Targeted Mental Health in Schools Project

Using the evidence to inform your approach: a practical guide for headteachers and commissioners

Targeted Mental Health in Schools (TaMHS) is a new project funded by the Department for Children, Schools and Families. Its aim is to transform the way that mental health support is delivered to children aged 5 to 13, to improve their mental wellbeing and tackle problems more quickly.

There are 25 pathfinders, each of which are being funded to develop and deliver an innovative model of mental health support. This model will be made up of two key elements:

Strategic integration – all agencies involved in the delivery of child and adolescent mental health services (schools, local authority services, PCTs, other health trusts, the voluntary sector) working together strategically and operationally to deliver flexible, responsive and effective early intervention mental health services for children and young people.

Evidence-informed practice – interventions for children and families at risk of and experiencing mental health problems, which are planned according to local need and grounded in our increasing knowledge of 'what works'.

This document summarises existing knowledge about effective interventions to help children with mental health problems – those who, in a school context, would broadly be described as having behavioural, social or emotional problems. And it offers a framework for using this evidence in a local context which builds on local strengths and knowledge.

In the document, 'schools' refers not just to mainstream schools, but also to special schools, pupil referral units (PRUs) and other settings where 5 to 13 year olds are being educated. Special schools and PRUs should be given special consideration as the pupils attending these settings are significantly more likely to experience mental health problems than pupils in mainstream schools.

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Introduction

This booklet is for everyone involved in deciding which services to deliver in their TaMHS pathfinder project, including headteachers, commissioners in the local authority and primary care trust (PCT) and TaMHS project managers.

It summarises existing knowledge about effective interventions to help children with mental health problems – those who, in a school context, would broadly be described as having behavioural, social or emotional problems. And it offers a framework for using this evidence in a local context which builds on local strengths and knowledge.

All the evidence we discuss is open to question and challenge – no evidence is perfect. However, at the core of the TaMHS project is the view that it is better to use the most rigorous evidence available and to be aware of its limitations, than to base the delivery of key services to children and families on assumptions or precedent.

- If you want to read a **summary** of this document, go to the Executive Summary

- If you want to read more about **mental health in a school context**, go to Section 1

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- If you want to read more about **other factors that influence outcomes**, go to Section 3

- If you want to read more about the **research evidence base**, go to Section 4

- If you want to read more about **planning your services using the evidence**, go to Section 5

- If you want to read a **glossary of interventions**, go to Section 6.

This guide **is** intended to present an overview, which senior managers can use to plan and develop services – whether at children's trust or individual school level.

This guide **is not** intended to help practitioners identify which children have additional needs in this area, or decide what intervention is appropriate for a specific individual. One of the aims of the TaMHS project is to bring more practitioners with mental health expertise into schools to help school staff develop their skills and confidence in identifying and supporting children with mental health needs.

Executive summary

1. This guide supports the second of the two core aims of the TaMHS project:

Strategic integration of all agencies involved in the delivery of child and adolescent mental health services (including schools) so that they can work together to deliver flexible, responsive and effective early intervention mental health services.
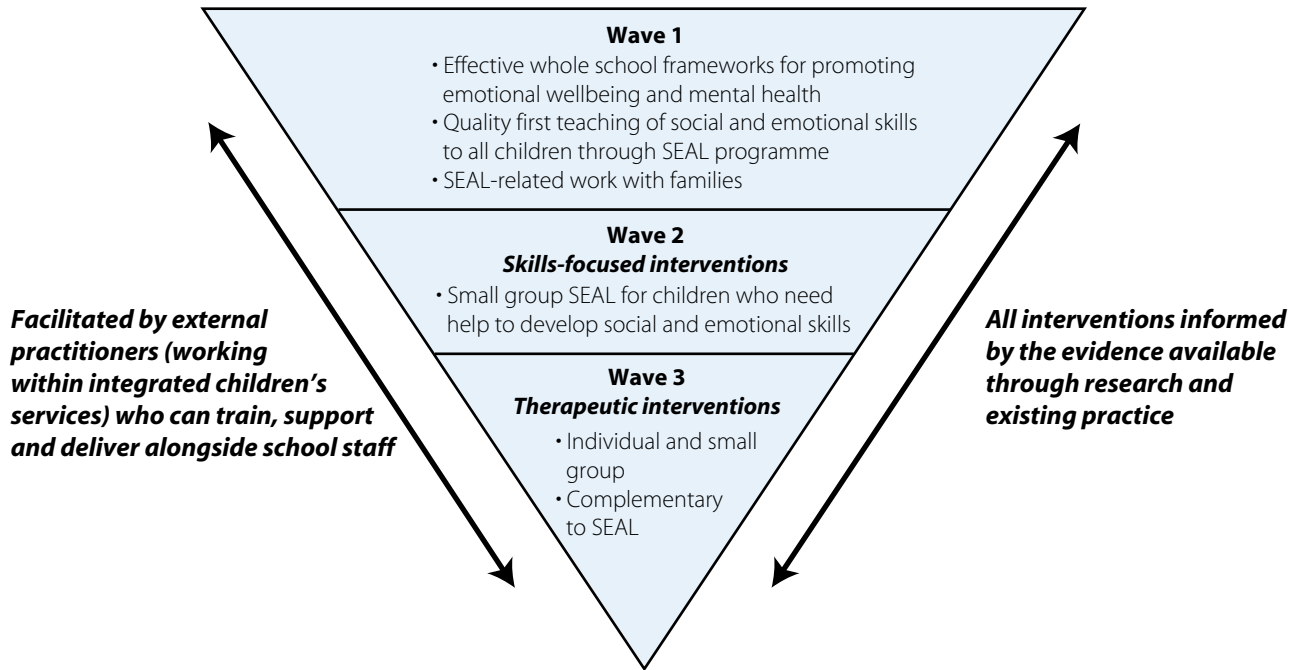
The delivery of mental health interventions which are grounded in the available evidence about 'what works' in helping children and families with or at risk of experiencing problems.

2. The guide summarises existing knowledge about effective interventions to help children with mental health problems – those who, in a school context, would broadly be described as having behavioural, social or emotional problems. It gives an overview of the strongest evidence from research studies, which senior managers can use to plan and develop services at children's trust or individual school level. It offers a framework for drawing on the evidence in a way which is sensitive to the local context and which builds on local strengths and knowledge. In particular, we are encouraging pathfinders to develop their own, local evidence base through a combination of knowledge from research and knowledge from the evaluation of their own practice.

3. TaMHS emphasises an 'ecological' approach to promoting mental health, where children's strengths and needs are viewed in the context of the environments and structures they are part of (family, peer group, class, school, wider community) – not simply in relation to the child themselves. This means that a whole school approach should be at the heart of TaMHS pathfinders:

4. This '3-waves' intervention model will be familiar to schools from the national literacy and numeracy strategies. The range of interventions proposed is centred upon the Social and Emotional Aspects of Learning (SEAL) programme; and is aligned with the recommendations of the National Institute for Clinical Excellence (NICE) on promoting social and emotional wellbeing in primary schools (NICE, 2008).

5. The table on page 7 summarises effective interventions at each of the three 'waves' of intervention. These have been identified from the research evidence base. We have looked at existing systematic reviews and individual studies, and have summarised the key findings. However time and resources have not permitted us to carry out our own systematic review.

Wave 1
- Effective whole school frameworks for promoting emotional wellbeing and mental health
- Quality first teaching of social and emotional skills to all children through SEAL programme
- SEAL-related work with families

Wave 2
Skills-focused interventions
- Small group SEAL for children who need help to develop social and emotional skills

Wave 3
Therapeutic interventions
- Individual and small group
- Complementary to SEAL

Facilitated by external practitioners (working within integrated children's services) who can train, support and deliver alongside school staff

All interventions informed by the evidence available through research and existing practice

6. It is important to draw on the evidence in planning TaMHS pathfinders for a number of reasons:

- Because it is more ethical to develop services which are grounded in some knowledge about 'what works'

- To help us understand how proven clinical interventions work in a school context

- To get maximum benefit from the resources that are being invested in the project.

7. There are many different types of evidence, each with their own advantages and disadvantages. The common view is that the most robust way to demonstrate evidence of *effectiveness* is to compare the outcomes for a sizeable group of people who have received that service with the outcomes for a similar group of people who received no service or a different kind of service. This type of study is called a randomised control trial (RCT). At the other end of the spectrum, a study which gathers the views of service users or

practitioners (a qualitative study) will give valuable insights into processes and techniques but cannot tell you whether a service is effective, as there is no comparison point or quantifiable measure.

8. In this guide, we have focused on evidence from RCTs and other comparative studies as we believe this is the most robust way to demonstrate effectiveness. However we recognise that, as with all evidence, there are limitations to what it can tell us. Many people are critical of RCTs of mental health interventions, because they tend to be carried out with people with single, low level disorders, while in reality many people face complex and overlapping problems. In addition, people argue that there are some outcomes which cannot be quantified in a meaningful way (particularly when interventions are addressing deep-seated psychological issues). Others question whether data obtained from RCTs carried out in the US (as many commonly are) can be applied in a UK context.

9.   In addition to the intervention model or technique, there are a number of other factors which influence the effectiveness of a piece of work with a child and their family. These include:

- Interpersonal factors between the person delivering and the person receiving the intervention (e.g. the attitude and approach of the person receiving the intervention and the relationship between therapist and client)

- The skills and experience of the person delivering the intervention

- Family factors (for example the crucial role that parents play in effecting change)

- Systemic factors (the way that services work together to deliver support to children and families).

10. In view of these limitations on the research evidence base, we are encouraging pathfinders to supplement the knowledge from this guide with evidence from their own practice. This 'practice-based evidence' involves evaluating local practice in relation to the outcomes which have been set, and modifying their practice in relation to this evaluation. Evaluation can be carried out in a range of ways (for example through questionnaires, assessments and observations) and with individual children as well as cohorts. The key issue is that it requires a commitment to working in an outcomes-focused way, through a cycle of evaluation and improvement.

11. Ultimately, pathfinders will need to make a decision about what services to offer, based on both the research evidence base and their practice-based evidence. The most important requirement in planning and commissioning TaMHS services is to have a **clear, grounded rationale** for what you are doing, which takes into account your local context, available resources and desired outcomes, alongside the evidence (both research and practice-based). This will ensure you have taken the necessary practical steps to deliver evidence-informed practice, and in turn will develop into your own local evidence base – a key element of the TaMHS project, with implications for the way that child and adolescent mental health services are developed and delivered in future.

Wave 1

Multi-faceted, whole school programmes to promote wellbeing

Supportive and inclusive school culture and environment

Training for teachers in mental health/emotional wellbeing issues

Social and emotional learning programmes – problem-solving, social awareness, managing feelings etc

Involvement of parents and community – in learning and social aspects

Effective schools which value social and emotional outcomes alongside academic outcomes

Stong leadership　Safe and orderly environment

'Ecological' understanding of child – as member of and influenced by family, peer group, class, school, community

Consistency of approach　Personal development opportunites

High expectations and recognise achievements

Effective classrooms which promote participation in learning

Effective and responsive teaching

Positive classroom climate

Knowledge and use of:
– effective classroom management techniques
– effective behaviour management techniques

Wave 2

Early signs of externalising problems (i.e. disruptive behavioural problems)

Small group sessions with a focus on developing problem-solving skills and pro-social behaviour

Working with parents to reinforce small group work

Starting early and giving booster sessions if necessary

Also: well established nurture groups; play-based approaches

Early signs of internalising problems (i.e. anxiety/emotional distress)

Small group work with a focus on developing problem solving skills and changing thinking patterns

Working with parents to reinforce small group work

Starting early and giving booster sessions if necessary

Also: well-established nurture groups; play-based approaches

Wave 3

Behaviour problems

Parent training/education programmes

Plus problem-solving and social skills training for 8–12 yr olds

For adolescents: family-based approaches addressing full range of a family's needs; individual support taking cognitive behavioural approach

Also: well established nurture groups; play-based approaches; well-structured mentoring schemes with focus on education/training

Attention/concentration problems

ADHD diagnosis and no other explanations for behaviour: medication is treatment of choice

Supported by parent training and individual behavioural therapy if child does not respond to medication, or if child is also experiencing anxiety

Supported by psychosocial treatments where child's behaviour is challenging

Also: give teachers advice about how to work with young primary school children with ADHD-like behaviour

Anxiety problems

Therapy focused on thinking patterns and associated behaviours (CBT)

To be carried out with parents, where child is under 11 or there is high parental anxiety

Also: play-based approaches to develop attachment and relationships; psychoanalytic child psychotherapy

Depression

Therapeutic support – CBT, psychoanalytic child psychotherapy or family therapy depending on symptoms and associated problems

For adolescents not responding to psychological therapy, anti-depressant medication combined with longer term psychological treatment can be effective

Other disorders (e.g. attachment; eating disorders; self-harm; PTSD; substance misuse)

Various therapeutic approaches, often involving the family and looking at a range of systemic issues

School-based prevention and resilience enhancement programmes may be effective in preventing some problems, for example eating disorders and drug misuse

Good practice (not supported by robust evidence) with children in at-risk circumstances (e.g. refugee; looked after; young carers; bereaved)

Holistic approach addressing range of needs; including therapeutic support where appropriate

Supportive, stable home environment

Generally need opportunities to talk and be listened to

Supportive school environment

Key: non-italicised text = strongest evidence
italicised text = less strong evidence

1 Mental health and schools

1.1 What do we mean by 'mental health'

The 1999 Mental Health Foundation report *Bright Futures*[1] defined children who are mentally healthy as able to:

- develop psychologically, emotionally, intellectually and spiritually;

- initiate, develop and sustain mutually satisfying personal relationships;

- use and enjoy solitude;

- become aware of others and empathise with them;

- play and learn;

- develop a sense of right and wrong; and

- resolve (face) problems and setbacks and learn from them.

There is clear evidence that children who are emotionally or mentally healthy achieve more at school and are able to participate more fully with their peers and in school and community life. Research also shows that mental health in childhood has important implications for health and social outcomes in adult life.[2] Equally, children with problems in this area have a diminished capacity to learn and benefit from their time at school. They can also adversely affect the social and academic environment for others in their school.[3]

Terminology issues

We recognise that there is a wide range of related terminology in use, in particular the use of 'emotional health and wellbeing' which will be familiar to schools involved in the National Healthy Schools Programme. We felt it was important to use the term 'mental health' in this project, since a key aspect is to bring the expertise of mental health professionals into schools, so that schools are viewed as an access point for mental health services. However, we recognise that some practitioners from education and social care backgrounds can feel uncomfortable using what they see as 'medicalised' language. We would therefore encourage individual projects to think about issues of terminology at the start of the TaMHS project, and use it as an opportunity to develop a shared understanding and, where appropriate, a common language around these issues.

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1 *Bright Futures*. A report by the Mental Health Foundation (1999). See www.mhf.org.uk
2 Department of Health and Department for Children, Schools and Families. 2007. *Guidance for Schools on Developing Emotional Health and Wellbeing*. At www.healthyschools.gov.uk/resources
3 *Identification and Management of Pupils with Mental Health Difficulties: A Study of UK Teachers' Experience and Views*. Research report for NASUWT (2006). See www.nasuwt.org.uk/Templates/Internal.asp?NodeID=71899

1.2 Describing needs and problems

Many people, at some point in their lives, will experience mental health problems or needs. These can be defined as being actively detrimental to a child or young person's emotional, psychological or social development. Mental health problems and needs manifest themselves in different ways in different situations. They may be expressed in different ways, depending on who is describing the problem.

- Terms that a child might use include: being angry, worried, very sad, not able to concentrate, hating themselves, feeling picked on, getting into fights or getting into trouble.

- Terms that a parent might use include: being demanding, disruptive, insolent, aggressive, hyperactive, lacking concentration, withdrawn, isolated or troubled.

Each profession has a set of terms which they use to classify and describe the kind of problems described above:

Mental health

In clinical mental health there are two diagnostic manuals[4] which describe a full range of mental health problems. The categories most relevant to this guidance are:

- conduct disorders, for example defiance, physical and verbal aggression, vandalism;

- emotional disorders, for example phobias, anxiety and depression that may be manifested in physical symptoms;

- hyperkinetic disorders, for example attention deficit hyperactivity disorder (ADHD);

- attachment disorders, for example children who are markedly distressed or socially impaired as a result of an extremely abnormal pattern of attachment to parents or major caregivers;

- substance misuse problems;

- eating disorders, for example pre-school eating problems, anorexia nervosa and bulimia nervosa; and

- post-traumatic stress disorder.

Education

Children experiencing these problems (in particular behaviour problems) in schools tend to be defined as having behavioural, emotional and social difficulties (BESD). BESD is used within an educational context, to describe a range of difficulties that children might experience as a result of adverse experiences in the early years, difficult family relationships or ineffective behaviour management or means of engaging children effectively within the school. Such a definition will include many children who experience or are at risk of experiencing mental health problems; such as those who are so withdrawn and anxious that it is significantly impacting on their ability to learn, or those whose behaviour is so extreme they are not able to sit and concentrate.

However, not all children with clinically-identified mental health problems will necessarily have special educational needs. Some children, for example those who are extremely anxious and isolated, may

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4   ICD-10 is produced by the World Health Organization and has traditionally been used by the psychiatric profession in the UK. DSM-IV is produced by the American Psychiatric Association.

be in need of additional help and support within the school in order to help them overcome their difficulties. Other children, for example a child with an eating disorder, may be in need of support outside school, but which the school with an effective pastoral and/or counselling service can help the child access. For other children, their behavioural difficulties (which often have a significant emotional element to them) may be so intertwined with their inability to concentrate, to learn and to get on with their peers, that an approach which does not include attention to the educational alongside their emotional, social and behavioural needs will fail to provide the range of support that they require. Such children may be defined as having a behavioural, emotional or social difficulty within an educational context. However, by a medical practitioner the same child may be defined as having a conduct disorder, a mental health term used to describe children with overly oppositional or defiant behaviour.

Social care

The main classification used by the social care profession is 'child in need'. Social care staff primarily come into contact with very vulnerable children experiencing severe family problems. In relation to mental health issues, they tend to use the language of attachment problems, abuse, neglect or relationship problems.

Youth justice

The main classifications used by the youth justice profession are 'anti-social behaviour' and 'offending', because of the point at which they come into contact with a child or young person. In addition, they use the language of mental health and its associated disorders to describe the complex range of needs and overlapping problems that the young person may be facing – for example depression, anxiety or substance dependency issues.

Classification issues

In the absence of a common terminology for problems and difficulties, we have chosen to present the evidence in this guide in two ways:

1. First we use the categorisation used by mental health practitioners to summarise a range of evidence. We attempt to describe the relevant problems and needs in language which is relevant to all professional backgrounds

2. Secondly, we consider the needs of children and young people in circumstances (for example being looked after or being bereaved) which place them at a greater risk of mental health problems. This risk is often accompanied by a range of other social and material problems and needs.

1.3 Describing positive outcomes

The most common mental health needs among children and young people are behavioural problems, attention problems, anxiety problems and depression.[5]

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5   The most common mental disorder in the 5-10 year age group is conduct disorder (6.5% boys and 2.7% girls) followed by emotional disorders (3.3% in both sexes) and hyperkinetic (attention deficit hyperactivity) disorders (2.6 % boys, 0.4% girls). General behaviour problems may affect over 10% of the population. As identified in Adi, Killoran, Janmohamed and Stewart-Brown. 2007. *Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools Report 1: Universal approaches which do not focus on violence or bullying*. Published by NICE and available at www.nice.org.uk/nicemedia/pdf/MentalWellbeingWarwickUniReview.pdf

By targeting children and young people with or at risk of experiencing mental health problems, we envisage that the TaMHS project will achieve the following outcomes for children, families and schools:

- improvements in overall mental health;

- improvements in attendance and attainment of children and young people involved in intervention work within the project;

- improvements in parents'/carers' confidence and skills in supporting their children and preventing problems arising;

- increase in staff knowledge and awareness of children's mental health issues;

- increase in staff confidence and ability to identify children with mental health problems;

- increase in staff confidence and skills in working with children and young people at risk of and experiencing mental health problems;

- reductions in staff stress levels;

- reductions in rates of exclusions (temporary and permanent), and in behaviour 'incidents' within the school;

- the development of a supportive whole school environment for promoting children and young people's mental health; and

- appropriate referrals of children to child and adolescent mental health services (CAMHS) provided by the PCT and other providers such as mental health trusts and acute trusts.

1.4   Who delivers mental health services?

Many services contribute to the mental health and emotional wellbeing of a child or young person. Child and adolescent mental health services (CAMHS) is an umbrella term for them. However the term is used in a number of ways.

- 'Generic CAMHS' refers to all services – universal, targeted and specialist – who are involved in supporting children's mental health in some way. Practitioners include teachers, GPs, school nurses, health visitors, social workers, youth justice workers and voluntary agency staff, as well as practitioners with a mental health specialism.

- 'Specialist CAMHS' refers to specialist services staffed by practitioners with mental health qualifications and experience, for example primary mental health workers, counsellors and therapists, psychologists, psychiatrists and psychiatric nurses. They are employed by a range of agencies, including local authorities, primary care trusts, mental health trusts or acute trusts.

CAMHS services are configured and delivered in a number of ways, ranging from support, advice and mental health promotion for all children, through to specialist outpatient and inpatient services for the most serious problems (for example eating disorder units, forensic psychology services and services for abused children).

In this document we use the term 'CAMHS' in the generic sense. This stresses the key role that schools and other community services have to play in supporting all children's mental health and quickly identifying problems. It also highlights the

need for a comprehensive range of services to meet all the mental health needs of children and young people in an area, with clear referral routes between them.
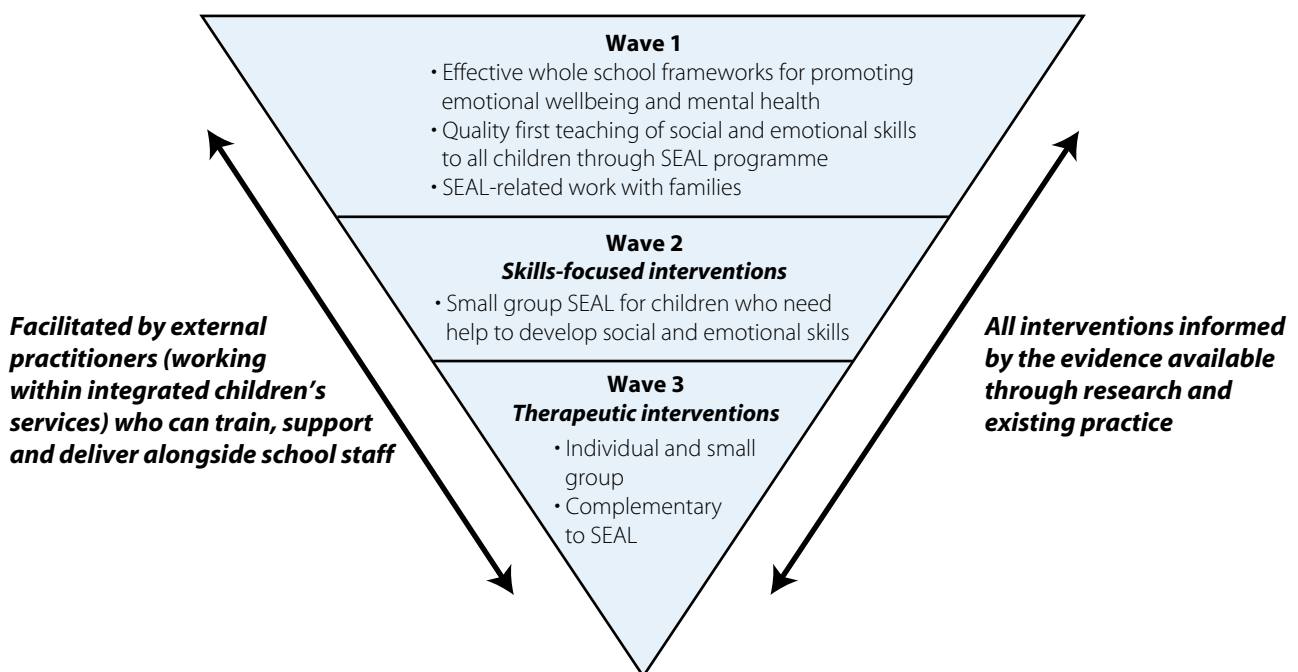
1.5   The TaMHS model and how it links with other school programmes

There is evidence[6] that **children with mental health needs are supported most effectively when there is universal provision to promote the mental health of all pupils, reinforced by targeted support for those with particular needs**. In view of this, the Targeted Mental Health in Schools project requires schools and support services to develop a multi-component, integrated approach to address mental health problems which includes whole-school work. This 'ecological' approach to promoting mental health involves

viewing the child not just in terms of their problems or needs, but in relation to the environments and structures they are part of (family, peer group, class, school, wider community).

This means that TaMHS pathfinders will involve work at a number of different levels, for example whole school work on creating a safe physical environment, class work on promoting social and emotional skills, advice and support for teachers on behaviour management, peer support, parenting support and individual sessions for a child with particular needs. We are aware that many schools are already actively involved in this type of work. Where schools are already addressing emotional wellbeing or developing links with mental health support services, the

Figure 1: The TaMHS model

Wave 1
- Effective whole school frameworks for promoting emotional wellbeing and mental health
- Quality first teaching of social and emotional skills to all children through SEAL programme
- SEAL-related work with families

Wave 2
Skills-focused interventions
- Small group SEAL for children who need help to develop social and emotional skills

Wave 3
Therapeutic interventions
- Individual and small group
- Complementary to SEAL

Facilitated by external practitioners (working within integrated children's services) who can train, support and deliver alongside school staff

All interventions informed by the evidence available through research and existing practice

6   See Weare K and Markham W. 2005. What do we know about promoting mental health through schools? In *Promotion & Education*, XII, (3-4), 14-18. Available at http://eprints.soton.ac.uk/24083/

TaMHS project will complement this work and will be able to offer additionality for example:

- bringing in expertise to build the capacity and confidence of school staff;

- funding additional therapeutic services; and

- embedding good working relationships and shared processes between all the relevant services dealing with child and adolescent mental health.

We have developed a model for the way in which TaMHS will operate within schools (see Figure 1). It will be familiar to schools as it uses the 3-wave intervention model originally developed for the national literacy and numeracy strategies. The relationship between TaMHS and a range of existing programmes for schools are described below.

TaMHS and the NICE guidance for schools

The National Institute for Clinical Excellence (NICE) has produced evidence-based guidance on promoting social and emotional wellbeing in primary schools.[7] It makes a range of recommendations for practice in schools, including specific recommendations on interventions. These state that children's trusts and schools should:

- Develop and agree arrangements as part of the Children and Young People's Plan (and joint commissioning activities) to ensure all primary schools adopt a comprehensive, 'whole school' approach to children's social and emotional wellbeing.

- Provide a comprehensive programme to help develop children's social and emotional skills and wellbeing (including a social and emotional skills curriculum, training and support for staff, support for parents and integrated activities across the school).

- For children with early signs of social and emotional difficulties, provide a range of interventions that have been proven to be effective, according to the child's needs. These should be part of a multi-agency approach to support the child and their family and may be offered in schools and other settings. Where appropriate, they may include:

  – problem-focused group sessions delivered by appropriately trained specialists in receipt of clinical supervision

  – group parenting sessions for the parents or carers of these children, run in parallel with the children's sessions.

The TaMHS model incorporates these three aspects. A school which is carrying out the kind of whole school approach envisaged by TaMHS will be putting the NICE approach into practice, and will be extending it by offering individual, more intensive support to children and families where appropriate.

TaMHS and the Social and Emotional Aspects of Learning (SEAL) Programme

SEAL is an integral part of the TaMHS model. It is the key intervention identified at Waves 1 and 2 of the TaMHS model. It provides an effective school-based programme to promote social and

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7   Promoting children's social and emotional wellbeing in primary education. NICE, 2008. Available at www.nice.org.uk/guidance/index.jsp?action=download&o=40117

emotional wellbeing through both a curriculum and whole school approach. It also provides ideas for supporting pupils with additional needs through small group intervention and for supporting parents and carers.

The SEAL programme develops the social and emotional skills associated with self-awareness, managing feelings, motivation, empathy and social skills. These skills also underpin effective learning, positive behaviour, regular attendance, staff effectiveness as well as the emotional health and wellbeing of all who learn and work in schools. The SEAL programme proposes that these skills will be most effectively developed through:

- using a whole-school approach to create the climate and conditions that implicitly promote the skills and allow these to be practised and consolidated;

- direct and focused learning opportunities for whole classes (during tutor time, across the curriculum and outside formal lessons) and as part of small group work;

- using learning and teaching approaches that support pupils to learn social and emotional skills and consolidate those already learnt; and

- continuing professional development for the whole staff of a school.

There are two sets of resources, one for primary and one for secondary. Primary SEAL is organised into seven themes which can be covered within a school year, for example New Beginnings and Going for Goals. Each theme is designed for a

whole-school approach, including an overview, assembly and suggested follow-up activities across the curriculum. There are also ideas for activities which children can take home and do with their parents, staff development activities and learning opportunities for use in small groups. The themes are revisited each year, so that by Year 6 a child who entered the school at Foundation Stage will have experienced the ideas and skills behind each theme at the appropriate level each year.

Secondary SEAL builds on the work of Primary SEAL, and provides resources which include guidance, continuing professional development materials for staff and themed learning opportunities for work across the curriculum. All the materials can be located at www.teachernet.gov.uk/seal

The SEAL programme is intended to build on the effective work that many schools are already doing to develop social and emotional skills, and can be used flexibly and integrated with other related work.

Therapeutic work and SEAL

Those planning and delivering therapeutic interventions will need to be familiar with the aims and principles of the SEAL programme, and the materials being used in their participating schools. Because they are taking place within a whole school environment, it will be important for therapeutic interventions to complement and reinforce what the child is learning and experiencing through the rest of the SEAL programme.

Annex B sets out a summary of the theoretical framework that underpins primary SEAL. Some of the key points to note are:

- The SEAL programme has its basis in research on the affective competencies variously described as emotional intelligence or emotional literacy; in long-standing experimental psychological research on empathy, social problem-solving and anger management, and in cognitive-behavioural theories.

- It focuses on developing skills across the five domains of empathy, self-awareness, managing feelings, motivation and social skills.

- Many behavioural approaches focus on rewarding good behaviour. SEAL places more emphasis on self-motivation and encouraging individuals to set their own goals and work towards them.

TaMHS and the National Healthy Schools Programme

Nine out of ten schools are involved in the National Healthy Schools Programme (NHSP) and more than half have achieved National Healthy Schools Status. This means that most schools will be aware of and committed to the promotion of emotional health and wellbeing, one of the key strands of the programme.

Emotional health and wellbeing is defined as incorporating:

- emotional wellbeing (including happiness, confidence and the opposite of depression);

- psychological wellbeing (including autonomy, problem solving, resilience and attentiveness/ involvement); and

- social wellbeing (good relationships with others, and the opposite of conduct disorder, delinquency, interpersonal violence and bullying).

The guidance sets out nine criteria to ascertain how schools are promoting emotional health and wellbeing.

1. How does the school identify vulnerable individuals and groups and establish appropriate strategies to support them and their families?

2. How does the school provide clear leadership to create and manage a positive environment which enhances emotional health and wellbeing in school – including management of the behaviour and rewards policies?

3. What are the curriculum opportunities for children and young people to understand and explore feelings using appropriate learning and teaching styles?

4. Does the school have a confidential pastoral support system in place for children and young people and staff to access advice – especially at times of bereavement and other major life changes – and does this system actively works to combat stigma and discrimination?

5. Are there explicit values underpinning positive emotional health which are reflected in practice and work to combat stigma and discrimination?

6. Is there a clear policy on bullying, which is owned, understood and implemented by the whole school community?

7. Does the school provide appropriate professional training for those in a pastoral role?

8. Does the school provide opportunities for children and young people to participate in school activities and responsibilities to build their confidence and self-esteem?

9. Does the school have a clear confidentiality policy?

Schools already involved in the NHSP will be working on the development of a whole school approach. For them, the TaMHS project offers an opportunity to focus on aspects which are particularly challenging or under-developed. This may include work on developing values and ethos; staff training or work with parents.

TaMHS and extended schools

An extended school works with the local authority, local providers and other schools to provide access to a core offer of integrated services:

- a varied range of activities including study support, sport and music clubs, combined with childcare in primary schools;

- parenting and family support;

- swift and easy access to targeted and specialist services; and

- community access to facilities including adult and family learning, ICT and sports grounds.

These will often be provided beyond the school day but not necessarily by teachers or on the school site.

Early evaluations have found that extended services can help to improve pupil attainment, self-confidence, motivation and attendance; reduce exclusion rates; enable teachers to focus on teaching and learning; and enhance children's and families access to services.

The structural aspects of the TaMHS project – i.e. the development of an innovative, integrated approach between schools and other services to provide mental health services – is very much in line with the extended schools ethos. This means that there are opportunities for schools to enhance their existing range of extended services through the TaMHS project.

1.6   Moving forward

The challenge for TaMHS pathfinders is to find ways in which practitioners from a range of disciplines, and using a range of approaches, frameworks and discourses, can operate effectively together. Across children's services, and driven forward by the *Every Child Matters* agenda, there is a great deal of positive practice in developing such work. This is often not without difficulties and compromises among all those involved, often requiring the development of new understandings and ways of working between the different professionals. However the gains for all – those children experiencing problems, their peers, teachers and other school staff, often the school as a whole – outweigh the initial difficulties of developing this work.

2 What is an evidence-informed approach?

There is an increasing amount of evidence about interventions that have a positive impact on mental health outcomes for children and young people. From the outset, one of the aims of the TaMHS project has been to encourage pathfinders to use this evidence base to inform their approach. We believe this is important for a number of reasons:

- to maximise the opportunity to improve mental health outcomes for children and families – focusing on interventions, which already have a track record of success is more ethical than building an approach based on hunches, assumptions or precedent;

- to help us understand how these interventions work in a school context – many of the well-researched interventions have been delivered in a clinical context. We need to understand the implications for schools and families of delivering them in a school context, to help extend the evidence base; and

- to get maximum benefit from the resources that are being invested in the project – the TaMHS project is not about doing 'more of the same' but about offering proven interventions within an innovative and integrated framework for service delivery.

2.1 What counts as evidence?

There are many different types of evidence. These can be categorised according to the kind of information they produce (for example quantitative or qualitative data) and can range from large studies which compare outcomes between two different approaches, through to the personal experience of one service user or practitioner. A range of sources of evidence are summarised overleaf:

Most rigorous evidence

- A systematic review or meta-analysis
  – a systematic review rigorously analyses the conclusions of two or more controlled trials (ideally RCTs – see below)
  – a meta-analysis 'pools' the results of several independent trials to reanalyse the data with a larger sample, with the aim of drawing more generalisable conclusions.
- A single, well-conducted randomised control trial (RCT)
  – individuals are allocated at random to one group which receives an intervention and another which does not.
- A single case-control study
  – a case-control study involves comparing outcomes for two groups, one which has received a particular treatment, the other which has not. The allocation is not done on a randomised basis. This may be referred to as a 'quasi-experimental' design.
- Non-experimental, descriptive studies
  – for example cohort studies (which follow a group of people over an extended period of time), non-comparative evaluative studies (which only measure outcomes for the treatment group) and qualitative studies.

Least rigorous evidence

- Expert opinion.
- Personal experience.

2.2 Experimental studies

Randomised controlled trials (RCTs) are often viewed as a 'gold standard' in research. This is driven largely by the importance in the medical field of thoroughly testing new drugs before they come to the market. RCTs are now conducted in a number of fields, including health and education. Where the researchers are not able to randomly allocate the participants themselves, they may still be able to compare outcomes for two different groups. These are called 'quasi-experimental' studies.

The great advantage of experimental research is that it gives researchers and practitioners confidence that the benefits are due to the intervention itself rather than to other factors. Such studies are possible when outcomes are quantifiable (e.g. assessment ratings carried out before and after an intervention) and when it is practical and ethical to find a control group who receive no treatment or an alternative treatment.

However, as with all research, there are a number of caveats that need to be considered in relation to experimental research:

- many outcomes of treatment are not quantifiable, for example individual quality of life and the functioning of the child in the social environment[8];

8   Fonagy, Target, Cotrell, Phillips & Kurtz. 2002. What works for whom? A critical review of treatments for children and adolescents. New York: Guilford Press.

- for educationalists and social scientists, context and environment are of central importance, calling into question the transferability of data from other countries[9];

- it can be difficult to answer complex questions on the impact of variables such as the timing of an intervention, the skills and style of those delivering it, and the relationship between those delivering and those receiving the intervention;

- such reviews are inevitably generalisations, and will apply to a greater or lesser extent to individuals; and

- some experimental studies use participants who have been recruited specifically for research purposes and as such they may have just one single, low-level disorder in order to test a single proposition. This does not reflect the complexity of cases seen by many child mental health practitioners.

2.3   Non-experimental studies

Though experimental methods can be used in education and social care research, more common is the use of non-experimental methods using techniques such as observations, interviews and surveys carried out with a single group of participants. These can involve large groups and may be carried out over a long period. They can provide insights into levels of need, methods of intervention and the views of practitioners and service users. This can help inform new theoretical understandings, professional practice and service development.

The drawback of non-experimental research is that you cannot use it to conclude that a particular intervention has contributed to a particular set of outcomes (without a control group, there is always a possibility that any improvement was due to other factors, such as the normal developmental processes that would occur in the child over the period of the intervention). When findings from one study are backed up by the findings from similar studies, and replicated over large populations, it is probably safe to conclude that this is the case. However, by itself, a non-experimental study cannot prove a hypothesis.

2.4   Our approach to evidence

This guide is intended to help people decide what interventions to include as part of their TaMHS project. For this reason – and to prevent the document from becoming unwieldy – we have restricted our definition of 'research evidence' to the most rigorous research available in the different fields. In the case of therapeutic interventions, this means **evidence from experimental research**. In the case of school effectiveness research, which has important implications for behaviour management and pupil support, this means **evidence from high quality cohort studies**. This is what we summarise in Section 4.

At the same time, we want to provide an approach for pathfinders to bridge the gap between the high level knowledge base that is emerging from research into mental health interventions, and the complex, highly specific and often chaotic situations of individuals with mental health problems.

9   Davies, Nutley and Smith. 2000. What Works? Evidence-based policy and practice in public services, Bristol: Policy Press.

Figure 2: Bridging the gap between experimental research and real life problems
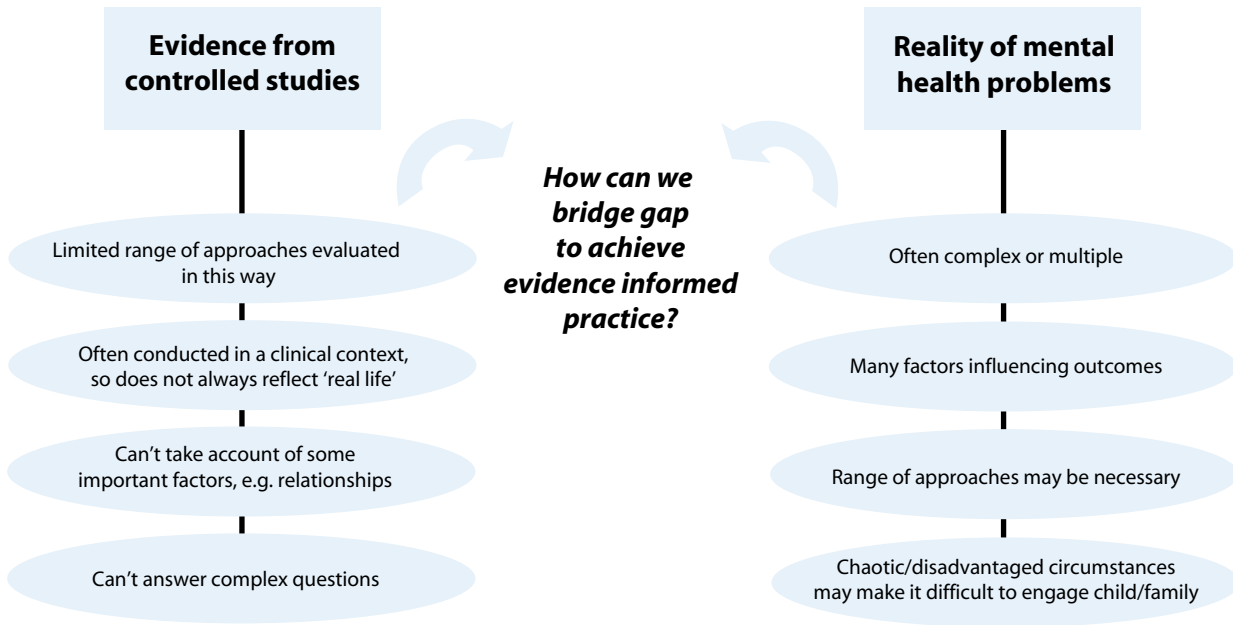
One way of doing this is to consider research-based evidence alongside **practice-based evidence**. This is defined as evidence from the 'real world', which is based on service user and practitioner experiences, and which has a clear connection and relevance to the changes that are being sought.[10] The concept was first popularised in the United States[11] but is gaining ground in the UK as academics and practitioners increasingly recognise the importance of local areas developing an evidence base which is specific and responsive to their local context.

Practice-based evidence involves practitioners and services evaluating their practice in relation to the outcomes which have been set, and modifying their practice in relation to this evaluation. Evaluation can be carried out in a range of ways (for example through questionnaires, assessments and observations) and with individual children as well as cohorts. The key issue is that it requires a commitment to working in an outcomes-focused way, to evaluating outcomes and to feeding this knowledge back into the development of practice.

Further information on evaluation, and in particular the links between the TaMHS national evaluation strategy, and the expectations on local pathfinders, is included in the TaMHS *Implementation Guidance* which has been issued to all pathfinders.

2.5   Building your own evidence base

Within the TaMHS project, we are encouraging pathfinders to cross-reference and supplement the findings of the research evidence base with their own local knowledge and experiences. This can be

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10   Simons, Kushner, Jones and James. 2003. From evidence-based practice to practice-based evidence: the idea of situated generalisation. In *Research Papers in Education* 18 (4): 347-364.

11   See for example the work of Barry Duncan and Scott Miller at www.talkingcure.com

Figure 3: Building your own evidence base

2. Consider evidence base
– what do you know from research and practice? [Year 2: what is your practice-based evidence from last year?]

3. Plan services
– taking into account the evidence base and available resources
– clear hypothesis linked to outcomes

1. Establish vision and set outcomes
– what kind of mental health needs are you dealing with?
– what are you aiming for?
– how will you know if you have been successful?

Iterative process, drawing on practice-based evidence from previous cycle

5. Evaluate
– identify outcomes
– identify benefits and challenges
– feed information into ongoing development of local evidence base

4. Deliver services
– evidence informed
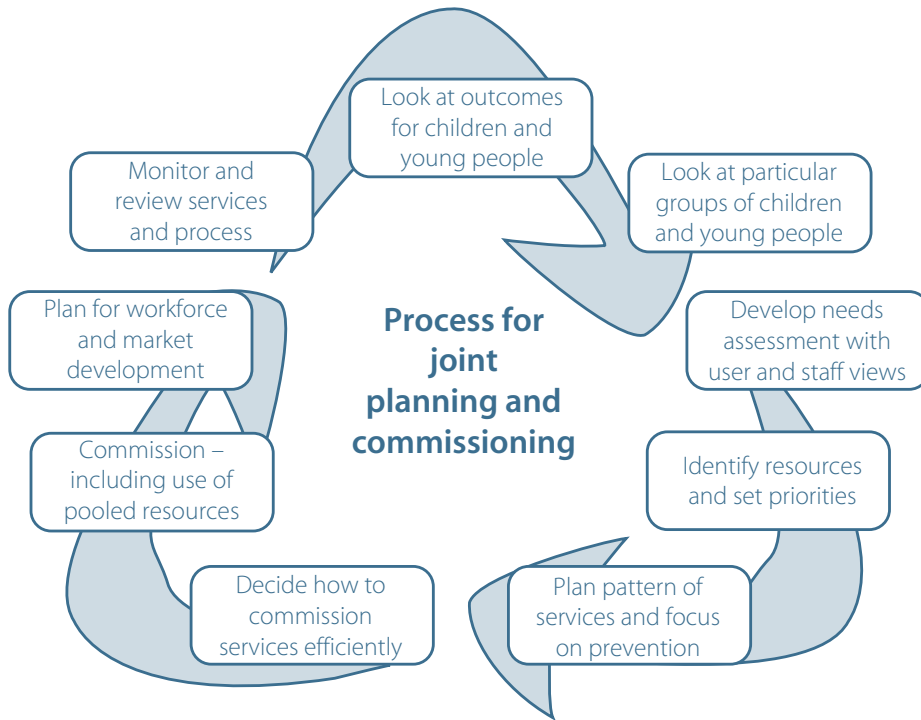– tackling complex reality of mental health problems

built into a cycle for planning, commissioning and delivering services which aims to help bridge the gap between evidence and practice, as illustrated overleaf.

When considering the evidence base in relation to your local context, and deciding what interventions are likely to be most effective in your TaMHS programme, the key requirement is to have a **clear rationale** for what you are doing. This needs to be grounded in your local context,

resources and desired outcomes, while taking into account the findings from other studies. **Section 5** sets out a template for pathfinders to use to guide them through the process of ensuring they have a rationale for the development of their interventions.

Ultimately, we envisage that this development process will become part of the wider cycle of joint planning and commissioning of children's services, as illustrated overleaf.

Figure 4: Joint planning and commissioning of children's services

Look at outcomes for children and young people

Monitor and review services and process

Look at particular groups of children and young people

Process for joint planning and commissioning

Plan for workforce and market development

Develop needs assessment with user and staff views

Commission – including use of pooled resources

Identify resources and set priorities

Decide how to commission services efficiently

Plan pattern of services and focus on prevention

3 Other key factors for effective practice

The research evidence base presented in Section 4 looks specifically at intervention models and techniques. However it is helpful to be aware that there are a number of other factors which influence the effectiveness of a piece of work with a child and their family. These include:

- interpersonal factors between the person delivering and the person receiving the intervention;
- the skills and experience of the person delivering the intervention;
- family factors; and
- systemic factors.

These are all important factors however it is not the remit of this guide to discuss them in detail. We provide a brief overview to highlight that they are additional factors which should be taken into consideration by schools and individual practitioners.

3.1 Interpersonal factors

Even where a well-evaluated model or technique is used by one practitioner with a group of children, the outcomes will differ for each of the children. This is because, in addition to the model used,

there are three other important factors which determine the outcome of an intervention.[12] These are:

- the attitude and approach of the person receiving the intervention;
- the effectiveness of the relationship between the client and person delivering the intervention; and
- hope and expectations (the so-called 'placebo effect', in which a portion of the improvement can be attributed to the client's knowledge that they are being treated and their expectations of progress).

This suggests that the individual practitioner – their approach and skills, the relationships they establish with children and families – is highly influential in relation to outcomes for children and families. For planners and commissioners, it also highlights the importance of staff training and development.

3.2 Skills and experience

The skills and knowledge underpinning effective work with children are summarised in the Common Core of Skills and Knowledge for the

12   Study conducted in 1992, reported in Hubble, Duncan and Miller. 1999. *The heart and soul of change: what works in therapy*. Washington: American Psychological Association. See for example the work of Barry Duncan and Scott Miller at www.talkingcure.com

Children's Workforce (DfES, 2005). The six core areas are set out below, along with illustrative skills and knowledge.

- Effective communication and engagement
  - listening and building empathy
  - summarising and explaining
  - consultation and negotiation.

- Child and young person development
  - understanding how babies, children and young people develop
  - understanding the context for the child or young person
  - knowing how to reflect and improve.

- Safeguarding and promoting the welfare of the child
  - relating, recognising and taking considered action.

- Supporting transitions
  - identifying transitions and providing support
  - understanding how children and young people respond to and manage change.

- Multi-agency working
  - communication and team work
  - understanding role and remit.

- Sharing information
  - information handling and understanding procedures
  - clear communication with and engagement of child, young person and parents/carers.

We summarise the Common Core here to emphasise the importance of all those involved in the TaMHS project having (or having the opportunity) to develop the required skills and knowledge. Further information on using the Common Core to aid workforce planning is available at:

See www.cwdcouncil.org.uk/projects/implementinglocally.htm

3.3 Family factors

The immediate and wider family has a profound influence on a child's mental health. In the majority of cases, this influence is positive and supportive. However in some families, it can be a risk factor, for example where there is overt parental conflict, inconsistent or harsh discipline, or hostility or abuse. Some families face complex and multiple disadvantages which make it difficult for a child to engage with schools and other services which can support their mental health.

The 'Think Family' review for the Cabinet Office found that around 2% of families – 140,000 across Britain – experience complex and multiple problems. It recognises that tackling entrenched exclusion requires an additional and more focused approach. It seeks to build the capacity of systems and services to 'Think Family', shifting the mindset of traditional service delivery to focus on the strengths and difficulties of the whole family rather than those of the parent or child in isolation.

The implications of this for targeted mental health work with children is that it encourages practitioners to see the child as a member of a wider system, and to use their links with other

services to help the family access additional services and a wider system of support. Much of the evidence on mental health interventions already recognises the crucial role that parents play, and will involve them, for example, through parent training and education. As such, work with the family is likely to be a central part of the TaMHS pathfinders. The 'Think Family' initiative highlights that many parents will need to access other practical support (for example benefits advice or drug and alcohol services) to give them the capacity to get involved in supporting their child's behaviour and mental health.

See www.cabinetoffice.gov.uk/social_exclusion_task_force/families_at_risk

3.4   Systemic factors

To be successful, the TaMHS project is dependent on services working together in new ways to support children's mental health. As such, practitioners are likely find they are delivering some services in a new (and hopefully more effective) way, and managers will find they are needing to support changes in practice, and to help people overcome any barriers to change.

This means that within the TaMHS project there is a focus on **process** as well as **outcomes**. Getting the broader system right and functioning effectively will, in turn, help to improve outcomes for children and young people.

Rigorous programmes to help people manage change effectively can help to ensure that:

- everyone stays focused on service users and improving outcomes;

- the project is inclusive, and values the input of practitioners, stakeholders, children, parents and communities;

- practitioners are supported in making changes to their practice and in working with others;

- a deeper understanding develops between practitioners from different professional backgrounds, which in turn provides a better experience for children and families receiving support; and that

- the improvement in the delivery of children's mental health services is sustainable.

Change across services

Integrated working has been at the heart of change in children's services for a number of years, driven by the *Every Child Matters* programme. Most practitioners involved with the TaMHS project will be familiar with the aims and outcomes of ECM, and probably already working in new ways, for example using the common assessment framework (CAF) or acting as the lead professional for children involved with a range of agencies.

The shape of the TaMHS project will vary from pathfinder to pathfinder, but in each case it will require continued efforts to promote multi-agency working, as this will be central to more effective delivery of mental health services in schools.

There is no precise formula for multi-agency working. It is complex, challenging and significantly influenced by the local context and personalities involved. That said, research[13] shows that there are a lot of things that can help to make it successful. In brief:

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13   Fitzgerald M. 2005. *Benefits of multi-agency working: research study*. Unpublished report for DfES.

- Clarity of vision and purpose

- Shared goals and common targets

- Clear definition of roles

- Focus on staff development and training

- Partnership agreements between key agencies

- Appropriate referral systems

- Good and lawful information exchange

- Effective and ongoing evaluation

- Community and voluntary sector involvement.[14]

See TaMHS Implementation Guide Resource 9 *for more information on change management processes and tools.*

Change within schools

Another key element of the TaMHS project is the need for schools to engage in a whole school approach to promoting children's mental health and preventing problems. This ties in with much work already underway in schools (see Section 1.4). Moreover, schools will be familiar with programmes to effect school-wide change, for example through the remodelling work associated with implementing the National Agreement and extended schools.[15]

There are some specific issues to consider in relation to the TaMHS project. These have been highlighted by research into systemic processes to support children and young people with emotional and behavioural problems. In many cases schools will already be addressing them, for example as part of the National Behaviour and Attendance strategy. Primarily they involve **challenging and enabling teachers** to:

- see the contribution that they can make to improving behaviour and pupil wellbeing;[16]

- change their practice in the classroom in line with evidence-based behavioural methods;[17]

- work in a structured, consultative way with each other and with professionals from outside agencies (e.g. educational psychologists);[18] and to

- see the child or young person 'in the round' and as a member of a number of different, temporarily 'overlapping' systems, each with their own rules and norms (e.g. school, family, community, peers).

See Section 4 for a summary of the evidence on systemic approaches to promoting mental health and supporting children with emotional and behavioural problems.

See Section 6 for a description of a whole school approach to promoting children's mental health.

14   HM Treasury. 2005. *Exploring the role of the third sector in public service delivery and reform: a discussion document*. Available at www.hm-treasury.gov.uk
15   For more information see www.tda.gov.uk/remodelling/managingchange.aspx
16   Hayes, Hindle & Withington. Strategies for developing positive behaviour management. Teacher behaviour outcomes and attitudes to the change process. In *Educational Psychology in Practice*. 23(2): 161-175.
17   As above.
18   Farouk. 2004. Group work in schools: a process consultation approach. In *Educational Psychology in Practice*. 20(3): 207-220.

4 Evidence from research

In this section we highlight some of the key findings from the available evidence base on mental health interventions. This evidence is drawn from health, education and social care research.

What is included

We have extracted the key messages from studies which fall into one of the following three categories:

- Systematic reviews in which a proportion of studies are randomised controlled trials (colour coded red/double line).

- Single randomised controlled trials and other evaluations which use a control or comparison group (colour coded blue).

- Large, well-reviewed cohort studies on school effectiveness in relation to supporting pupils and managing behaviour (colour coded yellow).

Despite the drawbacks already discussed (see Section 2), the findings from studies such as these remain the most reliable findings available, and in many cases have been demonstrated in numerous situations.

What is excluded

Setting these criteria means we are unable to mention approaches which have not been rigorously evaluated but which may be effective. It also limits the evidence to measurable interventions and techniques, rather than ongoing processes which may involve work within a range of contexts (for example the assessment and support work which may be provided for a child at 'School Action' within the Code of Practice for Special Educational Needs).

However, the alternative approach – to include the full range of evidence, including evidence which does not explicitly demonstrate effectiveness – would have been both unwieldy and not possible within the scope of this piece of work.

We hope that our decision to include only rigorous research, while leaving scope for pathfinders to draw on their own practice-based evidence, will provide both objectivity and flexibility. This approach will be reviewed over the course of the project.

How it is presented

We consider the evidence in a range of categories, as described below.

1 **Whole school approaches (evidence to support Wave 1 of the TaMHS model)**

    – whole school frameworks

    – classroom practice

2 **Targeted approaches for children with additional mental health needs (evidence to support Waves 2 and 3 of the TaMHS model):**

    – behaviour/conduct problems

    – attachment problems

    – deliberate self-harm

    – attention/concentration problems

    – eating disorders

    – post-traumatic stress

    – anxiety and depression

    – substance misuse

3 **Targeted approaches for children in circumstances which pose a risk to mental health, for example:**

    – refugee/asylum-seeking children

    – children in families experiencing separation

    – looked after children

    – children who have been bereaved

    – young carers

A note on risk and resilience

Research over a number of decades has given us a very clear picture of the factors which place children and young people at a greater risk of mental health problems, and the factors which protect them from problems. The greater the number of risk factors present, the greater the likelihood that the child will develop mental health problems. However, not all children in this situation will develop problems; some will be more resilient than others because of other, protective factors in their life.

According to the Mental Health Foundation[19], continuing risk arises from persistent disadvantage rather than from one irreversible early effect. The likelihood of developing mental health problems is greatly increased when adverse external circumstances, adverse family relationships and particular child characteristics reinforce each other. They also note that schools have an important role to play in strengthening a child's mental health, through actions they take to limit the impact of the risk factors and promote resilience.

The therapeutic approaches discussed in this guidance all address risk or resilience factors to some extent – for example by promoting problem-solving and social skills, a positive whole school ethos, effective discipline in the home and school, and positive and supportive child/parent relationships. When selecting interventions, it is helpful to be aware of the risk and resilience factors that may influence (positively or negatively) the outcomes you are seeking to achieve.

19 Mental Health Foundation. 2002. A Bright Future for All: Promoting mental health in education. London: MHF.
    Available at www.mhf.org.uk

Risk factors	Resilience factors
In the child	**In the child**
• Specific learning difficulties	• Secure early relationships
• Communication difficulties	• Being female
• Specific developmental delay	• Higher intelligence
• Genetic influence	• Easy temperament when an infant
• Difficult temperament	• Positive attitude, problem-solving approach
• Physical illness	• Good communication skills
• Academic failure	• Planner, belief in control
• Low self-esteem	• Humour
In the family	• Religious faith
• Overt parental conflict	• Capacity to reflect
• Family breakdown	**In the family**
• Inconsistent or unclear discipline	• At least one good parent–child relationship
• Hostile or rejecting relationships	• Affection
• Failure to adapt to a child's changing needs	• Clear, firm and consistent discipline
• Physical, sexual or emotional abuse	• Support for education
• Parental psychiatric illness	• Supportive long-term relationship/absence of severe discord
• Parental criminality, alcoholism, substance misuse or personality disorder	**In the community**
• Death and loss – including loss of friendship	• Wider supportive network
In the community	• Good housing and high standard of living
• Socio-economic disadvantage	• High morale school with positive policies for behaviour, attitudes and anti-bullying
• Homelessness	• Schools with strong academic and non-academic opportunities
• Disaster	• Range of positive sport/leisure activities
• Discrimination	
• Other significant life events	

Important note

This guide is intended for headteachers and commissioners making decisions about which services are needed at a school or local authority-wide level. As such, they are making decisions for large populations of children and young people, rather than individuals.

We would like to stress that in the case of individual practice with children and young people, it is important for practitioners to recognise that all evidence-based reviews are inevitably generalisations, and will apply to a greater or lesser extent to individual children and families.

In addition, this guide is not intended to help practitioners identify which children have the kind of additional needs described here, or to decide which intervention is most appropriate for a particular child. This needs to be part of a collaborative process, drawing on relevant mental health expertise where appropriate, and based on the individual needs and circumstances of that child.

1. Whole school approaches for promoting mental health

A whole school approach is fundamental to TaMHS. This is because the way a school functions has a significant impact on a child's mental health. Factors such as the culture and environment, teaching effectiveness, pastoral care arrangements and strategies for managing behaviour all contribute to how pupils and teachers feel and behave.

There is an extensive literature on what makes an 'effective school'. This can be defined as a school that promotes the progress of its students in a broad range of intellectual, social and emotional outcomes, and where students progress further than might be expected from knowledge of their backgrounds.[20]

Much of this literature focuses on the learning process and achievement. However, as the definition above shows, school effectiveness is inextricably linked with social and behavioural elements – for example, how pupils behave towards each other and towards staff, how staff feel about their environment and how the school deals with non-academic problems that a child may be facing.

The '3 waves' model which underpins both SEAL and the TaMHS project (see pages 5 and 12) sees a consistent, whole school approach as key. It benefits all children, including those with mental health needs and problems. Indeed evidence suggests that simply providing targeted support to these children is of little benefit unless it is

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20 As defined by Professor David Reynolds for the 'High Reliability Schools' project funded by the Department for Children, Schools and Families. See www.highreliabilityschools.co.uk/Shared/SchoolEffectiveness.aspx

reinforced by efforts across the school to promote positive mental health.[21]

This section discusses the evidence for school-wide support for mental health in two related contexts:

a) whole school frameworks

b) classroom practice

a) Whole school frameworks

The sections below present evidence about interventions specifically aimed at mental health promotion or prevention of bullying (red box, double line), as well as evidence from non-experimental but large scale studies on broader issues around school effectiveness (defined as one which promotes the progress of its students in a broad range of intellectual, social and emotional outcomes – yellow box).

Strongest evidence from experimental studies supports:

- **Children aged 5 to 11:** whole school, multi-component programmes in primary schools, focusing on promoting wellbeing, social and emotional skills and positive behaviour:

  – including a classroom teaching element;
  – providing teacher training;
  – involving parents where possible; and
  – taking place within a supportive school ethos and environment.

These are central elements of both mental health promotion and anti-bullying programmes. Evidence suggests that efforts to prevent bullying may be even more effective if:

  – there is an explicit focus on improving the school culture and environment, through efforts to shape values, attitudes and behaviours which improve relationships between students, and between staff and students; and if
  – they incorporate a peer mentoring element in which peer mentors help support cultural change.

- **Children aged 11 and over:** school-based promotion and prevention programmes using a range of methods to strengthen social and emotional skills, improve relationships with adults and peers, and improve behaviour. Methods from successful programmes include:

  – providing education in social and emotional skills and life skills;
  – setting clear standards for behaviour, for example through the use of teacher and peer role modelling;
  – involving the family and the community;
  – getting involved in the community through volunteering activities;
  – offering more opportunities for personal development; and
  – recognising achievements.

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21   See Weare K and Markham W. 2005. What do we know about promoting mental health through schools? In Promotion & Education, XII, (3-4), 14-18. Available at http://eprints.soton.ac.uk/24083/

Evidence from education supports:

In relation to school effectiveness in general:

- Strong leadership from the headteacher.

- A pervasive and broadly understood focus on teaching and learning.

- A safe and orderly school learning environment or 'climate' that is conducive to teaching.

- High expectations for achievement from all students.

- Parental involvement in homework, helping in lessons etc.

- Pupil involvement (both in the classroom and within the school in societies, sports teams, leadership positions, representative positions)

- Consistency across lessons in the same subjects, across different subjects in the same years and across different years in the pupil learning experiences they offer.

In relation to managing pupil behaviour:

- A staff culture which is comfortable with looking at a child as a member of both a school system and a family system, can work with the tensions that might arise from this (particularly when other agencies are involved) and can put a 'problem-solving approach' in place. This is possible when a number of factors are in place:

  - a highly supportive and supported staff (e.g. peer support and networking between teachers)
  - strong collaboration between school personnel and external agencies, and a sense of shared responsibility
  - meetings with families and other agencies, coupled with the skills to resolve anxiety and hostility
  - opportunities to reconsider attributions for poor behaviour
  - strategies which focus on 'small steps' for parents and teachers
  - a knowledge of the principles underlying behavioural approaches.

b) Classroom practice

Classroom teaching, management and climate make an important contribution to aspects of mental health. Unlike some other aspects of a whole school approach (for example physical environment or school leadership), a limited number of comparison studies have attempted to look at the contribution that different classroom practices can make to promoting mental health. The findings on classroom practice in the red and blue boxes below are broadly in line with major educational studies which provide insights both into effective teaching and effective classroom management strategies (yellow box).

Strongest evidence supports:

- Social and emotional learning programmes:
  - an explicit programme covering social problem-solving, social awareness and emotional literacy
  - can be effective on its own, but most effective programmes take place within a whole school approach to promoting mental health, wellbeing and positive behaviour.

Evidence also supports:

- Providing explicit training to teachers to strengthen classroom management strategies, promote prosocial behaviour and reading skills and reduce aggression and non co-operation in the classroom.

- Supporting teachers to collaborate with parents to develop consistency (e.g. in expectations) between home and school settings.

- A training programme addressing these points has achieved positive outcomes, particularly when used alongside a social skills curriculum for children and parenting skills training. The training involves:

  - understanding the importance of teacher attention, encouragement and praise
  - motivating children through incentives
  - preventing behaviour problems through proactive teaching
  - decreasing inappropriate behaviour
  - building positive peer relationships and problem solving.
  - The use of 'affective' teaching used alongside 'cognitive' teaching to support mental health and promote social skills.

Evidence on effective teaching and classroom management supports:

- **Effective teaching:** having a positive attitude; developing a pleasant social and emotional climate in the classroom; having high expectations of what pupils can achieve; lesson clarity; effective time management; strong lesson structuring; the use of a variety of teaching methods; using and incorporating pupil ideas; using appropriate and varied questioning.

- More specifically, **teaching which is responsive to context.** This will depend on factors such as the type of activity in the lesson; the subject matter; the pupils' backgrounds (e.g. age, ability, sex, ethnicity); the pupils' personal characteristics (e.g. personality, learning style, motivation).

- The use of **effective classroom management techniques**:

  - classroom rules and their careful formulation and explanation to pupils
  - starting lessons promptly
  - seating arrangements which are conducive to the type of learning taking place
  - maintaining momentum and leaving sufficient time at the end for reviewing, planning and any other instructions.

- The use of **effective behaviour management strategies**:

  - defining pupil behaviour in observable terms
  - selecting target behaviours to increase
  - use of immediate teacher praise as a reinforcer
  - avoiding over-reaction
  - using effective rewards and punishments.

- Maintaining a **positive classroom climate**, characterised by:

  - teachers who are perceived as being understanding, helpful and friendly and who show leadership without being too strict (this has been found to enhance achievement as well as affective outcomes)
  - teachers who are perceived as being enthusiastic about what they are teaching
  - teachers who are perceived as having positive expectations of pupils' achievement
  - a clean and attractive physical environment, including displays of pupils' work.

2. Targeted approaches for children with additional mental health needs

In addition to a supportive whole school environment, children with additional mental health needs will need extra, targeted support.

For some children this may take the form of small group work to promote social and emotional skills, through the SEAL programme.

Other children may have more complex or critical needs. They may have been identified as needing support at School Action or School Action Plus of the Code of Practice for Special Educational Needs. Or they may have problems which are not immediately affecting their educational progress. In both cases, support of a more therapeutic nature may be necessary. This would focus on their individual situations and explore how to bring about change.

This section describes a variety of interventions which have been shown to be effective in tackling a range of specific mental health needs. In all cases it is assumed that a supportive whole school framework will also be in place, with appropriate classroom management, anti-bullying and support strategies in place (see previous section).

It is important to remember that for children and young people with multiple needs, many other providers may be involved in securing better outcomes for them and their family. Therefore an important caveat in relation to all therapeutic work is that it should not take place in isolation. Practitioners need to be working together to a common set of goals for the child and family, which have been developed in conjunction with the family and which are regularly reviewed. This is in line with good practice around using the Common Assessment Framework (CAF) to deliver services to children with additional needs.

Before each section we provide a brief description of each area of mental health need, including the way in which difficulties might be manifested.[22]

2a) Behaviour/conduct problems

Overt behaviour problems often pose the greatest concern for practitioners and parents, because of the level of disruption that can be created in the home, school and community.

These problems may manifest themselves as verbal or physical aggression, defiance or anti-social behaviour. In the clinical field, depending on the severity and intensity of the behaviours they may be categorised as Oppositional Defiant Disorder (a pattern of behavioural problems characterised chiefly by tantrums and defiance which are largely confined to family, school and peer group) or Conduct Disorder (a persistent pattern of antisocial behaviour which extends into the community and involves serious violation of rules[23]).

It is estimated that around 4% to 14% of the child and adolescent population may experience behaviour problems. Many children with attention deficit hyperactivity disorder (ADHD) will also exhibit behaviour problems. Such problems are

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22   These descriptions are drawn from a range of sources, however we would particularly like to acknowledge the series of factsheets for parents, teachers and young people produced by the Royal College of Psychiatrists and available at www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthandgrowingup.aspx

23   Brosnan and Carr, Adolescent Conduct Problems', in Carr (2000) *What Works with Children and Adolescents*. London: Routledge.

the most common reason for referral to mental health services for boys, and the earlier they start, the more serious the outcome.[24] However there is evidence to support the effectiveness of early intervention.

Interventions for primary school pupils with behaviour/conduct problems

Strongest evidence supports:

Prevention/early intervention
- Multi-component programmes comprising:

  - focus on whole school environment;
  - teaching of social and emotional skills;
  - small group sessions for children with a focus on developing cognitive skills and pro-social behaviours;
  - working with parents (see below); and
  - staff training.

Where problems have been identified
- Working with parents in a structured way to address behavioural issues:

  - education and training programmes for parents are the 'treatment of choice' for younger children with less severe behavioural problems
  - for older children (aged 8 – 12) or those with more entrenched problems, parent training programmes can be combined with interventions with the child to promote problem-solving skills and pro-social behaviours.

- Starting as early as possible, and giving a 'booster' intervention at the end of primary school if possible.

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24   Mental Health Foundation. 1999. *Bright Futures: Promoting children and young people's mental health*. London: Mental Health Foundation.

Evidence also supports:

- Well-established nurture groups to address emerging social, emotional and behavioural difficulties.

- Use of approaches which use play as the basis for developing more positive child/parent relationships or for enabling child to express themselves.

- Use of specific classroom management techniques to support primary school pupils with emotional and behavioural difficulties, including behavioural strategies using token systems for delivering rewards and sanctions (though the impact is limited to the period of the intervention itself) and changing seating arrangements in classrooms from groups to rows.

- Use of a 'self-instruction' programme for pupils with emotional and behavioural difficulties, to help children learn to manage their own behaviour.

Interventions for secondary school pupils with behaviour/conduct problems

Strongest evidence supports:

Prevention/early intervention
- Multi-component school-based programmes for older children – both universal and targeted – though their impact is greater with younger children.

Where problems have been identified
- Working with the family. Therapeutic approaches are most effective when they look at the young person in the context of their family structure and work with all family members. Individual work focusing on cognitions and behaviour can also be helpful.

- For more severe and entrenched problems, a range of tailored, multi-component interventions. In multi-systemic therapy, therapists have multiple contacts each week and deliver a range of different evidence-based services according to each family's individual needs. However while effective, this approach involves high levels of professional resources.

- For chronic and enduring problems, specialist foster placement with professional support, within the context of a broader multi-agency intervention.

Evidence also supports:

- Well-structured mentoring schemes which carefully match an adult with a young person, and which follow strict guidelines and procedures. Benefits may be greater in relation to engaging a young person in education, training and work rather than in preventing offending or substance misuse.

2b) Attention/concentration problems

Although many children are inattentive, easily distracted or impulsive, in some children these behaviours are exaggerated and persistent, compared with other children of a similar age and stage of development. When these behaviours interfere with a child's family and social functioning and with progress at school, they become a matter for professional concern.

In the educational field, these children may be described as 'hyperactive' or as having behavioural, social and emotional difficulties.

ADHD is a diagnosis used by clinicians. It is defined in the American Diagnostic Manual DSM-IV. It involves three characteristic types of behaviour – inattention, hyperactivity and impulsivity. Whereas some children show signs of all three types of behaviour (this is called 'combined type' ADHD), other children diagnosed show signs only of inattention or hyperactivity/impulsiveness.

Hyperkinetic disorder is another diagnosis used by clinicians, based on a different diagnostic manual (the ICD-10, published by the World Health Organisation). It is a more restrictive diagnosis. It is broadly similar to what, in DSM-IV, would be 'severe-combined type ADHD', in that signs of

inattention, hyperactivity and impulsiveness must all be present. These core symptoms must also have been present before the age of seven, and must be evident in two or more settings.

Strongest evidence supports:

- Use of medication, where ADHD is diagnosed and other reasons for the behaviour have been excluded.

- Introduction of parent education programme and individual behavioural therapy where there is insufficient response to medication. These need to be provided in the school as well as home, as they do not appear to generalise across settings.

- For children also experiencing anxiety, behavioural interventions may be considered alongside medication.

- For children also presenting with behavioural problems (conduct disorder, Tourette's Syndrome, social communication disorders), appropriate psychosocial treatments may also be considered.

Evidence also supports:

- Making advice about how to teach children with ADHD-like behaviour in their first two years of schooling widely available to teachers, and encouraging them to use this advice.

2c) Anxiety

Anxiety problems can significantly affect a child's ability to develop, to learn or to maintain and sustain friendships, but they tend not to impact on their environment.

Children and young people may feel anxious for a number of reasons – for example because of worries about things that are happening at home or school, or because of a traumatic event. Symptoms of anxiety include feeling fearful or panicky, breathless, tense, fidgety, sick, irritable, tearful or having difficulty sleeping. If they become persistent or exaggerated, then specialist help and support will be required.

In the clinical field, professionals make reference to a number of diagnostic categories:

- Generalised anxiety disorder (GAD)
- Panic disorder
- Obsessive-compulsive disorder (OCD)
- Specific phobia (e.g. school phobia)
- Separation anxiety disorder (SAD)
- Social phobia
- Agoraphobia

While the majority of referrals to specialist services are made for externalising difficulties, which are more immediately apparent and more disrupting, there are increasing levels of concern about the problems facing more withdrawn and anxious children, given the likelihood of poor outcomes in later life.

Strongest evidence supports:

Prevention/early intervention

- Regular targeted work with small groups of children exhibiting early signs of anxiety, to develop problem-solving and other skills associated with a cognitive behavioural approach.

- Additional work with parents to help them support their children and reinforce small group work.

Where problems have been identified

- Therapeutic approaches focusing on cognition and behaviour:

  – for children with specific phobias, generalised anxiety and obsessive-compulsive disorder (in the case of OCD pharmacological intervention may be considered alongside therapy if therapy alone is not working)

  – this should include parents where the child is under 11 or where there is high parental anxiety.

Evidence also supports:

> - Use of play-based approaches to develop more positive child/parent relationships or to enable child to express themselves have reported positive outcomes in relation to anxiety.
>
> - Psychoanalytic child psychotherapy (focusing on the 'internal' world of the child and their unconscious processes) has reported positive outcomes in single studies looking at a range of anxiety disorders. Defining features appear to be:
>
>   – weekly short-term sessions for children with less severe problems
>
>   – more frequent and longer term treatment for those with more entrenched problems
>
>   – concurrent work with parents, for younger children in particular.

2d) Depression

Feeling low or sad is a common feeling for children and adults, and a normal reaction to experiences that are stressful or upsetting. When these feelings dominate and interfere with a person's life, it can become an illness. According to the Royal College of Psychiatrists, depression affects 2 in every 100 children under 12 years old, and 5 in every 100 teenagers.

Depression is an 'internalising' difficulty, in that it can significantly affect a child's ability to develop, to learn or to maintain and sustain friendships, but tends not to impact on their environment. There is some degree of overlap between depression and other problems. For example, around 10% to 17%

of children who are depressed are also likely to exhibit behaviour problems.[25]

Clinicians making a diagnosis of depression will generally use the categories major depressive disorder (MDD – where the person will show a number of depressive symptoms to the extent that they impair work, social or personal functioning) or dysthymic disorder (DD – less severe than MDD but characterised by a daily depressed mood for at least two years).

Strongest evidence supports:

> **Prevention/early intervention**
> - Regular work with small groups of children focusing on cognition and behaviour – for example changing thinking patterns and developing problem-solving skills – to relieve and prevent depressive symptoms.
>
> **Where problems have been identified**
> - Therapeutic support
>
>   – approaches focusing on cognition and behaviour, family therapy or inter-personal therapy lasting for up to three months
>
>   – psychoanalytic child psychotherapy for children whose depression is associated with anxiety
>
>   – family therapy for children whose depression is associated with behavioural problems.

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25   Moore and Carr, 'Depression and Grief' in Carr (2000) *What Works with Children and Adolescents*, London: Routledge.

- Use of anti-depressant medication for adolescents not responding to psychological therapy within six weeks of commencing treatment. This should be combined with a longer term psychological treatment.

- The provision of clinical follow up and booster sessions to help reduce relapse.

2e) Attachment problems

Attachment is the affectionate bond children have with special people in their lives that lead them to feel pleasure when they interact with them and be comforted by their nearness during times of stress. Researchers generally agree that there are four main factors that influence attachment security: opportunity to establish a close relationship with a primary caregiver; the quality of caregiving; the child's characteristics and the family context.[26] Secure attachment is an important protective factor for mental health later in childhood,[27] while attachment insecurity is a widely recognised as a risk factor for the development of behaviour problems.[28]

The strongest evidence supports:

- Behavioural interventions with the mothers of pre-school children with attachment problems, with a focus on enhancing maternal sensitivity.

Evidence also supports:

- Use of approaches which use play as the basis for developing more positive child/ parent relationships.

2f) Eating disorders

The most common eating disorders are anorexia nervosa and bulimia nervosa. Eating disorders can emerge when worries about weight begin to dominate a person's life.

- Someone with anorexia nervosa worries persistently about being fat and eats very little. They lose a lot of weight and if female, their periods stop.

- Someone with bulimia nervosa also worries persistently about weight. They alternate between eating very little, and then binging. They vomit or take laxatives to control their weight.

Both of these eating disorders affect girls and boys but are more common in girls.

Strongest evidence supports:

- For young people with anorexia nervosa, therapeutic work with the family, taking either a behavioural or a structural approach.

- For young people with bulimia nervosa, individual therapeutic work focusing on cognition and behaviour, for example to change thinking patterns and responses.

26   Berk. 2006. *Child Development*. 7th Edition. Boston: Pearson.
27   Prior and Glaser. 2006. *Understanding Attachment and Attachment Disorders: Theory, evidence and practice*. London: Jessica Kingsley.
28   McCartney, Owen, Booth, Clarke-Stewart & Vandell. 2004. Testing a maternal attachment model of behavior problems in early childhood. *Journal of Child Psychology and Psychiatry* 45: 765-778.

Evidence also supports:

- School-based peer support groups as a preventive measure (i.e. before any disordered eating patterns become evident) may help improve body esteem and self-esteem.

- For young people with late-onset anorexia, psychoanalytic psychotherapy may be effective.

2g) Substance misuse

This section will consider therapeutic approaches which have been shown to help children and young people who are misusing drugs or other substances. It does not address all aspects of the broader health promotion issues around preventing drug misuse.

Substance misuse can result in physical or emotional harm. It can lead to problems in relationships, at home and at work. In the clinical field a distinction is made between substance abuse (where use leads to personal harm) and substance dependence (where there is a compulsive pattern of use that takes precedence over other activities).[29]

Strongest evidence supports:

- Therapeutic approaches which involve the family rather than just the individual; this assists communication, problem-solving, becoming drug-free and planning for relapse prevention.

- A variation of family therapy known as 'one-person family therapy', where families cannot be engaged in treatment.

- Multi-systemic therapy (which considers wider factors such as school and peer group), where substance misuse is part of a wider pattern of problems.

Evidence also supports:

- The introduction of skills-oriented resilience enhancement programmes in schools and other community settings, as a preventive measure.

2h) Deliberate self-harm

Deliberate self-harm is a term used when someone causes acute and intentional harm to themselves. Common examples include 'overdosing' (self-poisoning), hitting, cutting or burning oneself, pulling hair or picking skin, or self-strangulation. The clinical definition includes attempted suicide, though some argue that self-harm only includes actions which are not intended to be fatal. It can also include taking illegal drugs and excessive amounts of alcohol. It can be a coping mechanism,

29   Cormack and Carr. 2000. *Drug abuse. In What works for children and adolescents.* London: Routledge

a way of inflicting punishment on oneself and a way of validating the self or influencing others.

Strongest evidence supports:

- Brief interventions involving the family, following a suicide attempt by a child or young person.

- Assessment of the child for psychological disturbance or mental health problems which, if present, should be treated as appropriate.

- The addition of group psychotherapy for young people who have self-harmed several times.

Strongest evidence supports:

- Therapeutic support which is focused on the trauma and which addresses cognition and behaviour. It should be adapted appropriately to suit age, circumstances and level of development.

- The evidence does not support routine prescription of drug treatments for children and young people with PTSD.

- The evidence does not support the routine practice of 'debriefing' immediately following a trauma.

2i) Post-traumatic stress

If a child experiences or witnesses something deeply shocking or disturbing they may have a traumatic stress reaction. This is a normal way of dealing with shocking events and it may affect the way the child thinks, feels and behaves. If these symptoms and behaviours persist, and the child is unable to come to terms with what has happened, then clinicians may make a diagnosis of post-traumatic stress disorder (PTSD).

3.   Targeted approaches for children in circumstances which pose a risk to mental health

Some children are more vulnerable to mental health problems than their peers because of historical and current circumstances such as a chaotic or unstable home life, family breakdown, neglect, abuse, poverty or housing difficulties. Not all children facing such adversities will experience mental health problems, however in general they are more at risk than their peers. There is not a firm evidence base on mental health interventions with vulnerable children. Where there are specific mental health needs – for example depression, anxiety or behavioural problems, these children should have access to the same services that are available to other children in their locality. What may be different is the general approach to working with these children and families, to ensure that mental health interventions have the greatest chance of success. For example, they may have other, higher priority needs which need to be tackled first (for example around housing or physical health) and which require a multi-agency response. They may also need more support to access mental health services (for example they may not speak English as their first language).

The following section summarises some of the key points emerging from the literature on risk and resilience, from the practical advice offered by expert organisations and practitioners, and where possible from research evidence.

3a. Refugee and asylum seeking children and families

Refugee and asylum-seeking children and young people are particularly vulnerable to mental health problems, due to their experiences both before and after their arrival in a country of refuge. Those exposed to traumatic events commonly experience post-traumatic stress disorder, affective and anxiety disorders. In addition, factors associated with settling in a new country pose risks to mental health, for example strain in family relationships, lack of social support, adjusting to a new culture and language, bullying and racial harassment, and socio-economic difficulties.[30]

Findings from the literature

There is as yet very little research evidence into effective interventions to address the mental health needs of refugee and asylum-seeking children and families. A recent review of the available literature[31] focused on issues of risk and resilience and describes what is considered to be good practice in relation to addressing these issues. The conclusions of this review are summarised below.

● These children and families present with a range of mental health needs, as well as other (sometimes more basic) needs which require a co-ordinated multi-agency response from support services.

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30   Elliott. 2007. Interventions and services for refugee and asylum-seeking children and families in Vostanis (Ed). *Mental Health Interventions and Services for Vulnerable Children and Young People*. London: Jessica Kingsley.

31   See above.

- Practitioners should listen to the views of children and families about their symptoms, concerns and difficulties, and their explanations of the causes of these. This should influence the type of work carried out.

- Interventions require a creative, flexible and holistic approach focusing on the various presenting issues. Provided adaptations are made to take into account particular cultural and contextual issues, the main models of treatment are likely to be the same as those used for the general population.

- In relation to therapeutic interventions:

  - There are some concerns about the efficacy of trauma counselling or 'debriefing', therefore it is not recommended as standard practice (see also Section 2i).

  - 'Talking therapies' may be outside the frame of reference of those from a non-Western background.

  - The family and social networks play a pivotal role in nurturing problem-solving strategies.

  - The process of engagement and the relationship with the therapist may be more important than the specific treatment or model used. Trust and rapport is likely to facilitate exploration of difficult issues.

- Access to services may be improved if interventions are flexible in terms how and where they are delivered.

> For further reading see 'Interventions and services for refugee and asylum-seeking children and families' by Viki Elliott in *Mental Health Interventions and Services for Vulnerable Children and Young People* (Vostanis, 2007)

3b. Looked after children

Looked after children are significantly more at risk of experiencing mental health problems than their peers. An ONS study in 2004 found that 45% of looked after young people aged between 5 and 17 had experienced mental health problems, compared with 10% from private households. The most common problems were behavioural, followed by emotional disorders and hyperkinetic disorders. These statistics are not surprising given that many of the risk factors that are associated with mental health are more prevalent in the population of looked after children and young people, for example physical, emotional or sexual abuse, family breakdown, lack of stable family and community support and engagement in risk-taking behaviours.

There is a limited evidence base on what works in the treatment of mental health problems for looked after children and young people. Good practice, drawing on the available literature and the views of looked after young people, has been drawn together as part of the Healthy Care initiative for looked after children, funded by the Department for Children, Families and Schools and run by the National Children's Bureau.[32]

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32   NCB. 2005. *Mental Health: Healthy care briefing*. Available at www.ncb.org.uk/healthycare

The Healthy Care programme spoke to looked after children and young people about what mattered to them in terms of healthy care. Emotional wellbeing was the most important issue, in particular:

1. a supportive and stable living environment with caring and consistent relationships – **at least one secure attachment to an adult; a stable placement**;

2. to be included and remembered – to **overcome isolation and loneliness by being part of the communities they live in; meeting other looked after children; and being able to talk about their experience of separation from their family**;

3. opportunities to express themselves – through **play and leisure activities including sport, art and drama**;

4. support and encouragement with education – **positive school experiences improve career options, boost self-esteem and confidence and provide friendship networks and social skills**; and

5. preparation for leaving care – with **continued support and encouragement into early adulthood**.

The Healthy Care programme states that there are two key areas to focus on when promoting the mental health of looked after children and young people:

- Enabling these children to develop the resilience and the emotional and social skills they need to cope with life and prevent mental health problems – in particular by helping them feel safe and valued, through opportunities for play and participation and through the development of social and emotional skills.

- Ensuring that when mental health problems do occur, they are identified and appropriate treatment provided through good access to mental health services.

3c. Young carers

Young carers provide care, support or assistance to another family member. Research suggests that there are between 20,000 and 50,000 young carers, many of whom receive no support from statutory or voluntary services. These children are more likely to experience problems at school, isolation, lack of time for leisure activities, feelings of conflict and guilt, lack of recognition and praise, feelings of difference and problems moving into adulthood.[33] According to the Social Care Institute for Excellence[34], other studies have found that substantial numbers of young carers report mental health and related problems, such as eating problems, difficulty in sleeping, and self harm. However they note that studies have not determined how far it is their role as a young carer that is contributing to these problems, or whether other mental health and socio-economic variables are playing the principal role.

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33   Referenced in Department of Health. 1999. *Caring for Carers: A national strategy for carers*.
34   Social Care Institute for Excellence. 2005. Research briefing 11: The Health and Wellbeing of Young Carers.
     Available at www.scie.org.uk/publications/briefings/briefing11/index.asp

Services for young carers and those they care for vary from area to area. Most local authorities and health authorities have policies to identify and support young carers, based on the Children Act and the Carers (Recognition and Services) Act 1995. The Carers National Strategy highlights that young carers need:

- recognition of their role;

- support with caring tasks (so that they can attend school and do homework);

- information about the support available to them; and

- emotional support (especially someone who they can talk to about their feelings).

Most targeted, direct work with young carers tends to be delivered through young carer projects. These offer a range of direct services to young carers and their families, as well as information, advocacy and support. Some projects are managed by national organisations (such as The Princess Royal Trust for Carers, Barnardo's and Crossroads for Carers). Others are smaller local voluntary organisations. Some, though not all, have formal service agreements and core funding from local authorities.[35]

Findings from the literature

There is a lack of rigorous evidence about what works in supporting carers in general, including a lack of information in relation to mental health support. Good practice suggests that schools can play a key role in supporting young carers:[36]

- They can promote an inclusive environment, with positive messages about disability and mental illness and a specific policy on identifying carers and their needs.

- They can nominate a staff member with lead responsibility for young carers to ensure that they have the same access to a full education and career choices as their peers; and to be responsible for promoting and co-ordinating the support they need and liaising with other agencies.

- They can provide flexible and sensitive support to the young carer when their caring role is particularly stressful or making it hard for them to complete work on time. Young carers say the following would be particularly beneficial: lesson notes for missed classes; identified time with staff for catching up/extra help; support from special educational needs (if educational attainment is affected); lunchtime homework clubs and flexibility with workloads and deadlines.

- Where appropriate, they can liaise with community care or adults' services to engage more support for the cared-for person, thus reducing the need for the pupil to take on inappropriate caring responsibilities.

- They can play their role in a coherent multi-agency approach when a range of services (e.g. health, social services and housing) are involved in supporting a family.

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35 The Princess Royal Trust for Carers and the Children's Society. 2002. *Making It Work: Good practice with young carers and their families.*
36 Based on recommendations in the Carers National Strategy (DH 1999) and Supporting Pupils who are Young Carers, a leaflet produced by the Young Carers Initiative. See www.youngcarer.com

No comparative evaluations of interventions for young carers could be identified for this project. The Social Care Institute for Excellence[37] points to consistent research showing positive feedback about young carers' projects. Their research suggests that young carers believe that these projects are the only settings which value, understand and recognise their problems and experiences. They perceive the support to be voluntary and non-intrusive. However, they are not accessible to all young people across England, with many projects concentrated in the south-east and north-west of England.

3d. Children in families experiencing separation

Parental separation affects many children and their families. Each year between 150,000 and 200,000 parental couples separate. Around a quarter of all children have experienced the separation of their parents (3 million out of 12 million children).[38] Many of these will experience adjustment problems particularly in the first two years following divorce. In boys these problems are likely to manifest themselves in disruptive behaviour. Girls are likely to become more withdrawn and anxious. Both may have difficulties with school work and in their relationships with family, school and peer group.[39] Over the longer term, most children will adjust to their new situation. In a small minority of cases, there can be significant long term effects both in terms of lower achievement and ongoing relationship problems.

There are a number of risk and protective factors which have been identified as having an impact on how children adjust to divorce and separation.[40] For example, boys between three and 18 with biological or psychological vulnerabilities (low intelligence, difficult temperament, low self-esteem, lack of confidence in their ability to effect change around them) are more at risk of adjustment problems than their peers. Problems are also more likely to occur if the child-parent relationship before divorce was not a good one (for example as a result of inconsistent or neglectful parenting). The child's own beliefs about the separation, the strength of their family and social networks, and their parents' response to the divorce also affects the adjustment process. Children with good problem-solving and social skills, high self-esteem and a belief in their ability to control the things that happen to them tend to adjust better than those without. Schools also have an impact: in schools with a pupil-centred, achievement oriented ethos and high levels of contact and supervision, children are more likely to show positive adjustment following divorce.

Findings from research evidence

A number of interventions have been developed to help children and families through parental divorce or separation. Those which have been evaluated tend to be group-based interventions

37   Social Care Institute for Excellence. 2005. Research briefing 11: The health and wellbeing of young carers.
     Available at www.scie.org.uk/publications/briefings/briefing11/index.asp
38   See HM Government. 2004. *Parental Separation: Children's Needs and Parents' Responsibilities*.
39   Carr A and O'Halloran M. 2000. Adjustment to parental separation and divorce. In Carr A (eds) *What Works for Children and Adolescents. A critical review of psychological interventions with children, adolescents and families*.
40   As above.

focusing on helping the child explore and validate what they are feeling, and find strategies to think about and deal with this. A review of nine studies[41] found that:

- Psychological treatment programmes are effective in helping children and teenagers deal with divorce. They can have a positive impact on negative moods, beliefs about their parents' divorce, self-esteem, behaviour problems and relationships with family and peers.

- Effective programmes include supportive psychoeducation (opportunity to express feelings and beliefs about the divorce and to get information about coming to terms with separation), problem-solving skills training, social skills training and stress management training. A number of methods can be used, including instruction, discussion, video modelling, therapist modelling and role play.

- Effective programmes span six to 24 sessions over a six to 16 week period and may be conducted on a group basis in school or community settings.

- Effectiveness may be enhanced by including a parallel parent training module which helps the parent develop their listening and discipline skills, and helps them support the child in transferring the skills they have learnt. Research into the involvement of fathers is limited, but a specific module for fathers who do not have custody of their children may increase effectiveness.

3e. Children who have been bereaved

According to the Child Bereavement Charity, up to 70% of schools have a bereaved pupil on their roll at any given time. These children are more likely to experience depression, to have more health problems and accidents, to underperform at school, to feel that events are out of their control and to be more pessimistic about their future.[42] At the same time, however, many of these children will be able to accommodate and adjust to their loss if they receive the right help and support through their usual networks. Others will require more specialist help.

Findings from the literature

Based on a review of relevant policy and research documents, the key points for service providers can be summarised as:

- Grief is a normal part of life and many children will cope if they have the right support networks around them.[43]

- Bereavement service providers believe that children who have been bereaved need access to:

  - information and education to understand death and what it means to them
  - communication and encouragement to talk honestly within the family
  - opportunities to understand and express their grief
  - chances to meet others and share similar experiences

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41 As above.
42 Stokes. 2004. *Then, Now and Always: Supporting children as they journey through grief*. Cheltenham: Winstons Wish.
43 Findings from the Child Bereavement Charity, www.childbereavement.org.uk

– opportunities to remember the person who has died. [44]

- Schools can provide valuable support for bereaved pupils through their pastoral care systems and through their links with other agencies. More generally, schools have an important preventive role to play, in establishing a supportive school ethos and in helping pupils develop coping skills, empathy and emotional awareness.

- The government's aspirations for bereavement care[45] are that schools use the Personal, Social and Health Education (PSHE) and citizenship framework to develop policy and practice on health-related issues including bereavement; that all local agencies are able to provide information to parents about the support services available, and that local authorities and PCTs work together to plan and provide bereavement support services.

- Some children have particular needs which arise as a result of bereavement. For example some enter public care because they have lost a parent; some are bullied because of their bereavement; and some families are placed in financial difficulty and may experience housing and other problems. In these cases a co-ordinated multi-agency response is required to deal sensitively and effectively with each particular situation.

- There are a range of service models though very few have been rigorously evaluated. Many of them are community-based and offer opportunities for talking and remembering. Others offer more specialist therapeutic input. Examples of service models include:

  – group sessions for children and parents (these may be 'closed' – i.e. the same attendees each week for a set period of time, or 'open');
  – family days and remembrance events;
  – one-to-one family support, ranging from befriending to in-depth counselling;
  – pre-bereavement support;
  – residential groups for children (e.g. a weekend camp); and
  – telephone, email or web support.

Some voluntary sector organisations offer a range of these services using an 'open door' policy in which service users can remain in contact with the service, but choose their level of involvement, depending on their particular needs.

- One area in which there have been a number of control group studies is that of grief therapy. A recent US review[46] of 13 relevant studies found that, overall, the interventions did not have the positive effect that is typically expected from psychotherapeutic work with children. The study used meta-analytic techniques and it identified a number of

44   Childhood Bereavement Network, 2007. Briefing on Childhood Bereavement.
     Available at www.childhoodbereavementnetwork.org.uk/documents/GriefmatterspolicypaperOct07_000.pdf
45   As set out in the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004).
46   Currier J, Holland J and Neimeyer R. 2007. The effectiveness of bereavement interventions with children: A meta-analytic review of controlled outcome research. *Journal of Clinical Child and Adolescent Psychology* 36 (2): 253-259.

methodological and practical reasons which may explain the lack of supportive evidence.

– In the studies, the average time between the death and the intervention was one and a half years, and in some cases up to five years. Interventions which started sooner were more effective. In the other interventions, the child may have already been through their own process of adjustment

– The more successful interventions were aimed at children showing clinical levels of distress or behavioural problems. The interventions which were open to all had less of an impact. This fits with research which suggests that only a minority of children will display lasting grief complications.[47] (e.g. Worden, 1996).

– There is no agreed measure of childhood grief, which means that other positive outcomes may have been achieved in the studies, but not measured. A research framework for this area is still under-developed.

- In therapeutic work with bereaved children the following practice points appear to be important

  – There are many determinants of grief, so each child will need an individualised approach

  – There is no clear evidence on which therapeutic approaches are most effective; the relationship between the therapist and the child or family is very important

  – Many children and families welcome the opportunity to access follow up support, for example by phone or web, or the opportunity to attend events to help them remember the bereaved and share experiences with others in similar situations.

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47   See for example Worden. 1996. *Children and Grief: When a parent dies*. New York: Guilford Press.

5 How to use the evidence base in planning your services

As outlined in Section 2, the most important requirement in your planning and commissioning work for the TaMHS programme is to have a **clear, grounded rationale** for what you are doing.

By considering both your local context, available resources and desired outcomes, alongside the findings from research and your own practice-based evidence, you will have taken the necessary practical steps to deliver evidence-informed practice.

In turn, this will develop into your own local evidence base. This is a key element of the TaMHS project, with implications for the way that child and adolescent mental health services are developed and delivered in future.

Overleaf we set out a template for pathfinders to use to guide you through the process of ensuring you have a rationale for the development of your interventions.

Developing a rationale for your intervention(s)	
What is the extent of need or the target population?	What are the target outcomes for them?
What does the research-based evidence say about this area of need?	What does your practice-based evidence say about this area of need? (include information from prior evaluations in your locality on particular projects etc)
What are your existing resources (across generic CAMHS)?	How will you encourage children and families to take part? Will these methods reach the target client group? How acceptable is the intervention to them?

What is your conclusion about what to do?

If your conclusion is to use an intervention which is not supported by strong research evidence, is there a clear hypothesis linking the intervention to a specific outcome or outcomes (for example risk or protective factors for mental health)?

How will you ensure staff involved in the programme have a clear idea of the purpose and aims of the programme, in relation to mental health outcomes, and is training and supervision available if necessary?

How will you evaluate it?

6 Glossary of approaches

This section provides more information on the aims and key features of different approaches discussed in this document.

- **Whole school approaches**
- **Social and emotional learning programmes**
- **Parenting education programmes**
- **Nurture groups**
- **Behavioural approaches**
- **Approaches to change cognitions and behaviour**
- **Systemic approaches**
- **Play-focused approaches**
- **Interpersonal psychotherapy**
- **Psychoanalytic child psychotherapy**
- **Counselling**

Whole school approaches to mental health promotion

Aim: To promote the mental health of all members of the school. Different programmes will have different aims, depending on the specific needs of the school. For example, some may have a specific focus on bullying.

Guiding theory: Ecological and systemic models in which schools are seen as made of many different elements which are interconnected and interdependent. Evidence shows that the effective promotion of mental health and wellbeing requires a 'whole school approach', rather than the piecemeal adoption of strategies.

- **What it involves:** There are a number of different approaches and ways of describing a 'whole school approach'. In England the National Healthy Schools Programme (NHSP) provides a framework which many schools are adopting. It suggests that there are ten areas of activity which define the 'whole school':

  - leadership and management
  - policy development
  - curriculum planning and resourcing
  - teaching and learning
  - school culture and environment
  - giving children and young people a voice
  - provision of pupil support services

– staff professional development needs, health and welfare
– partnerships with parents/carers and local communities
– assessing recording and reporting children and young peoples' achievement.

Each of these areas influences the way that a school promotes wellbeing and addresses problems. As such it provides a useful structure for thinking about how to take forward work in this area.

This is reinforced by a 2006 research report commissioned by NASUWT which concluded that there are two key factors behind the success of school-based mental health initiatives:

● A supportive school ethos

● Requiring leadership and commitment from management level staff; high levels of participation from staff, parents and pupils; positive relationships; a commitment to equal opportunities; valuing diversity; and clear policies on behavioural expectations.

● Consistent programme implementation.

Whole school approaches to mental health promotion

The recent NICE guidance on promoting social and emotional wellbeing in primary schools made the following specific recommendations, based on the available evidence:

● All primary schools should:

– create an ethos and conditions that support positive behaviours for learning and for successful relationships;

– provide an emotionally secure and safe environment that prevents any form of bullying or violence;
– support all pupils and, where appropriate, their parents or carers (including adults with responsibility for looked after children);
– provide specific help for those children most at risk (or already showing signs) of social, emotional and behavioural problems;
– include social and emotional wellbeing in policies for attaining National Healthy Schools status and reaching the outcome framework targets; and
– offer teachers and practitioners in schools training and support in how to develop children's social, emotional and psychological wellbeing.

Social and emotional aspects of learning (SEAL)

SEAL is the DCSF programme which takes a whole school approach to promoting social and emotional skills, which underpin the emotional health and wellbeing, and which also underpin positive behaviour and learning. It proposes that these skills will be most effectively developed by pupils and staff through:

● using a whole school approach to create the climate and conditions that implicitly promote the skills and allow these to be practised and consolidated;

● direct and focused learning opportunities (during tutor time, across the curriculum, in focus groups and outside formal lessons);

● using learning and teaching approaches that support pupils to learn social and emotional skills and consolidate those already learnt; and

- continuing professional development for the whole staff of a school.

It is consistent with and builds upon the Healthy Schools approach and whole school behaviour approaches.

Whole school approaches to managing behaviour

The benefit of a whole school approach is also supported by research from Ofsted on managing behaviour in schools. This is an important aspect of promoting mental health for staff and pupils. The Ofsted report is based on findings from school inspections and findings from research. It highlights the contribution of many areas of school life to understanding and managing pupil behaviour.

- Consistency of approach by staff, driven by strong leadership
  - clear direction and support for staff
  - a positive ethos in which each pupil is valued and respected and, where necessary, learns to manage and improve their behaviour
  - regular training, focused on classroom practice, combined with in-depth appreciation of child and adolescent development
  - good use of information systems to monitor behaviour and to take speedy and effective action.

- Appropriate adaptation of the curriculum and effective teaching and learning (including a positive classroom ethos with good relationships and teamwork).

- Well-focused pastoral support and guidance; good involvement of parents and carers, where they are seen as partners rather than being blamed for the poor behaviour of their children.

- A welcoming environment to foster a sense of belonging and to reduce vandalism, including a quiet room for pupils who need to calm down.

- Support from and partnership working with other services; monitoring and evaluation, including regular tracking of behaviour and impact of efforts to manage behaviour.

How to find out more:

www.healthyschools.gov.uk/Resources/Detail.aspx?ResID=205 Access to *Whole school approach to the National Healthy Schools Programme*

http://www.healthyschools.gov.uk/Uploads/Resources/643c6a76-8190-4397-86e1-5dea280a02f9/Emotional%20Health%20&%20Wellbeing.pdf Access to NHSP *Guidance for schools on developing emotional health and wellbeing*

www.ofsted.gov.uk/Ofsted–home/Publications–and–research/Care/Childcare/Managing–challenging–behaviour(language)/eng–GB Access to Ofsted's report *Managing challenging behaviour*

www.teachernet.gov.uk/SEAL Access to the SEAL materials for both primary and secondary school.

For a more in-depth theoretical perspective, backed up by research, see Andy Miller's 1996 book *Pupil Behaviour and Teacher Culture*, London: Cassell.

Social and emotional learning programmes

Aim: to develop children's social and emotional skills through an explicit, structured whole-curriculum framework.

Guiding theory: Most programmes have their basis in research on the affective competencies variously described as emotional intelligence or emotional literacy; in longstanding experimental psychological research on empathy, social problem-solving and anger management, and in cognitive-behavioural theories.

Who is it for? Programmes are available for both primary and secondary aged children. Though aimed at the whole class, programmes usually provide opportunities for follow-up support for children with particular difficulties. This is important because children with mental health problems often have deficits in their social and emotional skills. Developing specific skills such as problem-solving, anger management and self-discipline can enable a child to think through a situation consequentially, and work out the most appropriate response. Once these skills have been learnt, they can be applied in a wide range of situations.

What does it involve? In England, the Social and Emotional Aspects of Learning (SEAL) programme has been developed by the Department for Children, Schools and Families and is available to both primary and secondary schools. SEAL provides a whole curriculum framework within a whole school approach. Primary SEAL is composed of seven whole school themes, each with an assembly to launch the theme and teaching ideas

and materials for class-based follow-up in each year group. There is an additional set of differentiated resources for small-group work with children who need extra help to develop their social and emotional skills, a set of staff-development activities and information sheets, and a set of activities for families to use at home to accompany each theme. Secondary SEAL builds on the work of Primary SEAL and includes guidance and Continuing Professional Development (CPD) materials for staff and themed learning and teaching opportunities across the curriculum.

Features of effective programmes: A 2002 review by the Collaborative for Academic, Social and Emotional Learning (Casel) identified that effective social and emotional learning programmes share the following features:

- they are grounded in theory and research;
- they teach children to apply emotional and social skills and ethical values in daily life;
- they build connection to the school through caring, engaging classroom and school practices;
- they provide developmentally and culturally appropriate teaching;
- they help schools co-ordinate and unify programmes that may be fragmented (e.g. personal, social and health education, citizenship, pupil support);
- they enhance school performance by encouraging classroom participation, positive interactions with school staff and good learning habits;
- they involve families and communities as partners to promote external modelling of emotional and social skills;

– they establish appropriate organisational structures (strong leadership, alignment with other policies etc);

– they provide staff development and support; and

– they incorporate continuing evaluation and improvement.

How to find out more: Information on the Social and Emotional Aspects of Learning programme, developed by the Department for Children, Schools and Families for schools in England is available at: www.teachernet.gov.uk/seal More general information on social and emotional learning is available at: www.casel.org

Parenting education/training programmes

Aim: Varies according to the specific programme, but in general aim to strengthen a person's skills and confidence in parenting their child (for example skills of positive discipline and relationship building). Most seek to reduce behavioural problems exhibited by the child, and to strengthen the parent/child relationship. Some seek to encourage parental involvement in their child's school experiences to promote learning.

Guiding theory: Parenting education/training programmes are generally grounded in social learning theory, in particular the assumption that many behavioural and conduct problems reflect the difficulties some parents face in reinforcing appropriate forms of behaviour, while they may also be coercive in maintaining inappropriate behaviours.[48] Some programmes follow a more relationship-focused approach, following the work of psychoanalyst Alfred Adler. Programmes originated in the US and first evaluations there took place during 1970s.

Target audience: Parents with children under the age of 12. The evidence on the effectiveness of programmes for the parents of teenagers with entrenched behavioural problems is more mixed, and suggests an individual approach looking at family structures can be more effective.

What happens: Parents are invited to attend sessions, which can be individual or group-based. The main goals of parenting education/training programmes are to enable parents to improve their relationship with their child and to improve their child's behaviour. The training component is generally based on behavioural management principles. There are many programmes commercially available which are well-evaluated and supported by a manual and/or training.

Key features of effective practice: A NICE review of parenting education programmes for the treatment of conduct disorders[49] concluded that all group-based and individual programmes should:

– be based on principles of social learning theory (includes learning from observing other people);

– include ways of improving family relationships;

– offer enough sessions (usually between 8 and 12) to be as helpful as possible for those taking part;

– help parents to identify their own parenting goals;

– include role play during sessions and homework between sessions so that parents can apply what they have learnt to their own family's situation;

– be given by people who are suitably trained, skilled and supervised, who have access to any further training they may need, and who are able to work successfully with parents to help their children; and

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48 Fonagy, Target, Cotrell, Phillips & Kurtz (2002) *What Works for Whom? A critical review of treatments for children and adolescents*, New York: Guilford Press.

49 NICE. 2006. *Parent-Training/Education Programmes in the Management of Children with Conduct Disorders*. See www.nice.org.uk

– follow the programme's instruction manual and use whatever resources are needed to ensure that the programme is followed consistently.

For all programmes used, there should be good independent evidence that they work well. Those providing programmes should make sure that support is available to help parents take part if they would find it difficult to do so otherwise.

This advice only applies to the management of children with conduct disorders who are 12 years or younger, or who have a developmental age of 12 years or younger.

The systematic review by Wolpert et al[50] of parent training for children and young people with diagnosed conduct disorders found that parent training tends to be more effective (in terms of fewer drop-outs, greater gains and better maintenance) where children are younger, and where they have a higher IQ, less severe conduct problems, less socioeconomic disadvantage, lower parental discord, higher parental global functioning and absence of antisocial behaviour in parents. This review also found that media-based treatments using parent training tapes without significant input from a therapist have only very moderate effects.

Where to find out more: There are many commercially-available parenting programmes. The Department for Children, Schools and Families has selected three to be rolled out as part of its Parenting Pathfinders – Triple P, Webster Stratton and Strengthening Families, Strengthening Communities. In addition, Parenting UK has produced National Occupational Standards for those working with parents. These are informing the development of a new set of qualifications work with parents, which will be completed in May 2008.

www.nice.org.uk/nicemedia/pdf/TA102guidance. pdf for the NICE review of parenting interventions.

www.parentinguk.org/2/standards for information on the National Occupational Standards for those working with parents.

50 Wolpert, Fuggle, Cottrell, Fonagy, Phillips, Pilling, Stein and Target. 2006. *Drawing on the Evidence: Advice for child mental health professionals*. London: CAMHS EBPU.

Behavioural approaches

Aim: To change an individual's response to problematic situations and also, where appropriate, the environmental factors which shape the behaviour. In a therapeutic situation this kind of approach is referred to as 'behavioural therapy'. In a classroom situation these approaches underpin a wide range of behaviour management techniques.

Guiding theory: The main exponent of behaviourism was the psychologist BF Skinner. His core proposition was that 'abnormal' behaviour is the result of bad contingency management, which simply reinforces inappropriate behaviours. According to behaviourism the solution is to normalise the behaviour through more appropriate contingency management.

When is it used? Behavioural approaches are used in different ways in a number of different settings. In the classroom an example of a simple behavioural approach might be a token system to reward good behaviour. More complex approaches would involve looking at the effects of school culture and family influences. Behavioural approaches are also used in the therapeutic field – for example graded exposure to situations which are feared can be helpful in treating some anxiety problems, for example phobias.

What happens? In a therapeutic setting, treatment can take place individually or in groups. It usually involves regular meetings at the same time each week. In group therapy, children experiencing similar problems meet regularly with a therapist. For some problems this can be a more effective treatment than having an individual session, because the child benefits from the experience of discovering they are not alone, and also that they will be helping others in the group. In a school setting, action may take place at a whole school, whole class or individual pupil level.

How to find out more: The website of the British Association for Behavioural and Cognitive Psychotherapies has information on different approaches and details of centres and courses around the UK. See www.babpc.com

Approaches to change cognition and behaviour

Aim: To help a person feel better and respond more positively in difficult situations, by changing their adverse thoughts and beliefs.[51] In psychotherapy, this kind of approach is referred to as 'cognitive behavioural therapy' or CBT. However, the same approach also underpins more general, non-therapeutic work with children which may take place in a classroom or small group setting, for example problem-solving or social skills development.

Guiding theory: Combines concepts and techniques from cognitive and behaviour therapies, which are common in clinical practice. Behavioural approaches (see above) aim to solve problems by changing behavioural responses and environmental factors. Cognitive approaches challenge the negative way that individuals can perceive and think about the situations that are troubling them.

When is it used? Approaches which aim to change cognitions and behaviour are used in a number of different settings.

- As a therapeutic approach with children and young people with specific problems, it is used in the treatment of behavioural problems, anxiety, depression and bulimia. Where clinical disorders have already been identified, the specific intervention will need to be delivered by a qualified practitioner.

- In school settings, the techniques associated with cognitive behavioural approaches can be used to support the development of children's social and emotional skills. For example through problem-solving, anger management and social skills development. These techniques can be learnt by non-specialists and applied in work with individuals and groups of children.

- Problem-solving skills training (PSST) has been described as 'the treatment of choice' for pre-adolescents with behavioural problems.[52] It can also be effective for younger children aged 4 to 8, by complementing work undertaken with parents in parenting programmes.

What happens?

- Cognitive behavioural therapy can be offered to individuals or in a group. It focuses on current problems and difficulties rather than attempting to explore problems and situations from the past. It generally takes a problem, event or stressful situation as the starting point and explores the thoughts that arise from this, and in turn the physical and emotional feelings that arise from these thoughts, as well as the behavioural response. The therapist works with the individual to consider if these thoughts, feelings and behaviour are unrealistic or unhelpful; and how they interact with each other. Then the therapist

51   Definitions draw on Department of Health (2001) *Treatment Choice in Psychological Therapies and Counselling: Evidence-based Clinical Practice Guidelines*

52   Carr (2000); Fonagy, Target, Cotrell, Phillips & Kurtz (2002), *What works for whom? A critical review of treatments for children and adolescents*, New York

will help the individual work out the best ways for them to chance unhelpful thoughts and behaviour.[53]

– Skills development programmes used in a non-therapeutic context generally follow a clearly defined format which provide children with an opportunity to develop a language around emotions and the modelling, practice and reinforcement of new skills.

How to find out more: The website of the British Association for Behavioural and Cognitive Psychotherapies has information on different approaches and details of centres and courses around the UK. See www.babpc.com

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53   For a fuller description see the leaflet produced by the Royal College of Psychiatrists (2005): Cognitive Behavioural Therapy. Available at www.rcpsych.ac.uk/mentalhealthinformation/therapies.aspx

Systemic therapy

Aim: To think about the individual in the context of the wider 'system' in which they operate, in particular the family, and to use this understanding to alleviate the mental health problems being faced. As such, it is often referred to as 'systemic family therapy'.

Guiding theory: Social-ecological models of behaviour. The main therapeutic approaches respond to consistent findings from studies of crime, drug use and social exclusion, namely that anti-social behaviour has multiple determinants and is linked with the characteristics of the individual child, and his or her family, peer group, school, and community.

Who is it for? A systemic approach has been shown to work both with behavioural problems and with eating disorders. In the case of more entrenched behavioural problems, a systemic approach can be more effective than parenting programmes.

What happens? A therapist works with individuals or families and may consult more widely, for example with other professionals working with the individual or the family. In general they will actively intervene to enable people to decide where change would be desirable and to facilitate the process of establishing new, more fulfilling and useful patterns. It is often relatively short term.[54] There are a range of approaches which may be described as systemic:

- **Functional Family Therapy** (FFT) for adolescents with less severe behavioural problems. It is made up of three highly structured phases, each of which involves assessment and intervention components: (1) Engage and motivate; (2) Change behaviour: reduce and eliminate the problem behaviours and their associated family relational patterns; (3) Generalise changes: increase the family's capacity to use community resources adequately.

- **Multi-Systemic Therapy** (MST) is a family and community-based treatment programme for young people with complex clinical, social, and educational problems such as violent behaviour, drug abuse and school exclusion. MST therapists work in close partnership with the young person's family and community to strengthen protective factors known to reduce the risk of future offending and anti-social behaviour. Highly intensive, therapists have low caseloads and work with families over 3-6 months to provide around 60 hours of support.

How to find out more:

http://www.fftinc.com/

http://www.cabinetoffice.gov.uk/social_exclusion_task_force/multi_systemic.aspx

http://www.mstservices.com/

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54   Department of Health (2001), *Treatment Choice in Psychological Therapies and Counselling: Evidence-based Clinical Practice Guidelines*.

Interpersonal therapy (IPT)

Aim: To alleviate mental health problems such as depression and to improve social and interpersonal functioning.

Guiding theory: The NICE guideline on depression[55] regards IPT as a 'branch' of cognitive behavioural therapy (see page 63). It is a brief, structured, supportive therapy linking recent interpersonal events to mood or other problems, paying systematic attention to current personal relationships, life transitions, role conflicts and losses.

Who is it for? It has been shown to be effective primarily in the treatment of depression and eating disorders.

What happens? IPT will typically last for 12 to 16 sessions. According to the UK IPT Network, the therapist structures the work in three main phases. They specify goals for each stage and propose a range of strategies for achieving these. The first phase involves assessment, looking both at symptoms and at the interpersonal context. The overlap between the two guides the decision on what to focus on during treatment (phase two). This may be one of four areas: interpersonal dispute, interpersonal role transitions, grief and interpersonal deficits. The final phase focuses on ending the therapy and moving on.

How to find out more: The website of the UK Interpersonal Psychotherapy Network has information on IPT (primarily for treating depression) and details of centres and courses around the UK. See www.iptuk.org

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55   See British Psychological Society. 2005. *Depression in Children and Young People. Identification and management in primary, community and secondary care.* National Clinical Practice Guideline commissioned by NICE.

Psychoanalytic child psychotherapy

Aim: To alleviate mental health problems through an understanding and exploration of the individual's inner world (for example motivation and drives) and subconscious processes.

Guiding theory: This broad school of therapy was pioneered by early psychologists such as Sigmund Freud, Carl Jung and Alfred Adler. The method was initially applied to children by Melanie Klein and Anna Freud. Psychoanalytic theory explains an individual's behaviour in terms of their past experiences, instincts and inner drives. The relationship with the therapist is central in effecting change.

Who is it for? It is used with children with internalising disorders (for example depression, anxiety) as well as for other problems such as eating disorders and post-traumatic stress disorder. Parallel work with parents is important, and the number of sessions needs to be geared to the needs of the individual.

What happens? Child psychotherapists are trained within the psychoanalytic tradition to be aware of unconscious processes, as well as being familiar with systemic thinking, with attachment and child development research and the findings of neuroscience. Involvement with a child or young person may range from a few meetings as part of an assessment, to work over a longer period of time (sometimes two years or more). The structure of the sessions will vary from therapist to therapist. The therapeutic relationship is central to the process. It develops through play or talk, and aims to provide an opportunity for the child to understand themselves, their relationships and their established patterns of behaviour. Psychoanalytically-based treatments may include group psychotherapy, family work, consultation and brief psychotherapy.

How to find out more: The Association of Child Psychotherapists is the professional organisation for child psychotherapy in the UK. Its website provides brief information on psychoanalytic psychotherapy and has links to research and to other organisations: www.acp.uk.net

Counselling

Aim: To promote mental health by giving individuals an opportunity to explore and draw on their own emotional resources to gain a greater sense of wellbeing and overcome difficulties.

Guiding theory[56]: For each type of psychological therapy there is a form of counselling (e.g. cognitive behavioural counselling or psychodynamic counselling). While some use the terms 'counselling' and 'therapy' interchangeably, others locate them on a continuum, where therapy deals with 'disorders' while counselling focuses more on mental health promotion. This means that counsellors may often work with individuals whose needs are less severe. In practice, most counsellors are influenced by humanistic, process-experiential and psychodynamic principles. Their work tends to be general, however some will work with specific needs and problems, for example, bereavement or relationship counselling.

Who is it for? Humanistic counselling approaches – which focus on capabilities such as creativity and personal growth – are used to treat a range of problems. While the evidence base is limited, many schools have school counselling services which they value. In particular, children and young people appear to welcome the opportunity to talk to someone in confidence who will listen to them and give them the opportunity to talk through their problems.

What happens? Counselling is a very wide-ranging term and the process varies depending on the approach being followed and the needs being addressed.

To find out more: The British Association for Counselling and Psychotherapy has a Counselling Children and Young People division. For more information see www.ccyp.co.uk

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56   As described in Department of Health. 2001. *Treatment Choice in Psychological Therapies and Counselling.*

Nurture groups

Aim: To alleviate emotional and behavioural problems by providing the missed learning and nurturing experiences of a child's earliest years.

Guiding theory: Many children with emotional and behavioural difficulties often show emotions and behaviours that are developmentally inappropriate. Egocentrism is a characteristic of normal infant behaviour. To progress from this state and gain the social competence required in primary school, the child has to go through a nurturing process which equips them with the ability to meet their individual psychological needs through social interaction, through means that are compatible with the needs of others. This process is essential to healthy psychological development in general, promoting understanding and regulation of behaviour, formation of relationships and communication with others.[57] They were first developed in the 1970s in inner London, and now exist in several parts of the UK.

Target audience: Children in the lower years of primary school. They may be children who feel insecure in school or who are in need of more teacher attention than can be provided in their main class. Sometimes the children are described as being withdrawn or as having behavioural, emotional or social difficulties.

What happens? The group takes place in a room in the main school, but is separate to the classroom. The group is supported by two members of staff who themselves model positive social interaction and co-operation. There is an explicit and uniform daily routine. Periods of intensive interaction with individual pupils are balanced with periods of group instruction. The day is structured in line with the standard school day. Pupils share break times with other pupils in the school.

Key features of effective practice: There are a number of features shared by those implementing nurture groups:[58]

- the practical day-to-day work of the group is rooted in an understanding of the developmental needs of children, the interdependence of social, emotional and cognitive factors, and a commitment to the fostering of positive healthy development
- the work of the nurture group should be fully integrated into mainstream school and LEA policies and structures, so as to avoid the danger of groups becoming an exclusionary form of provision
- children's admission to, progress in, and eventual departure from the group should be informed by the use of appropriate diagnostic and evaluative tools, such as the Boxall Profile.

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57 Cooper and Whitebread. 2007. The effectiveness of nurture groups on student progress: evidence from a national research study. In *Emotional & Behavioural Difficulties* 12(3).

58 As identified by Cooper and Lovey. 1998. Early intervention in Emotional and Behavioural Difficulties: the nature and value of nurture groups. *European Journal of Special Needs Education* 14(2): 122-131.

There are four basic models currently in operation which call themselves 'nurture groups'. These are:

- the 'classic' model as developed in the 1970s by Marion Bennathan and Marjorie Boxall;

- new variant nurture groups which follow basic principles but may structure day/timings differently;

- groups using the title but which are structured very differently – e.g. after school or lunchtime groups; and

- 'aberrant' nurture groups which use the name but which are a vehicle for containment rather than development.

Where to find out more: www.nurturegroups.org

Play-focused approaches

Aim: To alleviate problems by using play rather than speech as the primary medium of exchange between child and therapist.

Guiding theory: There are two main forms of play therapy – directive and non-directive – each of which has their own theoretical starting point. **Directive play therapy** is grounded in the belief that an individual's main drive is towards 'relatedness' – i.e. forming relationships with other people – and that their personality develops as a result of their interactions with others. **Non-directive play therapy** is grounded in the person-centred approach of American psychologist Carl Rogers who believed that the person being treated is best able to explore and understand their problems, and that the role of the therapist is to encourage and clarify, rather than interpret or advise.

Who is it for? Most play therapy is carried out with younger children. The evidence base is still limited.

What happens? In **directive play therapy**, the focus is on the interactions and relationship between the child and the adult. This may be the therapist, or the parent guided by the therapist. Toys and other materials are generally not used. The child plays with the parent and/or therapist, with the adult using their expressions, voice, touch and physical presence to elicit a playful response from the child. The therapist may guide the parent to respond effectively to the child during the activities. In **non-directive play therapy** the activities are initiated by the child themselves, within certain behavioural parameters set by the therapist. The focus is on providing a space for the child to explore their conscious and subconscious feelings. Materials and equipment are available for the child to use (this may include toys, games, arts equipment, sandtrays, masks, music, puppets).

How to find out more:
Information and links for **non-directive play therapy** is available from the British Association of Play Therapists at www.bapt.info/professionalinfo.htm

A form of **directive play therapy** is Theraplay, which was developed as part of the well-evaluated Head Start programme that began in Chicago in the 1960s. Further information is available at www.theraplay.org. In the UK, Family Futures are licensed to provide training. See www.familyfutures.co.uk/services/training/theraplay.html

Peer support

Aim: To help pupils with social and emotional problems through befriending, listening and support.

Guiding theory: Young people are often inclined to turn to their peers to discuss concerns, worries and problems. Giving young people the opportunity to develop basic communication and listening skills means that they can support their peers with confidence and skill.

Target audience: Used mainly in secondary schools. As yet there is no evidence from experimental evaluations which demonstrates effectiveness. However, one effective violence prevention programme (the PeaceBuilders programme) used peer mentoring as a core part of the intervention.[59] In addition, large non-experimental studies have reported benefits for service users, peer supporters and schools (see additional reading below).

What happens? There are a range of peer support models. The Mental Health Foundation identifies three distinct models which can help young people with mental health problems: peer mentoring, peer listening and peer mediation. (Peer tutoring and peer education are two other models, used for other purposes.) They can include a number of different elements, for example

– one-to-one drop in sessions to discuss specific issues
– ongoing one-to-one work

– a playground listening service
– peer-led assertiveness skills workshops

The model you choose should be guided by the needs of the school and pupils. Introducing a peer support programme requires preparatory work and training to ensure that the school is supportive of the project and that trained peer supporters are available.

A peer support service does not take the place of professional support services from within a school or external agencies. It is supportive and preventative, reducing the likelihood of a student's problem escalating to a crisis.

How to find out more: A range of organisations run and can help to set up peer support programmes:

– The **Mental Health Foundation** publishes a two volume *Peer Support Manual* for setting up a peer listening service. It is free to download. Go to www.mentalhealth.org.uk/publications and search on 'peer'
– The **Childline in Partnership with Schools (ChiPS)** programme offers support and advice on setting up a peer support scheme, and has formed a network of schools involved in this are. A free guide to setting up a peer support programme and other resources are available at www.childline.org.uk/Schools.asp

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59   As described in in Adi, Killoran, Janmohamed and Stewart-Brown. 2007. Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools Report 1: Universal approaches which do not focus on violence or bullying. Published by NICE and available at www.nice.org.uk/nicemedia/pdf/MentalWellbeingWarwickUniReview.pdf

– The **Mentoring and Befriending Foundation (MBF)** is the national strategic body for practitioners and organisations working in mentoring and befriending. It is running a national pilot scheme with 180 schools in England.
See www.peermentoring.org.uk for more information on the project evaluation and peer mentoring in general.

Annex A Summary of sources of evidence

1a) Promoting mental health: whole school approaches

Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools. Report 1: Universal approaches which do not focus on violence or bullying **(Adi et al, 2007). Published by NICE. See** **www.nice.org.uk**

This recent review found good evidence to support the implementation of comprehensive mental health programmes implemented over a significant period of time, in which teachers receive significant training and ongoing support, parents receive support for parenting and students receive support for the development of the sort of skills necessary for mental health.

While the range of studies and variability of data made it difficult to draw sharp conclusions about the degree of effectiveness, there was sufficient evidence to provide pointers about effective practice. These suggested that whole school programmes should include curricular components, classroom management, support for teachers and support for parents. Most successful programmes adopted a whole school approach which attempts to change the school ethos and environment in some way. The components of parenting programmes which had a positive impact (usually in combination with a classroom component) included behaviour management and relationship building strategies.

The review acknowledges that the multi-component programmes evaluated in the review are likely to need adapting for UK use, however it believes that they are still widely applicable in the UK. It states that school-based interventions with similar characteristics are available in the UK but have not been the subject of robust trials. However there are a number of robust UK-developed parenting programmes and some good quality overseas programmes which have been evaluated and shown to be effective in the UK.

Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools. Report 3: universal approaches with a focus on prevention of violence and bullying (Adi et al, 2007). **Published by NICE. See www.nice.org.uk**

This companion review to the study above found that effective anti-bullying programmes comprised the same elements as effective programmes to promote mental health. In addition, it identified two studies in support of the PeaceBuilders programme which focused on changing the school ethos and environment. It aims to incorporate prosocial values and ways of behaving among children and staff into every aspect of school life. The programme also includes peer mentoring, parent advice, behaviour management by teachers and a small classroom component. While no long-term studies were available, effects were demonstrated at 2 years post implementation, as measured by teacher reports of social competence and aggression. The authors of the review suggest that putting the PeaceBuilders approach together with the components of the multi-faceted programmes including parenting education, teacher training and additions to the curriculum "is very likely to enhance effectiveness".

Positive youth development in the United States: Research findings on evaluations of positive youth development programs. **(Catalano, Berglund, Ryan, 1998). Accessed [March 2008] at http://aspe.hhs.gov/hsp/PositiveYouthDev99/**

The NICE review (above) focused on primary schools. We wanted to identify evidence relevant to an older age group as well. This meta-analysis by Catalano and colleagues looked at programmes for children and young people from age 6 up to age 20, with the average age being between 6 and 13. The authors identified 25 effective US programmes which took place in community, school, and family settings (or a combination of two or all three of these settings). School components were used in the vast majority (22) of the programmes.

The programmes addressed a wide range of outcomes for youth development yet shared common themes. All sought to strengthen social, emotional, cognitive and/or behavioural competencies, self-efficacy, and family and community standards for healthy social and personal behaviour. Seventy-five percent also aimed to improve relationships between youth and adults (develop 'healthy bonds') and increase opportunities for participation in positive social activities.

The programmes aimed at secondary-aged children used a range of methods, many of which were common across programmes. These included training in social and emotional skills (problem solving, positive relations, social development); clear behavioural standards for example through teacher and peer role modelling; parent and family involvement; parent training and volunteering activities in the community.

The study concluded that a wide range of approaches can result in positive behavioural and attitudinal outcomes and prevent problem behaviours (including drug and alcohol use, school misconduct, aggression, violence, truancy, high risk sexual behaviour and smoking).

The study highlighted two features which were generally present in the effective programmes – (a) the use of structured guidelines or manuals (curricula) that help those delivering the programme to implement it consistently from group to group, or from site to site and (b) allowing sufficient time for evidence of behaviour change to occur, and to be measured.

High reliability schools: school effectiveness research **(David Reynolds)**
See www.highreliabilityschools.co.uk/Shared/SchoolEffectiveness.aspx
See also: Muijs and Reynolds. 2005. *Effective Teaching: evidence and practice***. 2nd Edition.**
London: Sage.

The evidence on factors contributing to school effectiveness was drawn from the High Reliability Schools project led by Professor David Reynolds and funded by DCSF and CfBT (www.highreliabilityschools.co.uk). This site is based on the premise that schools are dependent upon research to ensure that they effectively support student learning, and there are significant bodies of knowledge available to help them in this endeavour. It defines a 'high reliability school' as one which promotes the progress of its students in a broad range of intellectual, social and emotional outcomes, and where students progress further than might be expected from knowledge of their backgrounds. As such, it is relevant to the concept of promoting mental health and emotional wellbeing.

The site provides access to a wide range of journal articles and other texts. The research is primarily US research from the 1970s, 1980s and 1990s, but the authors also look at UK data where this is available. It covers large scale cohort studies, international surveys and systematic reviews.

The points included in Section 1a are the key points identified by Professor Reynolds. Individual reports are all available on the website www.highreliabilityschools.co.uk .

Pupil behaviour and teacher culture **(Miller, 1996). London: Cassell**

This text uses extensive research evidence, including a national survey carried out by the author, to examine successful achievements in promoting discipline in primary schools. The author shows that primary school teachers are able to bring about positive behaviour in some of their most difficult pupils. The findings are broad and discursive, pointing to the influence of staff culture (on interactions with pupils, parents and outside professionals) as an important factor in the success of behavioural approaches.

1b) Promoting mental health: classroom practice

Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools. Report 1: Universal approaches which do not focus on violence or bullying (Adi et al, 2007). **Published by NICE. See www.nice.org.uk**

This review found reasonable quality evidence that long term programmes covering social problem solving, social awareness and emotional literacy, in which teachers reinforce the classroom curriculum in all interactions with children, are effective in the long term even when delivered alone. In addition, effective whole school programmes included the use of specific curricular components and classroom management techniques.

Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools. Report 3: universal approaches with a focus on prevention of violence and bullying (Adi et al, 2007). **Published by NICE. See www.nice.org.uk**

The multi-component programmes reviewed here all comprised a social skills development curriculum, alongside teacher training in management of behaviour and parenting education. The authors found that these programmes were effective in improving outcomes relevant to bullying, violence and mental health (as measured by observed aggression in the playground).

The Incredible Years Teacher Training Programme www.incredibleyears.com
Evaluation study reported is: Hutchings, Daley, Jones, Martin, Bywater and Gwyn (2006) Early results from developing and researching the Webster-Stratton Incredible Years Teacher Classroom Management Training Programme in North West Wales. School of Psychology, University of Wales, Bangor.

This study evaluated the Incredible Years teacher training programme, one of a series of three inter-linked training programmes (the other two are for parents and children). Its aim is to reduce conduct problems and promote children's social, emotional, and academic competence. It is classified as a 'model programme' by the Blueprints for Violence Prevention Programme at the University of Colorado (see **http://www.colorado.edu/cspv/blueprints/modelprograms/IYS.html**).

The parent training programme has been extensively and successfully evaluated both by Carolyn Webster-Stratton and her team, and in sites where it has been replicated in England, Wales, Canada and Norway. These studies have informed a number of systematic reviews which are described in Section 2a. The teacher training programme has been less extensively evaluated and replicated. Webster-Stratton has carried out two randomised control group evaluations in the US which indicated significant increases in use of praise and encouragement and reduced use of criticism and harsh discipline; increases in children's cooperation with teachers, positive interactions with peers, school readiness and engagement with school activities; reductions in peer aggression in the classroom.

In 2001 the teacher training programme was introduced in North Wales alongside the Dina Dinosaur classroom curriculum. An evaluation was carried out with the first two groups of teachers to receive the training, first to get their views on the training and second to observe them alongside a randomly selected group of teachers who had not undergone the training. The observers did not know who had received the training and who had not. They used ten measures to make the observations: six measures of teacher behaviour (including 'teacher positive', 'teacher negative', 'teacher praise') and four measures of child behaviour (child positive/negative and child compliant/non-compliant). The observations showed that trained teachers performed better then untrained teachers on nine of the ten measures, though the outperformance was only statistically significant in four of these (this may have been due to the small sample size).

Hutchings et al describe the training programme as follows: teachers are first encouraged to build positive relationships with hard to engage children and parents, using proactive strategies that achieve increased compliance, such as classroom rules, timetables, specific instructions and clear transition signals for moving from one activity to another. Next they practice strategies to increase behaviours they wish to see more of, through praise, encouragement and incentives, and to ignore inappropriate behaviours that are not disruptive to other children. Strategies to help parents to support their children's education are explored. The latter part of the programme focuses on managing non-compliance, including time-out and other consequences, and promoting children's emotional literacy and problem solving skills. The methods used include: 1) discussion about assignments and problem solving about real life situations; 2) watching videotaped examples of classroom situations to promote discussion and identify effective management principles; and 3) role-play and practice of key strategies. Teachers are set classroom assignments, such as building a connection with a challenging child, praising a difficult pupil, building a relationship with a parent, developing a behaviour plan, setting up classroom rules and developing a discipline hierarchy.

Affective teaching: a method to enhance classroom management (Shechtman and Leichtentritt, 2004). See www.standards.dfes.gov.uk/research/themes/behaviour/affectiveteaching/

In this Israeli study, researchers contrasted 'affective teaching' (which focuses on valuing student attitudes, feelings and beliefs and encouraged students to discuss their personal interests and experiences) with 'cognitive teaching' (which focuses on imparting knowledge and information). Pupils received lessons in both styles and their behaviour in each was compared. The study concluded that affective teaching encouraged pupils' personal growth, supported their mental health and promoted pro-social skills, and that it would be advantageous for teachers to include elements of affective teaching into their lessons to complement cognitive teaching.

***High reliability schools: teacher effectiveness research* (David Reynolds).**
www.highreliabilityschools.co.uk/Shared/TeacherEffectiveness.aspx
See also: Muijs and Reynolds. 2005. *Effective Teaching: evidence and practice*. 2nd Edition.
London: Sage.

The evidence on factors contributing to teacher effectiveness was drawn from the High Reliability Schools project led by Professor David Reynolds and funded by DCSF and CfBT (www.highreliabilityschools.co.uk). This site is based on the premise that schools are dependent upon research to ensure that they effectively support student learning, and there are significant bodies of knowledge available to help them in this endeavour. It defines a 'high reliability school' as one which promotes the progress of its students in a broad range of intellectual, social and emotional outcomes, and where students progress further than might be expected from knowledge of their backgrounds. As such, it is relevant to the concept of promoting mental health and emotional wellbeing.

The site provides access to a wide range of journal articles and other texts. The research is primarily US research from the 1970s, 1980s and 1990s, but the authors also look at UK data where this is available. It covers large scale cohort studies, international surveys and systematic reviews.

The points included in Section 1b are the key points identified by Professor Reynolds. Individual reports are all available on the website www.highreliabilityschools.co.uk .

2a) Behaviour/conduct problems

Mental wellbeing of children in primary education: targeted/indicated activities (Report 2).
(Shucksmith et al, 2007). Published by NICE. See www.nice.org.uk

Multi-component interventions designed for targeted groups of children suffering from conduct disorders show that improved social problem-solving and the development of positive peer relations are among the outcomes with the strongest programme effects. Two rigorous studies showed improved academic achievement as significant outcomes of intervention.

Timing may be critical. Early intervention has more impact with aggressive disruptive children, but there are also benefits in giving a booster intervention towards the end of primary education. In addition, there may be some adverse effects as a consequence of bringing aggressive hostile children together in small groups only in later elementary stages, with such groups setting up negative norms of aggressive behaviour.

Parenting programmes show positive impact, however recruitment and retention is a major challenge, even when incentives (for example, childcare and transport costs) are offered. Given a choice, parents may prefer targeted children to receive the intervention at school rather than at home.

Drawing on the evidence: advice for child mental health professionals. **2nd Edition.**
(Wolpert, Fuggle, Cottrell, Fonagy, Phillips, Pilling, Stein and Target, 2006).
See www.annafreudcentre.org/dote_booklet_2006.pdf

This guide draws on a systematic review conducted by the authors in 2002, updated in 2006. It summarises the strength of research findings about different forms of intervention, highlights the gaps that remain and draws out the implications for practice of that research which does exist. It focuses on clinical settings. In relation to diagnosed conduct disorders, it cites a range of evidence, including the following:

Parent training appears to have a positive impact on the behaviour of around two thirds of children under 10 years whose parents participate. The effects of parent training programmes are detectable in long-term follow-ups of up to four years.

Training in problem-solving skills is an effective intervention for conduct problems in children aged 8-12 years, delivered in combination with parent training.

Helping parents deal with their own problem solving as part of a programme to help their child develop problem solving skills, appears to improve both child and adult outcomes.

Mild conduct problems in children under 11 can be helped by social cognitive intervention programs, social skills training and anger management skills training. However there is no evidence for the use of these approaches on their own with more chronic and severe cases.

Parent training for conduct problems in adolescents appears to have limited effectiveness.

Evidence for the effectiveness of stand alone cognitive behavioural therapy (CBT), problem solving approaches and anger management programs for adolescents remains weak.

There is insufficient evidence to draw conclusions about the effectiveness of psychodynamic child psychotherapy.

Functional family therapy incorporating elements of cognitive behavioural approaches into a systemic model concentrating on changing maladaptive interactional patterns and improving communication and structural family therapy (also described as Family Effectiveness Training or Brief Strategic Family Therapy) have been shown to be effective in reducing behaviour problems and recidivism in adolescents who have multiply offended.

Multi-systemic therapy involving multiple interventions delivered in a planned and integrated manner, chiefly by a single practitioner working intensively with a child and family effectively reduces recidivism and improves individual and family functioning.

Therapeutic foster care has been shown to reduce the rate of recidivism, to increase placement stability in a hard to place population and to improve social skills.

***Positive youth development in the United States: Research findings on evaluations of positive youth development programs*. (Catalano, Berglund, Ryan, 1998). Accessed [March 2008] at http://aspe.hhs.gov/hsp/PositiveYouthDev99/**

The NICE review (Report 2 – see above) focused on primary schools. We wanted to identify evidence relevant to an older age group as well. This meta-analyses by Catalano and colleagues looked at programmes for children and young people from age 6 up to age 20, with the average age being between 6 and 13. The authors identified 25 effective US programmes which took place in community, school, and family settings (or a combination of two or all three of these settings). School components were used in the vast majority (22) of the programmes. It found universal and targeted programmes that were effective with all age groups, though the impact was greater with younger children.

Multi-systemic therapy. See www.mstservices.com/overview_a.pdf and www.dartington.org.uk/database

Multi-systemic therapy (MST) is an intensive home-based and family-driven intervention for 12 to 17 year olds displaying serious anti-social or criminal behaviour. Therapists see the young person and their family numerous times each week and deliver a range of different evidence-based services geared to the family's individual needs. According to the Dartington Effective Services Database (dartington.org.uk/database) there have been 14 randomised controlled trials of MST, covering more than 1300 young people. The database reports a 2005 evaluation by Schaeffer & Borduin which randomly assigned 176 young offenders to either MST or individual therapy. The participants who received MST were significantly less likely to have committed another crime (50% vs 81%) and they were sentenced to 61% fewer days of confinement in adult detention facilities and to 37% fewer days of probation as adults than the comparison group.

Functional family therapy; Blueprints Model Program at www.colorado.edu/cspv/blueprints/modelprograms/FFT.html

Functional family therapy (FFT) is a brief family-based intervention taking place typically over 12 sessions. It aims to help dysfunctional children aged 11 to 18 and their families by improving family communication skills (making it more supportive, less negative and blaming) and parenting skills. The Dartington Effective Services Database (dartington.org.uk/database) reports a quasi-experimental evaluation which showed that eighteen months after participating in the FFT programme, young people who were treated by competent therapists (i.e. as opposed to those who were not as well-grounded in the programme) differed positively from the control group in reoffending rates.

Mentoring disaffected young people: An evaluation of Mentoring Plus **(Shiner, Young, Newburn and Groben, 2004). York: Joseph Rowntree Foundation. Available at http://www.jrf.org.uk/knowledge/findings/socialpolicy/644.asp**

This study of 10 'Mentoring Plus' programmes run by Crime Concern and Breaking Barriers involved a cohort of 378 young people aged 12-19 on mentoring schemes, and a comparison group of 172 young people (though questionnaire response rates were much smaller). The programmes targeted disaffected young people and offered a one-to-one mentoring service (with a volunteer mentor recruited from the local community), a programme of education and training and a series of social activities (the Plus element). The key findings were that:

- more than half of the young people recruited onto the programme engaged with it on a monthly basis or more often;

- the programme appeared to be particularly successful in engaging those young people who were most at risk of social exclusion;

- mentoring disaffected young people was found to be a delicate, cyclical and reactive process. Many relationships did not progress beyond basic 'mundane' social interaction on to specific problem-focused or goal-oriented activity;

- evidence of impact was most marked in relation to engagement in education, training and work. Participation in the programme was associated with a heightened rate of engagement in these areas. This change was most marked in projects that were well implemented; and

- there was no clear evidence of the programme having an impact in relation to offending, family relationships, substance use and self-esteem.

Big Brothers Big Sisters of America (BBBSA); Blueprints Model Program at
www.colorado.edu/cspv/blueprints/modelprograms/BBBS.html

An evaluation of this mentoring programme assessed children who participated in BBBSA compared to their non-participating peers. After an 18 month period, BBBSA youth:

- were 46% less likely than control youth to initiate drug use during the study period.

- were 27% less likely to initiate alcohol use than control youth.

- were almost one-third less likely than control youth to hit someone.

- were better than control youth in academic behaviour, attitudes, and performance.

- were more likely to have higher quality relationships with their parents or guardians than control youth.

- were more likely to have higher quality relationships with their peers at the end of the study period than did control youth.

Support for pupils with emotional and behavioural difficulties (EBD) in mainstream primary classrooms: a systematic review of the effectiveness of interventions (Evans et al, 2003). Published by EPPI Centre, Social Science research Unit, Institute of Education.
See http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=124

This review identified five strategies that had been shown to be effective by at least one sound study (from US, Australia or UK):

1. Behavioural strategies using token systems for delivering rewards and sanctions to either the whole class or individuals within a whole class;

2. A relatively short cognitive behavioural programme, delivered outside of the classroom by a researcher to train children in self-instruction;

3. Multi-session interventions delivered by specialised personnel to help children cope with anger;

4. Multi-session social skills programme delivered by regular classroom teachers;

5. Changes in the seating arrangements in classrooms from groups to rows. Based on evidence from one sound study carried out in the UK with boys and girls aged seven to eight.

The effectiveness of nurture groups on student progress: evidence from a national research study. In *Emotional & Behavioural Difficulties* 12 (3) (Cooper and Whitebread, 2007)

This evaluation of nurture groups found that they help up to 80% of children with social, emotional or behavioural difficulties. (In the study the remaining 20% had very entrenched problems which required specialist support – e.g. autism or communication difficulties.) There were statistically significant improvements for nurture group pupils in terms of social, emotional and behavioural functioning.

Groups which had been in place for more than two years were found to be significantly more effective than groups which had been in existence for less than two years. Pupils with social, emotional and behavioural difficulties (SEBD) in mainstream classrooms improved in behavioural terms significantly better than pupils with and without SEBD attending schools that did not have nurture group provision. The greatest social, emotional and behavioural improvements took place over the first two terms, whilst improvements in behaviours associated with cognitive engagement in learning tasks continued to improve into the third and fourth terms.

Evaluating the effectiveness of Theraplay (Wettig, Franke and Fjordback, 2006) in *Contemporary Play Therapy: Theory, Research, Practice*. Edited by Schaefer and Kaduson, New York: Guildford Press

Theraplay is a directive and interactive form of play therapy focused on promoting five 'dimensions' of interactive behaviour between parent and child: structuring, challenging, stimulation, nurturing and play. This review of two controlled studies of Theraplay interventions in Austria and Germany concluded that the approach effectively reduced a range of externalising and internalising behaviours (for example attention problems, non co-operation, defiance, shyness). However the study was carried out with under 5s.

Evidence-based play therapy (D C Ray, 2006) in *Contemporary Play Therapy: Theory, Research, Practice*. Edited by Schaefer and Kaduson, New York: Guildford Press

This meta-analyses of a range of play therapy studies with a diverse range of children and young people concluded that play therapy has demonstrate its effectiveness in natural settings and with children with a range of diverse needs. It appears to be more effective for children aged seven or below.

All studies had a control or comparison group. In one study with five to nine year olds identified as lacking coping mechanisms, a child-centred play therapy intervention increased their feelings of self efficacy. In another study with children who had witnessed domestic abuse, play therapy was offered. After the intervention, children reported a higher self concept, mothers reported fewer behaviour problems and there were higher levels of physical proximity between mothers and children. Studies with adolescents did not show significant effects.

2b) Attention/concentration problems

Drawing on the evidence: advice for mental health professionals working with children and adolescents. **(Wolpert et al, 2006). Interventions to treat disturbances of attention (covering the diagnostic categories ADHD and hyperkinetic disorder).**
See www.annafreudcentre.org/dote_booklet_2006.pdf

This guide draws on a systematic review conducted by the authors in 2002, updated in 2006. It summarises the strength of research findings about different forms of intervention, highlights the gaps that remain and draws out the implications for practice of that research which does exist. It focuses on clinical settings and does not review the literature on prevention and promotion. In relation to diagnosed attention disorders, it cites a range of evidence which inform the conclusions detailed in Section 4 (2b, red box), in particular:

● Behaviour therapy has been shown to be more effective than no treatment and contributes to improvements in on-task behaviour and a reduction in disruptive and rule-breaking behaviour. Improvements from behavioural interventions in one setting do not generalise to other settings. Adding behaviour therapy to stimulant medication does not confer an additional benefit at the end of treatment, but may enable a lower dose of medication to be provided and earlier discontinuation of medication.

● Combining behaviour therapy and stimulant medication has been shown to be more effective than medication alone for children experiencing ADHD alongside anxiety.

● Adding a cognitive approach to behavioural therapy does not result in improved clinical outcomes.

● Parent training has been found to increase child compliance and reduces the time for task completion. It also appears to improve parental self-esteem and reduces parental stress. However, compliance with this approach is lower for parents with less educational attainments.

● Stimulant medication has been demonstrated to be effective and can lead to normalisation of attention, activity and impulsivity irrespective of age in 75% of treated children. It may produce mild growth suppression which is more marked in children receiving continuous treatment compared with those receiving 'holiday' breaks.

● Stimulants are beneficial if the child or young person is also experiencing conduct disorder, anxiety, generalised learning disability or specific learning disability.

Screening and interventions for inattentive, hyperactive and impulsive children (Tymms and Merrell, 2004). CEM Centre: University of Durham.
See www.cemcentre.org/Documents/PIPS/ESRCReport.pdf

This large-scale study sought to identify whether providing screening and support for ADHD could help improve pupil attitudes and behaviour.

Interventions were randomly assigned to 2040 schools and 24 local education authorities in England. School-level interventions involved naming pupils with ADHD-like behaviour, or providing evidence-based advice for teachers about how to teach pupils with ADHD-like behaviour, or both. The LEA interventions involved providing evidence-based advice on how to teach children with ADHD-like behaviour to key personnel. One treatment group received this advice with a supporting conference, the second received advice only.

There was no impact from LEA-level interventions. For school-level interventions, advice had a significant positive effect on the attitudes and behaviour of pupils with ADHD characteristics but not on their attainment levels. It also had a positive impact on teachers' quality of life. The authors concluded that providing schools with research-based advice on how to work with inattentive, hyperactive and impulsive pupils in the first two years of schooling is cost-effective and could be beneficially used on a wide scale.

Mental wellbeing of children in primary education: targeted/indicated activities (Report 2).
(Shucksmith et al, 2007). Published by NICE. See www.nice.org.uk

This systematic review excluded pharmacological interventions. It identified two studies (one from the US and one from Spain) which focused specifically on ADHD. One used a cognitive behavioural approach with ADHD children/young people, the other aimed to equip teachers to spot ADHD symptoms and respond appropriately. Neither study reported any significant degree of success. The authors hypothesised that this failure may reflect the co-morbidity of ADHD with other conduct disorders, despite its possibly different neurological basis.

2c) Anxiety

Mental wellbeing of children in primary education: targeted/indicated activities (Report 2). **(Shucksmith et al, 2007). Published by NICE. See www.nice.org.uk**

Programmes targeted at reducing anxiety disorders, which take a cognitive behavioural approach, have been transferred successfully between countries, indicating a high degree of generalisability to other settings.

Brief targeted interventions (9-10 weeks) aimed at reducing anxiety or preventing the development of symptoms into full blown disorders appear to be successful in groups of children showing the precursor symptoms associated with anxiety disorders. When parent training is combined with child group CBT there may be additional benefits for children.

Two studies of interventions aimed at children of divorce and children who are anxious school refusers show sustained benefit for children from approaches focused on changing cognitive patterns and behaviour.

Drawing on the evidence: advice for mental health professionals working with children and adolescents. **(Wolpert et al, 2006).**
Interventions to treat anxiety disorders (diagnostic categories: generalised anxiety disorder, obsessive-compulsive disorder, separation anxiety disorder, agoraphobia, panic disorders and phobias). See www.annafreudcentre.org/dote_booklet_2006.pdf

This guide draws on a systematic review conducted by the authors in 2002, updated in 2006. It summarises the strength of research findings about different forms of intervention, highlights the gaps that remain and draws out the implications for practice of that research which does exist. It focuses on clinical settings and does not review the literature on prevention and promotion. In relation to diagnosed anxiety disorders, it cites a range of evidence:

- In the randomised controlled trials of cognitive behavioural approaches, the anxiety disorder diminished in more than half the children treated.

  - there is evidence that generalised anxiety can be effectively treated using cognitive behavioural therapy
  - for children under 11 with specific phobias, in vivo exposure is particularly beneficial (in contrast to more cognitive techniques) and the support of parents has a positive effect. Brief therapeutic input (e.g. cognitive behavioural therapy, supportive psychotherapy) may only accelerate spontaneous improvement that might occur in this age group.

– in the case of school refusal, 'flooding' (a rapid return to school) can be successful but may not be more effective than 'educational support' (i.e. information about the nature and treatment of anxiety disorders, together with therapeutic listening and clarification).

Cognitive behavioural therapy for childhood anxiety disorders can be successfully delivered in a group, or family, as well as in an individual format, and it may be especially helpful if parents are included, for children under 11 and where there is high parental anxiety.

There is insufficient evidence to draw conclusions about the effectiveness of psychodynamic child psychotherapy, systemic family therapy and other psychosocial approaches.

Based on this evidence it draws a number of implications which are reflected in Section 4 (2c, red box).

The effectiveness of nurture groups on student progress: evidence from a national research study. In *Emotional & Behavioural Difficulties* 12 (3) (Cooper and Whitebread, 2007)

An evaluation of nurture groups found that they help up to 80% of children with social, emotional or behavioural difficulties. (The remaining 20% having very entrenched problems which require specialist support – e.g. autism or communication difficulties.)

There were statistically significant improvements for nurture group pupils in terms of social, emotional and behavioural functioning. Groups which had been in place for more than two years were found to be significantly more effective than groups which had been in existence for less than two years. Pupils with SEBD in mainstream classrooms improved in behavioural terms significantly better than pupils with and without SEBD attending schools that did not have nurture groups, suggesting that nurture groups may contribute to a more supportive whole school climate.

The greatest social, emotional and behavioural improvements took place over the first two terms, whilst improvements in behaviours associated with cognitive engagement in learning tasks continued to improve into the third and fourth terms.

***Child and adolescent psychotherapy: a systematic review of psychoanalytic approaches* (Kennedy, 2004). Commissioned and published by North Central London Strategic Health Authority. Available at www.nscap.org.uk/Systematic_Review_Final.pdf**

This review of the evidence base identified 32 research studies deemed to be of 'sufficiently high quality', including six randomised controlled trials. The majority of studies were undertaken with clinically referred samples rather than samples recruited for research, so the children had a range of diagnoses and problems. This suggests that the findings are likely to have relevance in a 'real world' setting.

Three of the studies included children with specific diagnoses of anxiety disorder, and a high proportion of the other studies included children with 'emotional disturbance'. Overall, the review reported evidence of improvement against a range of standardised psychiatric and psychological measures, particularly improvements in relation to the diagnosis itself, rather than improvements against other measures (e.g. social competence).

The treatment time ranged from 11 sessions to sessions over two years. The authors concluded that the combined findings suggest that younger children are more likely to improve with treatment; that children with less severe levels of disturbance appear to respond equally well to less intensive (e.g. weekly) or short-term treatment as to more intensive (e.g. 3 times weekly) or longer-term treatment. Work with parents or families alongside the individual treatment is an important component of treatment (in one study the long term outcomes were better for family therapy, and indeed deteriorated after one year for individual psychodynamic psychotherapy).

Evaluating the effectiveness of Theraplay (Wettig, Franke and Fjordback, 2006) in *Contemporary play therapy: theory, research, practice*. Edited by Schaefer and Kaduson, New York: Guildford Press

Theraplay is a directive and interactive form of play therapy focused on promoting five 'dimensions' of interactive behaviour between parent and child: structuring, challenging, stimulation, nurturing and play. This review of two controlled studies of Theraplay interventions in Austria and Germany reported that the approach effectively reduced a range of externalising and internalising behaviours (for example attention problems, non co-operation, defiance, shyness). However the study was only carried out with under 5s.

Evidence-based play therapy (D C Ray, 2006) in *Contemporary play therapy: theory, research, practice*. Edited by Schaefer and Kaduson, New York: Guildford Press

This meta-analysis of a range of play therapy studies with a diverse range of children and young people concluded that play therapy has demonstrate its effectiveness in natural settings and with children with a range of diverse needs. It appeared to be more effective for children aged seven or below.

All studies had a control or comparison group. In one study with five to nine year olds identified as lacking coping mechanisms, a child-centred play therapy intervention increased their feelings of self efficacy. In another study with children who had witnessed domestic abuse, play therapy was offered. After the intervention, children reported a higher self concept, mothers reported fewer behaviour problems and there were higher levels of physical proximity between mothers and children. Studies with adolescents did not show significant effects.

2d) Depression

Mental wellbeing of children in primary education: targeted/indicated activities (Report 2).
(Shucksmith et al, 2007). Published by NICE. See www.nice.org.uk

The review looked at five studies which aimed to prevent depression or treat symptoms of depression. Four were from the US and one was Australian. All of them used approaches based on changing cognition and behaviours. One study showed that it may be possible to relieve and prevent depressive symptoms using a targeted school-based approach where a traditional cognitive behaviour component was allied with a social problem-solving component.

Evidence from other treatment programmes with children with mild to moderate depressive symptoms is mixed. Co-morbid conditions with depression (often expressed in conduct or hyperkinetic disorders) make intervention delivery difficult and can confound treatment effects.

One study attempted to see whether a brief intervention (8 weeks) was as effective as a longer programme in producing improvements in depression scores. The trial was judged effective, but this was a non-diagnosed sample.

Interventions directed at indicated subgroups show some degree of success. A study of young people exposed to violence showed reasonable effect sizes. The programme involved a high proportion of children from black and minority ethnic backgrounds and also used trained school personnel to deliver part of the programme.

***Drawing on the evidence: advice for mental health professionals working with children and adolescents.* (Wolpert et al, 2006).**
Interventions to treat depressive disorders.
See www.annafreudcentre.org/dote_booklet_2006.pdf

This guide draws on a systematic review conducted by the authors in 2002, updated in 2006.
It summarises the strength of research findings about different forms of intervention, highlights the gaps that remain and draws out the implications for practice of that research which does exist.
It focuses on clinical settings and does not review the literature on prevention and promotion.
In relation to depression, it cites a range of evidence:

- There is a high rate of spontaneous remission amongst untreated children, although there are high rates of relapse amongst both treated and untreated groups.

- The overall evidence for the effectiveness of individual CBT is inconclusive. In some studies CBT is no more effective than waitlist or general clinical management but in other studies it has been shown to be more effective than comparison treatments (relaxation therapy, non-directive supportive therapy).

- CBT may speed up the recovery compared with no treatment and may reduce the length of the depressive episode compared with other treatments. These differential effects were not sustained at longer term follow-up although this was mainly due to ongoing improvements of comparison conditions.

- Group CBT and brief non-directive therapy may be effective treatments for mild depression.

- There is inconclusive evidence for the effectiveness of family therapy in the treatment of depression.

- Evidence from one comparison study suggested brief 30 session psychotherapy may be an effective treatment.

- Interpersonal Psychotherapy (IPT) is effective in reducing depressive symptoms although evidence in achieving remission is inconclusive. In direct comparison with CBT there was no difference in outcome between the two treatments.

From this evidence it drew a number of implications which are set out in Section 4 (2d, red box).

Depression in children and young people – identification and management in primary, community and secondary care **(British Psychological Society, 2005). National Clinical Practice Guideline commissioned by NICE. See www.nice.org.uk**

NICE has summarised the key recommended actions within a stepped approach to managing the disorder, from prevention through to treating severe depression. It recommends the following actions:

1. Detection (through risk profiling).

2. Recognition (i.e. identifying and assessing those with depression).

3. Treating mild depression (by 'watchful waiting' and through a range of approaches, for example non-directive supportive therapy, group cognitive behavioural therapy or guided self-help).

4. Treating moderate to severe depression (through brief psychological therapy plus medication as appropriate).

5. Treating unresponsive depression, recurrent depression or psychotic depression (through intensive psychological therapy plus medication as appropriate).

This is a complex guideline which should be referred to in full by practitioners working with children and young people with depression.

***Child and adolescent psychotherapy: a systematic review of psychoanalytic approaches* (Kennedy, 2004). Commissioned and published by North Central London Strategic Health Authority. Available at www.nclha.nhs.uk/publications/workforce/index.shtm**

This review of the evidence base identified 32 research studies deemed to be of 'sufficiently high quality', including six randomised controlled trials. The majority of studies were undertaken with clinically referred samples rather than samples recruited for research, so the children had a range of diagnoses and problems. This suggests that the findings are likely to have relevance in a 'real world' setting.

Five of the studies included children with specific diagnoses of depression, and a high proportion of the other studies included children with 'emotional disturbance'. Overall, there was evidence of improvement against a range of standardised psychiatric and psychological measures.

The treatment time ranged from 11 sessions to sessions over two years, and included parallel sessions with parents. The authors concluded that the combined findings suggested that younger children are more likely to improve with treatment; that children with less severe levels of disturbance appear to respond equally well to less intensive (e.g. weekly) or short-term treatment as to more intensive (e.g. 3 times weekly) or longer-term treatment. Work with parents or families alongside the individual treatment is an important component of treatment (in one study the long term outcomes were better for family therapy, and indeed deteriorated after one year for psychodynamic psychotherapy with no family intervention).

2e) Attachment

Understanding attachment and attachment disorders: theory, evidence and practice **(Prior and Glaser, 2006). London: Jessica Kingsley.**

A 2003 meta-analysis described in Prior (2006) found that interventions with an exclusively behavioural focus on maternal sensitivity appear to be most effective in both enhancing maternal sensitivity and promoting the child's attachment security. However the studies were conducted with pre-school children and the authors cited some methodological difficulties.

Statement by British Association of Adoption and Fostering.
See www.baaf.org.uk/about/believes/ps4.pdf

Attachment theory has not developed a widely applicable, evidence-based set of interventions based on current diagnostic categories. However, there are a number of important developments in attachment-based interventions which are being evaluated. **Good practice suggests that each child will need an individual care/treatment plan that identifies the nature of the difficulties and possible ways of alleviating the distress for the child and the carers and other family members. This may involve a single form of therapy or a number of approaches. Helpful approaches may include individual therapy for the child, support, training or therapy for the parents/carers, or work with the whole family.**

The most effective intervention for attachment disorders (disorders arising from lack of bonding with parents, which can have long term emotional and behavioural consequences) is prevention. Services must be available **that enable and support all parents to develop sensitive, attuned, reliable ongoing relationships** with their children from birth. Some parent/s will require intensive support to enable them to do this. When this is not possible, alternative arrangements must be made to ensure that children have at least one reliable and sensitive long-term relationship with an adult that will last as long as they need it.

2f) Eating disorders

Drawing on the evidence: advice for mental health professionals working with children and adolescents. **(Wolpert et al, 2006).**

Interventions to treat eating disorders. See www.annafreudcentre.org/dote_booklet_2006.pdf

This guide draws on a systematic review conducted by the authors in 2002, updated in 2006. It summarises the strength of research findings about different forms of intervention, highlights the gaps that remain and draws out the implications for practice of that research which does exist. It focuses on clinical settings and does not review the literature on prevention and promotion. In relation to eating disorders, it cites a range of evidence:

- Family therapy (behavioural/structural) is an effective treatment for anorexia nervosa in young people, and is more effective than individual therapy where the illness is not chronic. However, there is insufficient evidence to determine whether conjoint (patient and parents meet together) or separated (therapist meets patient and parents separately) forms of family therapy are more effective.

- Individual psychodynamic therapy shows benefit in those with late-onset anorexia and may contribute to the prevention of relapse after discharge from hospital treatment.

- Therapeutic work with adults with bulimia shows that individual therapies such as interpersonal therapy (short-term non-introspective psychotherapy), behaviour therapy and cognitive behavioural therapy may be helpful but these have been insufficiently studied in relation to children and young people for any clear recommendations to be made.

- Physical treatments for anorexia and bulimia have not been sufficiently evaluated in research studies for any firm conclusions about their effectiveness to be drawn, however clinical consensus suggests that early intervention and hospitalisation (including re-feeding) are likely to be helpful, especially for young children and those with severe emaciation (less than 70% of average weight).

From this evidence it drew a number of implications which are set out in Section 4 (2f, red box).

School-based peer support groups: a new approach to the prevention of disordered eating. (McVey, Lieberman, Voorberg, Wardrope and Blackmore, 2003) in *Eating Disorders* 11(3) pp. 169-185

This study evaluated the effectiveness of a school-based peer support group designed to improve body esteem and global self-esteem and to reduce negative eating attitudes and behaviours. The participants were aged 11 and 12; the group met for 10 sessions and was facilitated by nurses. Compared with a control group, participants reported increases in weight-related esteem and decreases in dieting. A total of 214 students were involved. However, when the support group was replicated (McVey et al, 2003b) it was found that participation in the group did not lead to the same improvements. However, participants in the second study exhibited higher disordered eating scores at baseline than those participants in the original study, which suggests that the programme may need to be matched with developmental and symptom levels.

2g) Substance misuse

***Drawing on the evidence: advice for mental health professionals working with children and adolescents.* (Wolpert et al, 2006).**

Interventions to treat substance misuse. See www.annafreudcentre.org/dote_booklet_2006.pdf

This guide draws on a systematic review conducted by the authors in 2002, updated in 2006. It summarises the strength of research findings about different forms of intervention, highlights the gaps that remain and draws out the implications for practice of that research which does exist. In relation to problems around substance misuse, it cites a range of evidence:

- Family therapy (behavioural/structural) has been shown to be superior to other treatment modalities, and has been shown to enhance the effectiveness of other approaches.

- Family psycho-education and family support groups alone have not been found to be effective.

- There is insufficient evidence to draw conclusions about the effectiveness of psychodynamic psychotherapy, cognitive behavioural therapy or behaviour therapy.

- Motivational interviewing has advantages over treatment as usual in reduction of substance misuse particularly cannabis, nicotine and alcohol.

- Comprehensive community-based treatments, such as multi-systemic therapy (which include family therapy), have been shown to be effective in reducing substance misuse.

- Prevention approaches that include dealing with resistance skills, psychological inoculation, and personal and social skills training have been shown to significantly improve knowledge and to reduce drug use for periods of over one year. The unique contribution of each component in these types of multi-component therapy has not been established. However, psycho-educational programmes delivered to the general child/adolescent population have been found to be ineffective.

From this evidence it drew a number of implications which inform the summary presented in Section 4 (2g, red and blue boxes).

2h) Deliberate self harm

Drawing on the evidence: advice for mental health professionals working with children and adolescents. **(Wolpert et al, 2006).**
Interventions to treat deliberate self-harm. See www.annafreudcentre.org/dote_booklet_2006.pdf

This guide draws on a systematic review conducted by the authors in 2002, updated in 2006. It summarises the strength of research findings about different forms of intervention, highlights the gaps that remain and draws out the implications for practice of that research which does exist. It focuses on clinical settings and does not review the literature on prevention and promotion. In relation to eating disorders, it cites a range of evidence:

● Clinical consensus suggests that all children who self harm should be assessed by a professional with specialist child mental health training.

● There is evidence that approaches focusing on prevention of further suicide attempts may not be effective where the young person also has depression.

● Brief intervention (problem solving) with families of adolescents following a suicide attempt can improve adolescents' feelings of depression and suicidality, enhance positive maternal attitudes towards treatment and reduce subsequent use of residential and foster care.

● The limited number of trials comparing treatment as usual with enhanced care (involving 24 hour access to services) have not clearly demonstrated the advantages of the latter in terms of reduction in incidence of suicide attempts.

● School based interventions can improve knowledge and attitudes amongst young people towards disclosure of self harm by their peers, but have not been shown to increase help seeking amongst high risk groups (in particular young men and those who have already self-harmed).

● Schools based programmes that inadvertently "glamorise" self harm e.g. via use of inappropriate materials, may increase self harm rates.

● There is evidence that for adolescents who have repeatedly self harmed, the addition of group therapy to treatment as usual reduces the likelihood of repetition.

● The method of self harm amongst young people already referred to a specialist service does not necessarily indicate seriousness of intent (e.g. self cutting does not necessarily mean less serious intent than other forms amongst this population of young people).

From this evidence it drew a number of implications which are set out in Section 4 (2h, red box).

2i) Post traumatic stress

Drawing on the evidence: advice for mental health professionals working with children and adolescents. (Wolpert et al, 2006).
Interventions to treat post-traumatic stress disorder.
See www.nclha.nhs.uk/publications/workforce/index.shtm

This guide draws on a systematic review conducted by the authors in 2002, updated in 2006.
It summarises the strength of research findings about different forms of intervention, highlights the gaps that remain and draws out the implications for practice of that research which does exist.
It focuses on clinical settings and does not review the literature on prevention and promotion.
In relation to PTSD, it cites a range of evidence:

- A number of studies, particularly in children aged 7 and over who have been sexually abused, suggests that individual trauma focused CBT delivered to children and young people with PTSD may be of value.

- Delivering CBT to the mother as well as the child does not appear to lead to any benefit over treatment of the child alone in regards to the PTSD symptoms. However CBT for the mother only has been shown to reduce severity of PTSD symptoms in the child at 2 year follow up.

- Studies with adults suggest trauma-focused CBT within the first month may be beneficial if symptoms are severe.

- Two studies indicate Eye Movement Desensitisation and Reprocessing (EMDR) may be effective, but further studies are required.

- A number of randomised controlled trials with adults and one with children have found that 'debriefing' (providing a systematic, brief, single session intervention focusing on the traumatic incident shortly after the trauma) does not lead to clear benefit in comparison to no treatment.

- There is insufficient evidence to draw conclusions about the potential effectiveness of psychodynamic child psychotherapy, systemic family therapy and multi-modal therapy.

- There is no conclusive evidence that drug treatment is beneficial for PTSD in children.

From this evidence it drew a number of implications which are set out in Section 4 (2i, red box).

Annex B Summary of the theoretical framework for Primary SEAL

1.   The stimulus for the development of the Primary SEAL programme was the growing evidence base from the US on the impact of social and emotional learning (SEL) on a range of areas including school achievement, and the Government's wish to draw together preventative work on mental health and work to tackle behaviour issues in schools. The programme needed to integrate developments in schools in anti-bullying work and citizenship, with work on tackling racism and promoting positive approaches to diversity, with the emotional health and wellbeing strand of National Healthy Schools Programme, and with the developments in teaching and learning spearheaded by 'Excellence and Enjoyment' (the Government's strategy for primary schools).

2.   Existing programmes were reviewed and their core principles were identified. These were used to guide the development of the SEAL programme and include:

- a holistic approach which recognises the importance of the school environment for developing social and emotional competencies

- a focus on staff development for the adults involved

- quality pro-active first teaching for all pupils, which also helps those usually targeted using 'deficit' support models

- explicit teaching of skills, using teaching methods that are participative and experiential rather than didactic

- the involvement of parents and the community

- starting early and taking a long-term developmental approach through a spiral curriculum in which key learning is constantly re-visited.

3.   The materials were developed around the five emotional intelligence domains of empathy, self-awareness, managing feelings, motivation and social skills. The materials are structured so that there is developmental progression of the social and emotional skills addressed in each of the five domains.

4.   These five competencies are aligned alongside cognitive skills (enquiry, problem-solving, creative thinking, information processing, reasoning, evaluation, communication) in the eleven aspects of learning that underpin the Primary National Strategy's core professional development resources for schools.

5.   SEAL, like most of the existing US programmes, has its basis in research on the affective competencies variously described as emotional

intelligence or emotional literacy (Salovey and Mayer, popularised by Goleman); in long-standing experimental psychological research on empathy (Feshbach), social problem-solving (Spivack and Shure) and anger management (Novaco), and in cognitive-behavioural theories (Bandura, Kendall). However, there are some key similarities and differences. They are:

Key similarity between SEAL and existing programmes

- A focus on empathy , emotional awareness and regulation, anger management and social problem solving

Key differences between SEAL and existing programmes:

- An additional focus on managing uncomfortable emotions other than anger – for example anxiety, responses to bereavement and loss, coping with change

- An explicit focus on skills children need to be effective learners – working in groups and teams, managing attention and concentration, persisting in the face of difficulty, bouncing back after setbacks, setting goals and working towards them

- An explicit focus on valuing others and responding to diversity, and on reducing bullying.

Because it aims to develop children as learners as well as to reduce aggression and improve behaviour, SEAL adds substantial work on motivation to the empathy, emotional awareness and regulation, and social problem solving that form the core of transatlantic programmes. It also adds work on awareness of oneself as a learner, appreciation of multiple intelligences and, from social psychology, developing the skills needed to work effectively in groups and teams.

Theoretical base shared with US programmes	Sources
Labelling , understanding and regulating feelings	Joseph LeDoux , Antonio Damasio, Mark Greenberg
Relationships between thoughts, feelings and action	Aaron Beck, Albert Ellis
The development of empathy	John Mayer and Peter Salovey, Carolyn Zahn-Wraxler
Anger management	Raymond Novaco
Calming down	Joseph LeDoux
Conflict resolution , negotiation	Morton Deutsche, Roger Fisher and William Ury, John Burton, Marshall Rosenberg
Interpersonal problem-solving	Myrna Shure and George Spivack , Roger Weissberg

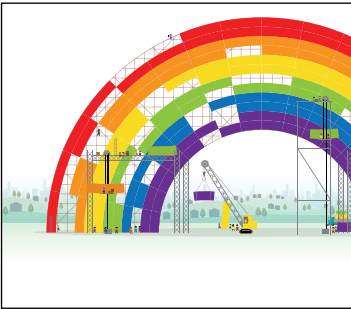| Theoretical base additional to SEAL	Sources
Promoting optimistic states, fixing faulty thinking patterns, positive self-talk	Antonio Demasio, Martin Seligman, Aaron Beck, Albert Ellis, Catherine Corrie
Solution focused brief therapy	Steve de Shazer
Collaborative group work	Art Costa, Robert Slavin, David and Robert Johnson
Creating a classroom environment that meets fundamental human needs	Abraham Maslow
Theories of bullying – victim, bully, bystander	Anatol Pikas, Dan Olweus, Peter Smith
Assertiveness, I messages, peer pressure and conformity	Thomas Gordon, Peter Wyman, Philip Zimbardo, Stanley Milgram
Communication skills – active listening skills, non-verbal communication	Carl Rogers, Michael Egan, Michael Argyle
Perspective taking, theory of mind	Simon Baron-Cohen
Intrinsic and external motivation	Carol Dweck
Resilience and resourcefulness	Guy Claxton
Multiple intelligences, habits of mind, making wise choices	Howard Gardner, Art Costa, Robert Sternberg
Assessment for Learning	Paul Black and Dylan William
Attribution theory and self efficacy: locus of control, learned helplessness	Fritz Heider, Harold Kelly, Edward Jones, Lee Ross, Carol Dweck
Responses to change and loss	Kurt Lewin, Michael Fullan, Elizabeth Kubler-Ross, John Bowlby
Philosophy for children	Matthew Lipman
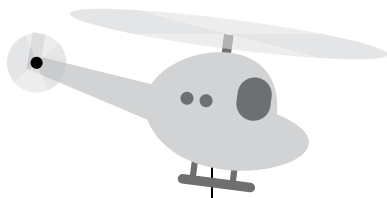
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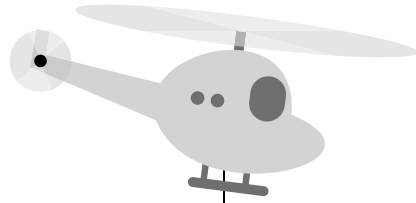
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