior management team (SMT) member
Membership from specialist health staff, such as the school nurse and/or local child and adolescent mental health services staff, are desirable but optional. The action group must meet at least six times per school year (i.e. approximately once every half-term).

The action group develops an action plan that coordinates delivery of the following intervention outputs:
1. Reviewing and revising school rules and policies relating to discipline, behaviour management and staff-student communication
2. Implementing restorative practices throughout the school. Restorative practices include circle-time (which brings students together with their teacher during registration periods or other lessons to maintain good relationships, or be used to deal with specific problems) and conferencing (used to deal with more serious incidents and brings together relevant staff, students, parents and, where necessary, external agencies).
3. Additional tailored actions to address local priorities.
4. Delivering the six-module social and emotional skills curriculum for years 8-10. The curriculum targets students in years 8-10 who receive 5-10 hours teaching and learning per year on restorative practices, relationships, and social and emotional skills based on the Gatehouse Project curriculum. The curriculum is designed as a set of learning modules which schools can address using our own or existing materials if these aligned with our curriculum. Modules cover: establishing respectful relationships in the classroom and the wider school; managing emotions; understanding and building trusting relationships; exploring others needs and avoiding conflict; and, maintaining and repairing relationships. Informed by the needs-assessment data, schools tailored the curriculum to their needs and could deliver modules either as stand-alone lessons, for example within PSHE, and/or integrated into various subject lessons (e.g. English).

The intervention enables local tailoring, informed by the needs survey and other local data sources. These locally adaptable actions occurred within a standardized overall process with various core standardized intervention elements, such as the staff training in restorative practices; review and revision of school rules and policies; and the social and emotional skills curriculum. This balance of standardisation and flexibility is a common practice in complex interventions, enabling a balance between fidelity of the core components with local adaption. This allows schools to build on their current good practice, and also encourages students and staff to develop ownership of the work, which may be a key factor in intervention effects. To support this, the facilitator works with schools to ensure all members of the action group are supported to identify and undertake locally determined actions to improve the school environment.

Internally facilitated intervention year: The third intervention year will be identical to the externally facilitated intervention described above, with the exception that there will be no provision of external facilitation. One of the roles of the external facilitator over the two facilitated years will be to ensure the school action group and SMT develop the capacity to undertake this internal facilitation in the third year.

Intervention Type
Other

Phase
Not Applicable

Primary outcome measure

These will be measured at 36 months (i.e. after three intervention years) through student survey self-reports. As is conventional in trials of interventions addressing violence and aggression in schools, the trialists will rely on self-reports from students, rather than observations or teacher reports because of respectively the impracticality and greater likelihood of information bias of the latter two. The primary outcomes measures include one measure of bullying victimization and one measure of perpetration of aggressive behaviours:
1. Gatehouse Bullying Scale (GBS). The GBS is a short, reliable tool to measure the occurrence of bullying victimisation in schools. This measure was designed by one of our collaborators (LB) and has been shown to be related to other measures of social attachments, school engagement, and anxiety and depressive symptoms. The scale has 12 items, and asks about being the subject of recent teasing, name calling, rumours, being left out of things and physical threats or actual violence from other students in the last 3 months. Each section asks about the recent experience of that type of bullying (yes or no), how often it occurred, and how upset the student was by each type of bullying.
2. Edinburgh Study of Youth Transitions and Crime (ESYTC) school misbehaviour subscale. The ESYTC measures several domains of violence and aggression at school.

Secondary outcome measures

Current secondary outcomes as of 03/04/2017:
The GBS and ESYTC outcomes will be measured at 24 months as secondary outcomes.

In addition the following will be measured at 24 and 36 months:
1. Student level self-report outcomes: These will be measured through student survey self-reports:
1.1. Paediatric quality of life inventory (PedsQL) version 4.076 will be used to assess overall quality of life. The 30-item PedsQL has been shown to be a reliable and valid measure of quality of life (QoL) in normative adolescent populations. It consists of 30 items representing five functional domains: physical, emotional, social, school and well-being, and yields a total QoL score, two summary scores for Physical Health and Psychosocial Health and three subscale scores for Emotional, Social, and School functioning
1.2. Psychological function and well-being:
1.2.1. The Strengths and Difficulties Questionnaire (SDQ) is a brief screening instrument for detecting behavioural, emotional and peer problems and pro-social strengths in children and adolescents. It is brief, quick to complete, and validated in national UK samples
1.2.2. Short Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS) is a seven-item scale designed to capture a broad concept of positive emotional well-being including psychological functioning, cognitive-evaluative dimensions and affective-emotional aspects, with a total Well-being Index generated

1.3. Risk behaviours:
1.3.1. Substance use. Validated age-appropriate questions taken from national surveys and/or previous trials will be used to assess smoking (smoking in previous week; ever smoked regularly), alcohol use (use in previous week; number of times really drunk; binge drinking) and illicit drug use (last month; lifetime use)
1.3.2. Sexual risk behaviours: Age of sexual debut and use of contraception at first sex will be examined using Ripple trial measures. The trialists will consult with schools about the acceptability of asking these questions at baseline as well as at follow-up (Year 10)
1.3.3. The Modified Aggression Scale Bullying sub-scale (Cronbach's alpha=0.83). It is coming from the Centers for Disease Control and Prevention guidance document on bullying measures. It includes a five-item scale assessing the level of bullying perpetration (last three months)

1.4. Use of NHS services: self-report use of primary care, accident & emergency, other services in the past 12 months

1.5. Contact with police will be assessed using the Young Peoples Development Programme (YPDP) evaluation measure which asks whether the young person has been stopped, told off, or picked up by the police in the last 12 months

2. Student-level data collected from schools
2.1. School attendance will be measured via routine school data on each student expressed as number of half days absent; for which the trialists will seek students informed consent to access
2.2. Educational attainment: this will be assessed by an independent team based at the University of Manchester drawing on routine data

3. Individual staff-level outcomes. The following secondary outcomes will be measured through survey self-reports from teachers and teaching assistants:
3.1. Staff attendance will be measured via routine school data on each staff-member expressed as number of half days absent; for which the trialists will seek staff-members informed consent to access
3.2. Staff quality of life will be measured using the SF-12 version 2 Health Survey, a brief well-validated measure of adult health-related quality of life
3.3. Staff burnout will be measured using the Maslach Burnout Inventory, an established scale which uses a three dimensional description of exhaustion, cynicism, and inefficacy

4. School-level outcomes: Routinely collected data on school rates of temporary and permanent exclusions

Previous secondary outcomes:
The GBS and ESYTC outcomes will be measured at 24 months as secondary outcomes

In addition the following will be measured at 24 and 36 months:
1. Student level self-report outcomes: These will be measured through student survey self-reports:
1.1. Paediatric quality of life inventory (PedsQL) version 4.076 will be used to assess overall quality of life. The 30-item PedsQL has been shown to be a reliable and valid measure of quality of life (QoL) in normative adolescent populations. It consists of 30 items representing five functional domains: physical, emotional, social, school and well-being, and yields a total QoL score, two summary scores for Physical Health and Psychosocial Health and three subscale scores for Emotional, Social, and School functioning
1.2. The Strengths and Difficulties Questionnaire (SDQ) is a brief screening instrument for detecting behavioural, emotional and peer problems and pro-social strengths in children and adolescents. It is brief, quick to complete, and validated in national UK samples
1.3. Short Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS) is a seven-item scale designed to capture a broad concept of positive emotional well-being including psychological functioning, cognitive-evaluative dimensions and affective-emotional aspects, with a total Well-being Index generated
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2. Student-level data collected from schools:
2.1. School attendance will be measured via routine school data on each student expressed as number of half days absent; for which the trialists will seek students informed consent to access
2.2. Educational attainment: the trialists intend to explore students progress between key stages 2 and 4 in English and Maths but this will require additional data collection after the end of the trial i.e. after student participants have sat GCSE examinations in 2018. This will be the subject of a Bloomsbury PhD studentship or a small grant proposal to the Educational Endowment Foundation

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4. School-level outcomes: Routinely collected data on school rates of temporary and permanent exclusions

Overall study start date
01/03/2014

Completion date
28/02/2018

Eligibility

Key inclusion criteria
Planned inclusion/exclusion criteria (applied only to schools):
1. Secondary schools within the state education system (including community, academy or free schools, and mixed or single sex) in England.
2. Ofsted rating (most recent) of requires improvement/satisfactory or better.

Participant type(s)
Patient

Age group
Child

Sex
Both

Target number of participants
40 schools

Key exclusion criteria
1. Private schools, non-mainstream schools (e.g. for those with learning disabilities) and pupil referral units.
2. Schools with an inadequate/poor Ofsted rating

Date of first enrolment
28/03/2014

Date of final enrolment
01/07/2014

Locations

Countries of recruitment
England

United Kingdom

Study participating centre
UCL Institute of Child Health
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Sponsor information

Organisation
UCL Institute of Child Health (UK)

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Sponsor type
University/education

ROR
https://ror.org/02jx3x895

Funder(s)

Funder type
Government

Funder Name
National Institute for Health Research (UK) Grant- 12/153 PHR Researcher-Led

Alternative Name(s)
National Institute for Health Research, NIHR Research, NIHRresearch, NIHR - National Institute for Health Research, NIHR (The National Institute for Health and Care Research), NIHR

Funding Body Type
Government organisation

Funding Body Subtype
National government

Location
United Kingdom

Results and Publications

Publication and dissemination plan
Planned publication in a high-impact peer reviewed journal in March 2018.

Intention to publish date
01/03/2018

Individual participant data (IPD) sharing plan
The current data sharing plans for the current study are unknown and will be made available at a later date.

IPD sharing plan summary
Data sharing statement to be made available at a later date

Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
Protocol article	protocol	30/09/2014		Yes	No
Protocol article	protocol update	25/05/2017		Yes	No
Results article	baseline survey results	11/07/2017		Yes	No
Results article	results	08/12/2018		Yes	No

Results article	results	01/06/2019	25/02/2019	Yes	No
Results article	results	01/10/2019	06/11/2019	Yes	No
Results article	results	15/05/2020	18/05/2020	Yes	No
Results article	results	10/09/2020	15/09/2020	Yes	No
Results article		27/02/2022	01/03/2022	Yes	No