Children and young people’s emotional resilience evidence review.  
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Introduction
Young people’s emotional and psychological health is crucial, in its own right and also as it greatly impacts on physical health as well as social and economic outcomes. As a result, research carried out on children and young people’s resilience supports that good social, emotional and psychological health helps build their resilience and protect young people against emotional and behavioural problems, violence and crime, teenage pregnancy and the misuse of drugs and alcohol (NICE, 2008).

Resilience is defined as achieving positive outcomes in the face of adversity, coping successfully with traumatic experiences and avoiding negative paths linked with risk (Alvord and Grados 2005). Protective and risk factors are therefore essential components of resilience, helping in the promotion of positive outcomes and reducing negative outcomes (Ferguson and Zimmerman, 2005).

This review aims to explore the evidence base for building emotional resilience among children and young people, aged 5 – 19, focusing on factors and interventions that help build children and adolescents’ resilience.

Literature search and sources
This review is based on a structured literature search strategy supplemented by identifying research from the reference lists of published studies. The following electronic databases were searched for relevant journal articles: the Cochrane Collaboration, the Campbell Collaboration, AMED, Embase, Health and Psychosocial Instruments, HMIC, ERIC, Medline, PsycEXTRA, PsycINFO, SCIE, as well as internet searches on Google, Department for education, C4EO, National Foundation for Educational Research (NFER), CfBT and NCB (National Children’s Bureau). No restrictions were placed on date of publications.

The search terms were: children, adolescent resilience, emotional mental wellbeing, protective factors, resilience interventions, and related terms. The review included evidence from randomised controlled trials, evidence based guidelines such as NICE guidelines, systematic reviews and meta-analysis and evaluations of interventions. Case studies that have not been evaluated were excluded and studies from developing countries were excluded due to the lack of population comparability with the UK, West Sussex population. Majority of the evidence found in this review is based on interventions and studies that were conducted in the USA and some evaluations of UK interventions.

Summary of evidence
The evidence on resilience has highlighted different protective factors are instrumental in building emotional resilience. Protective factors are defined as variables that offset, or buffer against, the effects of risk factors. In short, resilience is inhibited by risk factors and promoted by protective factors and therefore, resilience is optimized when protective factors are strengthened at an
ecological level (individual, family and community) see appendix 1 (Alvord & Grados, 2005). Consequently, interventions that strengthen protective factors in children and adolescents promote positive appropriate responses, building their emotional resilience, and fostering mental wellbeing. Young people's social and emotional wellbeing is influenced by a range of factors, from their individual make-up and family background to the community within which they live and society at large and therefore, an understanding of risk and protective factors that nurture children and youth’s resilience is essential in order to improve and support resilience in children.

This review found the following evidence in promoting children's emotional resilience

- School based interventions that adopt a whole school approach have been evidenced to be more effective compared to classroom based interventions.
- Content of interventions: Principles of SEL are proven to be effective in building children's resilience and also programs that provide multi-component and with interactive element.
- Parental/ family engagement is crucial for the success of programmes to promote emotional wellbeing. Parental engagement involves parent training and involvement in children’s learning activities and group activities.
- Faith has been identified as protective factor and therefore, interventions that support young people's access have been recommended.
- Taking a universal approach that focuses on preventing difficulties by developing social and emotional wellbeing for all, not just targeting those who have been identified as having problems.
- Integrating carefully targeted interventions into more general approaches, for example by reinforcing small-group learning through classroom activities.

**School based interventions**

There is strong evidence that schools have a crucial role to play in building young people’s resilience and that interventions that adopt the whole school approaches have been more effective (Rooney et al 2013, Rivers et al 2012, NICE 2009, Durlak 2011). Research shows that the most effective way to ‘narrow the gap’ for the at risk children is to address the barriers to learning and to support emotional resilience together. Initiatives to address these issues should be embedded within schools’ wider initiatives for all children and young people (Dyson et al, 2010).

Wells et al (2003) conducted a systematic review to assess whether school-based mental health promotion interventions that take a universal approach have shown a positive impact in improving young people’s mental health and to identify attributes that are common to successful school-based mental health promoting interventions adopting a universal approach. Three interventions were reviewed; 1) whole school approach interventions that involved all teachers and students, in the addition to changing some aspects of the social environment of the school and involving the wider community; 2) classroom-based interventions that were confined to changes in the curriculum or changes in the classrooms teacher’s approach; 3) interventions
that extended beyond the classroom to other parts of the school but that did not meet the criteria for being a whole-school approach. Of all the 17 controlled studies included, only 3 reached more than 70% of positive outcomes measured. The two interventions specifically designed to promote mental health showed a higher proportion of positive outcomes than other programmes, including programmes to prevent mental health problems. The two programmes that adopted a whole-school approach or a beyond school approach showed a higher percentage of positive results (95% and 100%). The evidence highlights the effectiveness of programmes that take a whole-school approach, aimed at promotion of mental health as opposed to prevention of mental health.

Targeted Mental Health in Schools (TaMHS) is a three-year pathfinder programme aimed at supporting the development of innovative models of therapeutic and holistic mental health support in schools. It is aimed at children and young people aged 5–13 who are at risk of, and/or experiencing mental health problems. It also aims to support the families of children and young people who are at risk. The TaMHS Evidence-Based Guidance highlights that there is strong evidence to support whole school approaches in promoting wellbeing, social and emotional skills and positive behaviour of young people. School-based promotion and prevention programmes that use a range of methods to strengthen social and emotional skills, improve relationships with adults and peers, and improve behaviour have been effective in children aged 11 and over (Department for Children, Schools and Families, 2010).

NICE guidelines (2008, 2009) also recommend whole school approach interventions to support and develop young people’s emotional and social wellbeing in secondary and primary schools. In addition, a review by C4EO recommended that the success of school based interventions depends on implementing the programmes in the context of a whole-school environment that supports social and emotional skills (C4EO 2010). The national Social and Emotional Aspects of Learning (SEAL) initiative demonstrates that whole school and small group teacher-led interventions in schools are effective in improving and protecting children’s mental health and wellbeing (Adi et al, 2007; Humphrey et al, 2008).

A systematic review by Wilson et al (2001) of environmentally and individually focussed school interventions shows evidence to support the effectiveness of school-based prevention practices in reducing risk factors such as alcohol, drug misuse and other behavioural problems, however the magnitude of effect of the outcomes is small.

**Components of effective programs**
Features common to the programs/interventions reporting a positive impact on emotional wellbeing included the implementation of cognitive behaviour programs that aimed at improving self-esteem and social and emotional learning (SEL). Such programs, for example, FRIENDS, RULER, AUSSIE OPTS reported increased self-esteem, lower levels of anxiety, depression and emotional distress (Stallard et al 2005, Durlak et al 2011). A meta-analysis by Durlak et al (2011) showed that social
emotional learning programs had a positive impact across skill, attitudinal, behavioural, academic domains for the students who received the interventions compared to the control groups.

Targeted Mental Health in Schools (TaMHS) reports that there is a strong evidence base on the effectiveness of social and emotional learning programs that are explicit, covering social problem-solving, social awareness and emotional literacy. It also highlighted that SEL programs can be effective on their own, but most effective programmes take place within a whole school approach to promoting mental health, wellbeing and positive behaviour (Department for Children, Schools and Families, 2010). Targeted early interventions during the early school years may be critical to maintain competencies of resilient children and to overcome the initial vulnerabilities of other children. Based on their study on children of adolescent mothers, Weed et al (2006) found that children of adolescent mothers were more likely than children borne of adult mothers, to have trouble meeting age appropriate expectation in cognitive, academic and psychosocial domains. They reported that children who may have benefitted from early intervention do not receive services until the risks are transformed into specific academic or behavioural problems that often surface once children begin formal schooling around age 5. The research results indicated that only 15% of the children who were experiencing problems in at least one critical domain of functioning at the start of schooling had met age appropriate expectations in cognitive, academic, and psychosocial domains by age 8, and that many who had begun school with adequate levels of competence showed marked deficiencies over the early elementary years.

Stallard et al (2005) evaluated FRIENDS for life, a cognitive behavioural therapy programme for primary and secondary schools to promote emotional resilience and prevent anxiety. The 10-session programme was led by classroom teachers with special training and aimed to promote self-esteem, problem solving, self-expression and positive relationships with peers and adults. An evaluation of its use with children aged 9–10 years in a UK primary school found that FRIENDS resulted in reduced anxiety in 92% of participating children, and significant improvements in over half those with the most severe emotional problems (Stallard et al,2005). Moreover, the programme was rated acceptable by 89% of the children, 81% thought it was fun, 77% would recommend it to a friend and 72% thought they had learned new skills. Nearly half (41%) said they had since helped someone else with their new skills.

PATHS stands for Promoting Alternative Thinking Strategies. It is a long-term (up to 60 sessions), classroom-based programme designed to improve primary school children’s emotional literacy, self-control, social competence, positive peer relations, and interpersonal problem-solving skills. The main aim is to prevent or reduce social, emotional and behavioural problems by helping pupils become more self-aware and have a positive attitude to life and school. PATHS lessons are taught at least twice a week for a minimum of 20-30 minutes. Teachers receive training in
a one day and two half-day workshops and can be supported through regular
teacher support group meetings. The curriculum programme also includes
information and regular homework tasks to involve parents and encourages them
to use at home the strategies and vocabulary of feelings their children learn in the
classroom. PATHS was evaluated (Greenberg et al, 1995; Adi et al, 2007), and is
recommended in NICE guidance (NICE, 2008). A three-year pilot programme in six
primary schools in West Lothian also found improvements in behaviour scores,
literacy and numeracy in participating children.

Challen et al (2009) evaluated the UK Resilience Programme is the UK
implementation of the Penn Resiliency Program (PRP), a US well-being programme
that has been trialled more than 13 times in different settings. Thirteen controlled
trials have found PRP to be effective in helping protect children against symptoms
of anxiety and depression, and some studies have found an impact on behaviour.
However, the research on PRP has reported some inconsistent findings, and a
meta-analysis of the PRP research, which includes both published and unpublished
research, found mixed results across studies (Brunwasser, Gillham & Kim, 2009).
Some studies found no effect on depressive symptoms, while others found an effect
on some groups but not others. The UK resilience program pilot reported some
improvement in depression scores and absence from school in the intervention
groups, however, this improvement had faded by one year follow up. The
evaluation also found that the impact of intervention varied by pupil characteristics.
Pupils who were entitled to free school meals; who had not attained the national
targets in English or maths at Key Stage 2; or who had worse initial symptoms of
depression or anxiety were all more likely to experience a larger measured impact
of the workshops on their depression and anxiety scores, particularly girls with
these characteristics. The impact for these groups was also less likely to have faded
by the one-year follow-up (Challen et al 2009).

Evidence in this review suggests that prevention programs with an active learning
component such as homework, and also parental engagement have a greater effect
on participants (Stice et al 20 and Durlak et al 2011, and C4EO 2010). In addition,
the NICE (2008, 2009) guidelines for primary and secondary school children
recommends curriculum approaches that integrate relevant activities into social
and emotional skills, working with parents and families. SEL programs that followed
the Sequenced Active Focused Explicit (SAFE) approach had more significant
outcomes compared to those that did not follow SAFE practice(Durlak et al 2011))

**Family involvement and community support**

Poor parenting is a well-established risk factor for mental health problems in
childhood. NICE (2008, 2009) guidelines recommends partnership working with
parents, families and carers to promote young people’s social and emotional
wellbeing. A C4EO review of evidence also recommended that interventions to
improve young people’s behavioural and emotional outcomes are more likely to be
effective when parental engagement is ensured (C4EO 2010). Such a holistic
approach emphasizes on the context of young people’s lives and their home and socio-economic environments that impact on their emotional and mental wellbeing. Out of school environment’s impact on young people is supported by evidence from longitudinal study on risk, resilience and recovery by Werner (1993). The study found that characteristics and care giving styles of parents/carers were identified as protective factors for those children who were resilient. In addition, the resilient children had the opportunity to establish a close bond with at least one care giver (Werner 1992). This is also supported by a study carried out by Weed et al (2006) which found that resilience was lower in those children of adolescent mothers with high maternal adversity. This suggests that parental/family engagement is key to strengthening young people’s protective factors and thereby building their emotional resilience.

NICE (2008) guidelines and research evidence on parental engagements in building young people’s resilience and emotional wellbeing supports the implementation of parenting programs and supporting parents, carers and other family members, especially in high risk groups, to fully participate in activities to promote social and emotional wellbeing and also reinforce young people’s learning (NICE, C4EO 2010). NICE guidance also recommends group parenting sessions for the parents or carers of these children, run in parallel with the children’s sessions.

Brody 2004 conducted a randomized controlled trial, contrasting families who took part in the Strong African American Families Program (SAAF), a preventive intervention for rural African American mothers and their 11-year-olds, with a group of control families. Under the SAAF programme, these families were randomly assigned to either the SAAF programme or to a control group. Compared with control group families, parents and youths in the intervention group reported larger changes in communicative parenting and protective factors that reduce risk factors of early onset of sexual activity and alcohol use (Brody 2004). The outcome of Brody’s study also supports evidence that youth protective factors can be strengthened through interventions that promote communicative parenting.

Evidence to support parental engagement has also been reported by Beardslee et al (2003) in an investigation of family centred primary prevention study of children who are at risk for depression and other psychopathology because of parental mood disorder. Beardslee et al (2003) evaluated the impact of a program that targeted the family as a unit and aimed to reduce risk factors and enhance protective factors for the children by increasing positive interaction between parents and children and by increasing understanding of the illness for everyone in the family. The prevention approaches were designed to provide information about mood disorders to parents, to equip them with the skills they need to communicate information to their children and to open a dialogue with their children about the effects of parental depression. The study reported that the internalizing score for all children decreased with increased time since intervention, with a larger impact in the clinician-facilitated program. However, the study lacked methodological rigor and therefore should be taken with caution.
Another protective factor identified in this review and is associated with positive mental wellbeing for young people is church membership. The role of the church or faith has been recommended by NICE to ensure young people have access to pastoral care and support if required. The role of the church/faith has also been supported by Werner and Smith’s study which found religious faith characterised many of the resilient youth in the high risk groups. In addition, this review also found that there is evidence to support that young people’s ability to build relationships with adults is instrumental in improving emotional resilience. Werner and Smith (1992) longitudinal study found that resilient boys and girls sought and found emotional support outside of their own family. They relied on an informal network of kin and neighbours, peers and elders, for counsel and support in times of crises. Many had a favourite teacher who became a role model, friend, and confidant for them.

The National Institute for Health and Clinical Excellence (NICE) recommendations for effective interventions to promote children’s social and emotional wellbeing in primary schools (NICE, 2008) include: provision of specific help for those children most at risk (or already showing signs) of social, emotional and behavioural problems; training and support for teachers and practitioners in schools in how to develop children’s social, emotional and psychological wellbeing; training for teachers and practitioners to identify and assess early signs of anxiety, emotional distress and behavioural problems among primary schoolchildren, and refer for specialist help where appropriate; problem-focused group sessions delivered by appropriately trained specialists in receipt of clinical supervision; and group parenting sessions for the parents or carers of these children, run in parallel with the children’s sessions.

THE EVIDENCE

Reducing depression in 9-10 year old children in low SES schools: A longitudinal universal randomized controlled trial (Rooney et al 2013)

 Subjects: 910, 9-10 year old students from low socio-economic status schools were recruited. 12 schools were randomly selected from the largest and poorest schools in the West Australian districts of Swan and Canning. Each of the 12 schools selected was matched to another school from the same district in terms of SES, class size, and school size. 22 matched schools agreed to participate. 467 children in the intervention group and 443 in the control group. The mean age of the students was 8.75years and no significant between group differences in age, gender and ethnicity.

 Design: Longitudinal randomized controlled trial.
**Intervention:** the Aussie Optimism: Positive Thinking Skills Program (AOP: PTS) designed to meet the needs of children in middle primary school. The revised program in the study included 10 weekly 60-min sessions, based on cognitive behavioural principles.

Programme content:
- Module 1 Introduction and planning for fun activities
- Module 2 Identifying feelings and being BRAVE
- Module 3 Feelings, situations and thoughts
- Module 4 The thought feeling connection
- Module 5 Helpful and unhelpful thinking
- Module 6 Looking for evidence and thinking positively e Brave
- Hierarchy steps begin
- Module 7 Think before you sink
- Module 8 Challenging situations and thinking the worst
- Module 9 Best, worst and most likely outcomes
- Module 10 Being positive

The intervention was implemented by classroom teachers, with all children in the classroom participating. The control group received their regular Health Education curriculum.

**Measures:** Within schools, consenting Year 4 students were assessed on four occasions: Pre-test, post-test, 6-month, 18-month follow-ups. Students completed questionnaires on depression, anxiety, and attribution style using the CDI (children’s depression index), Spence children’s anxiety scale (SCAS), Children’s attributional style questionnaire (CASQ) and the Diagnostic interview for children and adolescents IV (DICA-IV). At risk students were further assessed with the computerised Diagnostic Interview for Children and Adolescents. Parents reported on their children’s externalising and internalising problems at home.

**Results:**
Children in the intervention condition reported a significant pre-test to post-test reduction in depressive symptoms, and there was a significant pre-post reduction in parent-reported emotional difficulties which was maintained at 6 month follow-up. The control group showed similar significant decreases between post-test and the 6-month follow-up, and between the 6-month and 18-month follow-ups however, the control group showed no significant change between pre-test and post-test.

Both groups showed significant improvements in child-reported anxiety and attribution style, and significant improvements in parent-reported pro-social behaviours. For both groups, there were no significant post-baseline changes in incidence and recovery rates for depression, anxiety, or internalising symptoms.

The AOP-PTS did not significantly impact on anxiety, attribution style, parent-reported prosocial behaviours, or incidence and recovery rates for depression, anxiety, or internalising symptoms. The intervention reduced depressive symptomatology for children from low socio-economic backgrounds at post-test.

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Overview
The Notre Dame Adolescent Parenting project is a longitudinal project that followed a sample of adolescent mothers and their children from the prenatal period through adolescence. The study is posited on the belief that resilience to adversity during the early years establishes a pathway toward competence that is resistant to adversity encountered later in development. This research aimed to:

1) investigate the stability of resilience from the age 5-8 in a sample of children born to adolescent mothers based on the;
2) explore the moderating effect of maternal adversity on stability;
3) investigate maternal and child variables as predictors of resilience at age 8; and
4) Identify maternal and child variables related to change in resiliency status between age 5 and age 8.

Country/area: India, USA

Sample
A sample of primiparous adolescent mothers was selected from the participants of Notre Dame Adolescent Parenting Project (NDAPP), an on-going longitudinal study. The majority of the participants (81%) were from a moderate-sized town in the Midwest, with a smaller subsample (19%) from a rural community in the Southeast. Most (68%) of the sample was African American, with 8.5% Mexican American, and the remaining 23.6% European American. 54.7% of the children were male. The average age of the adolescent mothers was 17.1 (SD = 1.27) years, with a range from 14 to 19.5, when their first child was born. Eight-year follow-up data were available for 109 of the 143 dyads (76%), who remained in the sample at the time of the five-year follow-up. Due to missing data on some of the measures, the analysis was based on 106 dyads with complete data.

Methods
All participants were seen in a university laboratory setting when their children were 5 and 8 years of age. Mothers and children participated in several joint activities, and were subsequently interviewed separately. Mothers completed a life history questionnaire, a measure of social support, and several measures of psychosocial adjustment. Children completed a variety of cognitive and achievement tests. The sessions lasted approximately 3 hours and mothers were paid for their participation. Children received a small gift for their participation.

Competence at ages 5 and 8 was assessed by performance in the domains of intelligence, adaptive behaviour, and psychosocial adjustment. Reading skills were included at the 8-year assessment. Age-appropriate expectations were considered as scores within one standard deviation of the mean. All measures used to assess child competence were standardized instruments with demonstrated reliability and validity.

Outcomes
68% of the children maintained the same status over time. Changes in status were more likely in a negative direction

Approximately 38% of the 5-year-old children met the criteria for resilience, achieving age-appropriate scores on intelligence and adaptive behaviour
assessments, with no evidence of psychosocial adjustment problems. None of the 5-
year-old children with problems in all domains met expectations in more than two
domains at age 8.

At age eight, 25% of the children met the resilience criteria, with age-appropriate
expectations in all four domains of intelligence, adaptive behaviour, psychosocial
adjustment, and reading. 30% showed evidence of problems in one domain,
approximately 18% with problems in 2 domains, 21% with problems in 3 domains
and 7% failed to meet all expectations in any of the 4 domains.

9.4% of the children showed positive changes and were reclassified as resilient at
age 8, and 22.6% showed evidence of decline from resiliency at 5 to vulnerability at
8.

Significant stability was achieved for children from high adversity environment with
78% congruent in resiliency status at ages 5 and 8. Although much of this stability
was accounted for by children retaining their vulnerable status, 12.5% of vulnerable
children in high adversity environments improved their status, and 44.4% of
resilient 5-year-olds maintained their resilient status.

63% of children from low adversity environment were stable in their resiliency
classification. Negative change was observed even with a more supportive maternal
environment, with only 45% of the resilient 5-year-old children maintaining the
same status at age 8.

Change in level of maternal adversity was included as a maternal predictor.
Consistency in level of maternal adversity was observed for 61% of the sample,
positive change was observed in 24%, and negative change in 15%.

Intelligence at age 5 was the strongest predictor of children's resilience three years
later. The odds ratio for intelligence at age 5 suggests that an increase of 1 point
on the WISC-III increased the likelihood of resiliency by 1.13 times.

Of the 40 children classified as resilient at age five years, 24 had significant
problems in one or more areas of development by age 8 and were subsequently
reclassified as vulnerable. Children who were reclassified as vulnerable at age 8 had
significantly lower intelligence scores at age 5 than those who remained classified
as resilient and mothers whose level of self-esteem declined over time. In contrast,
children who retained their resilient status had mothers whose level of self-esteem
increased.

In high maternal adversity—including anxiety, depression, or low self-esteem and
limited educational or occupational successes—only 22% of the children were
resilient. In contrast, the percentage of resilient children rose to over 53% in
environments characterized by low maternal adversity.

Fifty-six of the 66 children classified as vulnerable at age 5 retained their vulnerable
status 3 years later. The authors reported that the analyses indicated that
intelligence scores at age 5 were the only significant predictor of 8-year resiliency
status.

Key findings
Findings supported some past research suggesting children born to adolescent mothers are more likely than children of adult mothers to have trouble meeting age appropriate expectations in cognitive, academic, and psychosocial domains.

**Evidence grading: 2-**


**Overview**
The study aims to explore variables that promote resilience in children and adolescents. Resilience defined in the term of being competent despite exposure to stressful life experiences. In search of the factors that moderate the effects of stress, the study focused on personal attributes of the child - Intelligence; Locus of control; Social skills; Ego development – and the frequency of positive life events. The second objective of the study was to examine whether resilient children have elevated levels of symptoms such as depression and anxiety, despite their profiles of superior adjustment on behavioural measures of competence.

**Country:** Connecticut USA

**Sample**
The sample consisted of 144 (62 boys, 82 girls) adolescents enrolled in an inner city public school. Mean age of the sample was 15.3. In the school sampled, students were placed in five "gate" levels, with curricula of varying difficulties. For the study, students were drawn from 10 ninth-grade classrooms with two classes randomly selected from each of the five gate levels. Majority of the students were from low SES families and minority groups, 45% Blacks and 30% Hispanics.

Complete data were obtained for 83% of the students enrolled in the classes sampled. Of the 29 students who were not included, 11 were excluded because of incomplete data, two did not want to participate, and 16 were absent throughout the days of data collection.

**Methods**
Cross sectional study

Variables such as family size, ethnicity and household composition were self-reported. Parents’ education and occupation was reported by the parents. Competence, locus of control, social skills, intelligence, ego development, positive life events and measures of internalizing symptoms were all measured using rating scales and questionnaires.

Data for each student were collected during three 45-min class periods allocated for English, on three consecutive days. Testing of the children was done in groups of 10 to 20. Questionnaires were administered in the same order to all the groups, with relatively structured, nonthreatening measures administered at the beginning and end of each session.

**Outcome**
Internality and social skills showed some protective functions. Positive events and intelligence were involved in vulnerability processes, with school grades and sociable, respectively, as criteria.

Increasing levels of stress showed a sharp decline on the intelligent children’s social skills as compared to the less intelligent children who showed relatively little change.

In comparison to children with an internal locus of control, those with an external orientation showed greater declines in functioning with increasing stress levels.

Of the six types of social skills investigated in the study, social expressiveness was significant in protecting against stress.

At high levels of stress, intelligence was involved as a vulnerable mechanism rather than being a protective factor. At low stress levels, intelligence was positively related to competence for school grades as well as classroom assertiveness. When stress was high, on the other hand, the intelligent children appeared to lose their advantage and demonstrated competence levels more similar to those of less intelligent children.

Ego development was found to be a compensatory factor, correlated with school grades, classroom assertiveness, and classroom disruptiveness.

Children identified as resilient had higher scores on depression and anxiety measurements than did participants who were also high in competence but were from low-stress backgrounds.

Evidence grading 2-


Overview
Review examined the current literature on strengths and resilience with the aim of developing an understanding of positive life outcomes for children and youth within the contexts of children’s mental health, child welfare, youth justice and substance use.

The literature search
A systematic search of the current literature published between 2000 and 2010 was conducted using a variety of academic databases.

11 studies were included in the final review.

The Quality Assessment Tool for Quantitative Studies, which was developed by the Effective Public Health Practice Project (EPHPP 1998), was used to critique the 11 included studies.
Literature was ranked according to the robustness of the study design, controlled confounders, blinding, reliability and validity of data collection, attrition rates.

Based on the EPHPP tool, three studies met the high quality quantitative standards, six studies met the moderate quality quantitative standards, and two studies met the low quality quantitative standards.

**Outcomes**
The common themes of the above studies seem to include personal competency, coping strategies, social competency, pro-social involvement and cultural identity. Across the contexts of mental health, substance use, youth justice, and child welfare populations, personal competency, including higher reported self-esteem, self-efficacy, or optimism, was determined to be a strength, promoting positive development in children and youth.

*High quality studies*

**Barrett et al:** conducted a non-randomised controlled clinical trial of a project called FRIENDS, which is a cognitive-behavioural program that aims to build strengths by developing protective factors through social and emotional learning. At the end of the program, children reported an increase in self-esteem, improvements for expectations for the future and a decrease in anxiety symptoms from pre- to post assessment. High school students reported reduced levels of anxiety, depression, anger, post-traumatic stress, and dissociation from pre to post. Both elementary and high school comparison group participants reported no change in self-esteem or hopelessness and an increase in anxiety symptoms from pre- to post assessment.

**Cox:** Randomised controlled trial examining the impact of the strength-based assessment approach by administering the Behavioural and Emotional Rating Scale (BERS) to children and adolescents who had severe behavioural or emotional problems and it also looked at the impact of therapist’s orientation, based on a therapist’s Strength-Based Orientation (SBO) score, toward strength-based practice on proximal and distal outcomes.

The results revealed that youth in the BERS guided assessment condition did not make significant improvements in functioning compared to the usual assessment. However, youth in the intervention group demonstrated statistically significant treatment gains when their therapist was highly strengths-oriented.

**Shelton:** conducted a quasi-experimental evaluation of the Leadership, Education, Achievement and Development (LEAD) program. LEAD is a community based program aimed at developing awareness of self, improved communication skills, self-control, reduction of risk behaviours and development of self-esteem in minority youth involved with the juvenile justice system.

The outcome of the 3 year study showed statistically significant differences for the LEAD group compared to the control group.

*Moderate quality quantitative studies*

**Shek et al:** randomised controlled trial of the Positive Adolescent Training through Holistic Social Programs (PATHS) in Hong Kong high schools aimed at promoting positive youth development.
The results using the Chinese Positive Youth Development Scale (CPYDS) showed that the experimental group performed better than the control group on global indicators of bonding, resilience, social competencies, and self-determination.

**Stewart and Sun:** Cohort analytic comparison group study design, evaluating a health promoting school intervention approach aimed at facilitating the development of resilience and prevent depressive symptoms in primary school children in China.

There were significant differences between pre and post intervention groups on subclinical depression symptoms. Researchers also reported a negative relationship between depression and resilience, with higher levels of depression associated with lower levels of resilience.

**Noether et al:** quasi-experimental design study examining the effects of a standardized intervention model on children’s resiliency with mothers having co-occurring mental health and substance use disorders and histories of interpersonal abuse. The intervention model for the experimental group was composed of three components: (1) a clinical assessment, (2) service coordination and advocacy, and (3) a 12-session psycho-educational skills-building group that met once a week.

At 6-months when mothers were having positive outcomes so did their children regardless of group, however, experimental children improved slightly more. When mothers had negative outcomes, control children fared significantly worse. At the 12-month follow up, the mothers’ outcomes no longer played a role; children in the intervention group were having stronger and more significant positive outcomes.

**Barton et al:** Evaluated the Youth Competency Assessment (YCA) inventory at a secure youth detention and treatment centre. The YCA is an assessment tool designed to create new types of service plans, to aid in treatment and goals and to encourage the development of positive, pro-social behaviours.

Overall, a positive shift in behaviour and climate took place over the 6-month implementation of the YCA. The researchers demonstrated that the YCA is a promising strength based assessment tool that can be beneficial to youth assessment and treatment in juvenile or substance treatment settings if accompanied by shifts in treatment orientation.

**Pierre et al:** Examined the effectiveness of a multi-component after school programs aimed at reducing later substance use and enhancing protective factors. The intervention has three components: SMART kids, SMART teachers and SMART parents. The SMART kid program consisted of a 3 hour after school program each day that included homework assistance, after school educational activities, recreational activities, and a 10-week prevention curriculum that aimed to enhance youth’s social and personal competencies. The teacher and parent components targeted the academic and social needs of the program (experimental) children, such as helping parents and teachers support students’ academic success and school bonding.

Results showed positive effects of the program upon children’s personal competency skills, including refusing wrongdoing, solving peer and school
problems, showing courteousness to teachers, and behaving ethically compared to controls. Positive effects were recorded for the children receiving the program regarding feelings towards school and spelling grades.

**Belcher et al:** looked at the effectiveness of the Preventing the Abuse of Tobacco, Narcotics, Drugs and Alcohol (PANDA) curriculum with African American Head Start pupils. The study was a prospective cohort design with a pre and post intervention.

The program was favourably received by teachers who showed high satisfaction and resulted in improvements in self-concept in the experimental group compared to the control group.

**Weak quality quantitative studies**

**Osterling and Hines:** an exploratory study evaluating the effectiveness of the Advocates to Successful Transition to Independence (ASTI) program, which was designed to train mentors to facilitate adolescent foster youth in gaining the life skills required to transition successfully from foster care into adulthood. The study ran for two years with two phases containing both qualitative and quantitative data collection.

Qualitative results presented four common themes: (1) the nature of the relationship with the advocate to be helpful and supportive that offered encouragement and consistency, (2) changes experienced including interpersonal gains (open with feelings and less angry), completing tasks and getting into trouble less, (3) all youth reported an increase in their independent living skills (obtaining a job, saving money, and opening a bank account), (4) youth were satisfied with the program and liked how advocates were more hands on.

**Place et al:** Looked at the effectiveness of a supportive package called Strength to Strength that aimed to increase resilience in children with parents that have depression. The sample consisted of 20 families referred by mental health professionals. The intervention consisted of psycho-educational sessions aimed to help increase knowledge, relieve guilt and anxiety, and dispute false beliefs about their parent’s depression. Family sessions using narrative therapy techniques were held to focus on family strengths and potential, rather than on the problems faced by the family. Lastly, a skills development session focused on strengthening a child’s resilience elements such as self-esteem, social skills, problem-solving skills and independence.

Overall, the study highlighted some positive results of a resilience package to help children with parents with depressive symptoms.

**The evidence**

Since the studies included in the review did not compare a strengths and/or resiliency intervention to another form of intervention, the review was unable to conclude that the positive results are due specifically to the implementation of a strengths intervention.

**Evidence grading 1-**

Overview
This report presents findings from the UK Resilience Programme (UKRP) evaluation, commissioned by the Department for Education. The aim of the program was to improve children’s psychological well-being by building resilience and promoting positive thinking. It was delivered to Year 7 pupils across 22 secondary schools in three local authorities (South Tyneside, Manchester and Hertfordshire), who opted to become involved in the programme. The evaluation aimed to investigate whether the programme has an impact on children’s well-being, attendance and academic attainment.

The program was evaluated/followed up at 3 different times and this evaluation is the final evaluation of the program, looking at the same cohort of pupils reported in the 2 previous reports and examine the impact of the programme at the two-year follow-up point in June 2010.

The UK Resilience Programme is the UK implementation of the Penn Resiliency Program (PRP), a US well-being programme that has been trialled more than 13 times in different settings. Thirteen controlled trials have found PRP to be effective in helping protect children against symptoms of anxiety and depression, and some studies have found an impact on behaviour. However, the research on PRP has reported some inconsistent findings, and a meta-analysis of the PRP research, which includes both published and unpublished research, finds very mixed results across studies.

PRP is a manualised intervention comprising 18 hours of workshops. The curriculum teaches cognitive-behavioural and social problem-solving skills. Central to PRP is Ellis's Activating-Belief-Consequences model that beliefs about events mediate their impact on emotions and behaviour. PRP participants are encouraged to identify and challenge (unrealistic) negative beliefs, to employ evidence to make more accurate appraisals of situations and others’ behaviour, and to use effective coping mechanisms when faced with adversity. Participants also learn techniques for positive social behaviour, assertiveness, negotiation, decision-making, and relaxation.

Country: UK, 3 pilot localities (Tyneside, Manchester and Hertfordshire)

Sample
Approximately 2000 children in the workshop group for the UKRP evaluation and up to 4000 in the pooled controls.

Methods
Nonrandomised controlled trial design was used, with “treatment” i.e. workshop group and control groups in the 22 participating schools.

The evaluation was carried out using qualitative and quantitative methods. Quantitative data on psychological outcomes, behavioural outcomes, academic attainment, fidelity and participant satisfaction was collected using questionnaires and rating scales such as the Children Depression Index, data from the schools and also the National Pupil Database. Qualitative data was collected by interviewing pupils and facilitators.

Comparison:
All control groups were from within the participating schools. Those schools which wished to include all of their Year 7 pupils in workshops (seven schools) used the year-ahead group as the control group. In order to obtain baseline (start of Year 7) measures from these pupils they would have had to be surveyed in September 2006, before the project had begun. Because of this, only measures taken when the pupils were at the end of Year 7 are available for this group: there is no baseline for them, only a follow-up measure.

Those schools with within-year control groups had baseline measures for both workshop and control pupils. Six schools have both within-year and year-ahead control groups, and the remaining nine schools had a within-year control group only.

**Outcomes**
The quantitative findings suggested some impact of participation in UK Resilience Programme workshops on depression scores, absence rates, and academic attainment. However, this improvement had faded by one-year follow-up for the depression score and for absence from school. There was still an average impact on English grades by one-year follow-up. There was some impact on anxiety scores, but this was inconsistent and concentrated in a few groups of pupils.

No impact on behaviour scores, whether measured by pupil self-reports or by teacher reports, or on life satisfaction scores.

There was also a measured impact on maths scores at one-year follow-up but not in the short run (immediately post workshops).

The evaluation also found that impact varied by pupil characteristics. Pupils who were entitled to free school meals; who had not attained the national targets in English or maths at Key Stage 2; or who had worse initial symptoms of depression or anxiety; were all more likely to experience a larger measured impact of the workshops on their depression and anxiety scores, particularly girls with these characteristics. There was little difference by pupil characteristics on the absence rate. The impact for these groups was also less likely to have faded by the one-year follow-up.

Many of the pupils interviewed during the 2007-08 session reported that they had used some of the UKRP skills in real life.

The qualitative findings reported that pupils were able to recall some of the material they had learned in UKRP sessions and some were able to describe episodes in which they had applied UKRP skills to real life events.

**DYSON, A., F. GALLANNAUGH, et al., 2010, Closing the Gap in Educational Achievement and Improving Emotional Resilience for Children and Young People with Additional Needs, C4EO.**

**Overview**
Summary taken from the research review which identifies what works in narrowing the gap in educational achievement and improving emotional resilience for children and young people with additional needs. Based on a rapid review of the research, involving systematic searching of literature and presentation of key data, the
review focuses on generic issues to do with service organisation and delivery. The review addresses 5 questions:

1. What are the challenges for schools of working with children with additional needs? In what ways do they work with other services to address these challenges?

2. What does the evidence tell us about what works best in narrowing the achievement gap for those with additional needs, including strategies for maximising learning and re-engaging children and young people in learning?

3. **What does the evidence tell us about what works best in improving the emotional resilience of those with additional needs?**

4. Are schools and their partners focusing on early intervention? If so, is integrated working across children’s services helping to deliver early intervention? How is the CAF being used to support this? What evidence is there to link this with improved outcomes for children with additional needs?

5. What are the implications of providing services for children with additional needs at a local level (for example, for governance, strategy, processes and frontline delivery)?

However question 3 is the main focus of this summary as it addresses what works in improving emotional resilience of those with additional needs.

**Literature search**

Research literature was identified through systematic searches of relevant databases and websites, recommendations from C4EO Theme Advisory Group, and citations in identified studies (‘reference harvesting’). The review team used a ‘best evidence’ approach to select literature to ensure that the evidence presented is the most robust and relevant available.

The authors reported that data on emotional resilience is less widely available, although some longitudinal surveys include measures of children’s self-esteem and confidence.

**Outcomes**

The research literature indicates that interactive processes between factors at the level of the individual, the family and the community (including schools) make it more or less likely that children will be emotionally resilient.

the review highlighted that evidence is not yet available on whether individual strands in these wide-ranging interventions impact on emotional resilience and learning separately or simultaneously. The authors reported that it is unclear how emotional resilience and learning interact with each other and therefore, were not able to separate out the impacts of the different intervention strands from the available evidence.

There is promising evidence on the outcomes of interventions which are likely to have a direct or indirect impact on children’s emotional resilience. These include: improvements in children’s emotional wellbeing and social; improvements in family functioning and circumstances; and improved community relationships and opportunities for local people.
Some multi-agency interventions have been shown primarily to have an impact on emotional wellbeing and social functioning, for example out-of-hours clubs (Ofsted 2003; Edwards et al 2006; Ohl et al 2008). However, there is a significant overlap between the group of multi-agency interventions that have had impacts on emotional resilience and the group that have had impacts on barriers to learning. Interventions in both groups include full-service extended schools, multi-agency teams working with schools and alternative curriculum programmes.

School based interventions:
In a review of interventions to enhance wellbeing, Pugh and Statham (2006) found, for example, that some small group interventions and some one-to-one approaches in schools had brought about improvements in children’s self-esteem, in their social skills and in their relationships with peers and adults.

The review highlighted that evaluations indicated some positive impacts of the SEAL (Social and Emotional Aspects of Learning) programme in English primary and secondary schools. Changes in children’s social skills and relationships seemed to occur as a result of universal SEAL interventions, and there were changes in children’s emotional functioning after small-group interventions. There were also positive impacts on children’s ability to manage their behaviour (Hallam et al 2006; Humphrey et al 2008).

Some principles of the SEAL model have been highlighted in the wider literature as fundamental to successful social and emotional learning programmes:

- implementing programmes in the context of a whole-school environment that supports the development of social and emotional skills, for example through positive relationships between children and adults and between children themselves
- taking a universal approach that focuses on preventing difficulties by developing social and emotional wellbeing for all, not just targeting those who have been identified as having problems
- integrating carefully targeted interventions into more general approaches, for example by reinforcing small-group learning through classroom activities
- involving parents in programmes, for example through parenting programmes or therapeutic interventions with families.

Key messages
Improving resilience is unlikely to depend on any one type of intervention or on any particular service, but on a comprehensive strategy involving services working together.

There is promising evidence that integrated strategies that take into account multiple factors at multiple levels can address a range of resilience factors and processes. Outcomes of promising interventions include: improvements in children’s emotional wellbeing and social functioning; improvements in family functioning and circumstances; and improved community relationships and opportunities for local people.

School-based interventions have a clear role to play as part of a broader strategy for improving children’s resilience. Their success depends on: implementing programmes in the context of a whole-school environment
that supports social and emotional skills; taking a universal approach that focuses on preventing difficulties; integrating targeted interventions into more general approaches; and involving parents in programmes.

Werner E (1993) risk, resilience, and recovery: perspectives from the Kauai longitudinal study.

Overview
A summary of the major findings of a longitudinal study that traced developmental paths of a multiracial cohort of children who had been exposed to perinatal stress, chronic poverty and a family environment troubled by chronic discord and parental psychopathology.

Study design
Longitudinal study which followed children born in 1955 on a Hawaiian island of Kauai.

Participants
Early in the study, public health nurses interviewed and recorded the reproductive histories of the women who were going to give birth in 1955 and these were then followed through each trimester. 698 children were followed up at the ages 1, 2, 10, 18 and 32.

The study population consisted of an ethnically diverse sample (Japanese, Filipino, Hawaiians, Koreans, Chinese, Puerto-Ricans and some Anglo-Saxon Caucasians). One third of the participants were designated as high risk children because they were born into poverty, had experienced moderate to severe degrees of perinatal stress and they live in a family environment troubled by chronic discord, parental alcoholism or mental illness.

Methods
Preperinatal assessments and clinical rating based on the presence of conditions that were thought to have a deleterious effect on the foetus or newborn. The severity of 60 complications occurring during the prenatal, labour, delivery and neonatal periods were scored by a paediatrician and rated.

Public health nurses and social workers interviewed the mothers at home, when the children were one year old.

20 month screening, paediatric screening examinations were conducted to assess physical status.

Psychologist independently assessed the children’s cognitive development with Cattell infant and intelligence scale and other cognitive scales. Follow up data on each participant was also collected from records of physicians, hospitals, schools, public health, mental health and social service agencies, interviews with children’s mothers and family, rating scales and a survey (Werner and Smith 1977).

Outcomes
The study summary reported that two thirds of the children who experienced three or more risk factors, such as poverty, troubled family environment, parental alcoholism or mental illness, developed serious learning or behaviour problems by age 10. They also had mental health problems, delinquency records and or/teenage pregnancies by the time they were 18 years old.

One third of the high risk children grew into competent, confident and caring young adults, and none developed serious learning or behaviour problems in childhood or adolescence.

Temperamental characteristics were a protective factor in high risk children. As infants, resilient children displayed temperamental characteristics that elicited positive response from their care givers. They were more advanced in their language and motor development and in self-help skills than their peers who later developed serious learning and behaviour problems.

By the time they graduated from high school, the resilient youths had developed a positive self-concept and an internal locus of control.

2% of the cohort children suffered severe perinatal stress and those who survived till 18, four out of five had significant behaviour, learning and or physical problems (Werner and Smith 1982). The incidence of significant mental health problems were five times that found in the total cohort.

Characteristics and care giving styles were identified as a protective factor. Parental competence, as manifested in the educational level of the opposite sex parent (fathers for women and mothers for men) also proved to be a significant protective factor in the lives of the men and women on the Kauai who grew up in childhood poverty.

Most of the resilient children in the high risk sample were not unusually talented, in terms of academic performance, but they took great pleasure in interests and hobbies that brought them solace when things fell apart in their home lives.

The presence of an intact family unit in childhood and adolescence was a protective factor in the lives of delinquent youths in the birth cohort who did not commit any offences in early adulthood.

All the resilient children had had the opportunity to establish a close bond with at least one caregiver, from whom they received plenty of positive attention when they were infants. Some of this nurturing came from substitute parents, such as grandparents or older siblings, uncles or regular babysitters. Resilient boys and girls also sought and found emotional support outside of their own family through informal networks.

Evidence grading 2- (rated 2- as a precaution as details of the methods and analysis not given in the summary to enable a full appraisal of the quality of the study)

Overview
Presents data from the first year of a clustered randomized control trial (RCT) testing the impact of The RULER Approach ( "RULER" ) on creating classroom settings that promote resilience to achieve positive youth development. RULER is a Social and Emotional Learning (SEL) program that is applied universally (i.e., with all teachers and all students within a school, and includes professional development for school leaders, teachers, and staff, as well as classroom instruction protocols to enhance skill-building opportunities and characteristics of the learning environment. The theory underlying the RULER approach specifies that by changing the setting of the classroom, RULER will foster interactions between and among students and teachers, and therefore, youth are more likely to meet their social and emotional needs and, in turn, flourish; e.g., achieve academically, have meaningful friendships.

Country: New York, USA

Participants
62 Catholic schools of Brooklyn and Queens, NY were selected with 155 classrooms, 105 teachers and 3,824 students. Fifth and sixth grade English Language Arts (ELA) classrooms were selected to participate.

Intervention
Program school teachers attended a day and a half of training on RULER and also worked with a certified program coach for 5 sessions across the year.

Teachers in program schools were provided with 12 RULER units, each with five lessons or steps. Each unit was taught over a 2-week period and focused on one feeling word, such as “elation” or “shame.” The steps were designed to last 15-20 min and to be integrated into regular classroom instruction. The five steps followed a basic structure. Briefly, teachers introduced the feeling word using a personalized connection (Step 1); students connected the feeling word to academic material (Step 2); students demonstrated the meaning of the word through a creative arts activity (Step 3); students discussed the feeling word with family members and wrote a short paragraph about the conversation (Step 4); and the class discussed and evaluated the effectiveness of different strategies for managing the feeling (Step 5).

Data collection
3 waves of data collection, wave 1, baseline data collected, intermediate wave 2 and wave 3 end-of-intervention year data collection. Each wave of data collection lasted 8 weeks. Observational data were collected using video cameras that ELA teachers set up in their classrooms. Teachers recorded their ELA class on three different days of normal classroom activities.

Measures
Outcome variables were measured using observational indicators, teacher reports, and student reports. Observational Classroom emotional climate (CEC) was measured using the Classroom Assessment Scoring System (CLASS) which measures the quality of interactions among teachers and students and measures classroom social processes across 3 broad domains – emotional support, classroom organisation, and instructional support.

Teacher surveys included 3 assessments of CEC using the Classroom supportiveness scale, Emotion-focused Interaction scale, Cooperative learning strategies scale and a 5-point Likert type scales.

Student surveys included the Affiliation with Teacher Scale, Classroom supportiveness scale and a 5-point Likert-type scale (1=disagree a lot, 5= agree a lot)

RULER Training logs, teacher reports, student reports, and coach reports were used to assess implementation fidelity.

Program coaches assessed the quality of the lessons delivered through observations, completing the best practice checklists on 3 separate occasions, approximately 2 months apart.

Comparison
Schools were randomly divided into pairs and a random number generator used to assign either 0 or 1 to each pair. If the number generated was 0, then the first school of that pair was assigned to the comparison condition and if a 1 was generated, the opposite assignment was made.

Baseline school demographic variables highlighted that program schools had fewer students, smaller school size, compared to comparison schools and this was included in the analysis. No other demographic difference reported. No statistically significant difference on the baseline CEC processes between intervention and comparison groups except for student reports o teacher affiliation where higher in the program group than in the comparison group.

Outcomes
Schools assigned to use RULER had classrooms with higher emotional climate at the end of the school year compared to schools assigned to the comparison group. After the first 8 months of implementation, classrooms randomized to use RULER were rated both by observers and teachers as having a more positive emotional climate in contrast to those randomized to the comparison group.

Observers blind to the hypotheses and condition assignment rated RULER classrooms as having more behavioural markers reflecting positive climate (e.g., the presence of positive interactions and personal connection) and regard for student perspective (e.g., the extent to which teachers incorporate students’ ideas and interests in their teaching versus using a teacher-driven approach).

The program significantly impacted positive climate and teacher regard for student perspectives.
Larger effect size reported on emotional support domain, positive climate, regard for student perspectives, teacher rated emotion-focused interactions and cooperative learning strategies. Student reported


A meta-analysis of 213 school-based, universal social and emotional learning (SEL) programs involving 270,034 kindergarten through high school students. Studies were conducted in the years 1955-2007 with 186 studies from the USA and 27 outside the United States. Compared to controls, SEL participants demonstrated significantly improved social and emotional skills, attitudes, behaviour, and academic performance.

The SEL approach integrates competence promotion and youth development frameworks for reducing risk factors and fostering protective mechanisms for positive adjustment (Benson, 2006). The proximal goals of SEL programs are to foster the development of five interrelated sets of cognitive, affective, and behavioral competencies: self-awareness, self-management, social awareness, relationship skills, and responsible decision making (Collaborative for Academic, Social, and Emotional Learning, 2005).

**Literature search**
Systematic search of literature was conducted using four search strategies to secure a systematic, nonbiased, representative sample of published and unpublished studies.

**Participants**
The 213 studies involved 270,034 students. 56 percent were delivered to elementary school students, 31% involved middle school students (grades 6–8) and 12 percent were high school students. The schools were in a combination of areas, urban, suburban, and rural areas, with a majority in urban areas.

Although nearly one third of the studies contained no information on student ethnicity (31%) or socioeconomic status (32%), several interventions occurred in schools serving a mixed student body in terms of ethnicity (35%) or socioeconomic status (25%).

**Outcomes**
The mean combined effect size for studies of the impact of SEL interventions was 0.30, which is statistically significant from zero.

Compared to controls, SEL programs had a positive impact across skill, attitudinal, behavioural, and academic domains for the students in the program.

Children in the programs had lower levels of emotional distress.

SEL programs implemented by school staff were effective in all six outcome categories, (SEL skills, attitudes, positive social behaviour, conduct problems, emotional distress and academic performance). In contrast, classroom programs
delivered by non-school personnel produced only three significant outcomes (i.e., improved SEL skills and prosocial attitudes, and reduced conduct problems). Student academic performance significantly improved only when school personnel conducted the intervention.

Multicomponent programs (also conducted by school staff) were effective in four outcome categories.

Analysis of program impact suggested that program outcomes are moderated by the use of recommended training practices of SAFE (Sequenced, Active, Focused, Explicit) and implementation problems.

Programs following all recommended SAFE procedures produced significant effects for all six outcomes, as compared to programs that did not follow SAFE achieved significant results in only three areas.

Reported implementation problems also moderated outcomes. Whereas programs that encountered implementation problems achieved significant effects in only two outcome categories (i.e., attitudes and conduct problems), interventions without any apparent implementation problems yielded significant mean effects in all six categories.

Evidence grading 1++

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Organisation-wide approaches in secondary education help all young people to develop social and emotional skills, as well as providing specific help for those most at risk (or already showing signs) of problems. This guidance focuses on universal interventions used as part of an organisation-wide approach (that is, interventions that can be used to support all young people).

Nice guidelines recommends the implementation of a strategic framework by commissioners and providers of services for young people in secondary education and governors. The strategic framework should

- Enable all secondary education establishments to adopt an organisation-wide approach to promoting the social and emotional wellbeing of young people. The approach should be linked to the local children and young people’s plan and joint commissioning
- It should help achieve the Every Child Matters (ECM) Outcome Framework wellbeing objectives and targets (HM Government 2004). It should also contribute towards efforts to gain National Healthy Schools Status (NHSS).  
- Encourage the appropriate local authority scrutiny committee to assess the progress made by secondary education establishments in adopting an organisation-wide approach to social and emotional wellbeing.

Recommendation 2 – key principles and conditions

- Head teachers, teachers and governors should ensure social and emotional wellbeing of young people by leadership and implementation of supportive policies, systems and activities. These should be monitored and evaluated.
- Foster a culture that promotes mutual respect, learning and successful relationships with young people and staff.
- Provide a nurturing environment that encourages young people’s sense of self-efficacy, reduces the threat of bullying and promotes positive behaviours.
- Systematically measure and assess young people’s social and emotional wellbeing and use the outcomes for planning activities and evaluating their impact.
- Ensure access to pastoral care and support as well as specialist services for young people.

Recommendation 3 – Curriculum approaches
- Provision of a curriculum that promotes positive behaviours and successful relationships and helps reduce disruptive behaviour and bullying. This can be achieved by integrating social and emotional skills development within all areas of the curriculum. Skills that should be developed include: motivation, self-awareness, problem-solving, conflict management and resolution, collaborative working, how to understand and manage feelings, and how to manage relationships with parents, carers and peers.
- Tailoring social and emotional skills education to the developmental needs of young people.
- Reinforcing curriculum learning on social and emotional skills and wellbeing by integrating relevant activities into all aspects of secondary education.

Recommendation 4- Working with parents and families
- Partnership working with parents, carers and other family members to promote young people’s social and emotional wellbeing.
- Developing parenting skills for parents and carers to help reinforce young people’s learning from the curriculum.
- Supporting parents, carers and other family members living in disadvantaged circumstances, in order for them to fully participate in activities to promote social and emotional wellbeing.

Recommendation 5 working in partnership with young people
- Developing partnerships between young people and staff to formulate, implement and evaluate organisation-wide approaches to promoting social and emotional wellbeing.
- Introducing a variety of mechanisms to ensure all young people have the opportunity to contribute to decisions that may impact on their social and emotional wellbeing.
- Providing young people with opportunities to build relationships, particularly those who may find it difficult to seek support when they need it.
- Providing young people with clear and consistent information about the opportunities available for them to discuss personal issues and emotional concerns, taking into account education policies and protocols regarding confidentiality.
- Involving young people in the creation, delivery and evaluation of training and continuing professional development activities in relation to social and emotional wellbeing.

Recommendation 6 – training and continuing professional development
- Integration of social and emotional wellbeing within the training and development of all practitioners involved in secondary education.
- Ensure practitioners have the knowledge, understanding and skills they need to develop young people’s social and emotional wellbeing.


Overview
The paper summarises the results of published systematic reviews evaluating interventions to promote mental health and prevent mental illness in children.

Population
Systematic reviews covering mental health promotion or mental illness prevention interventions aimed at infants, children or young people up to age 19 were included in the study.

Methods
A search was undertaken of ten electronic databases using a combination of medical subject headings (MeSH) and free text searches. Reviews of drug and alcohol prevention programmes or programmes to prevent childhood abuse and neglect were excluded. Studies were critically appraised using the eight-point Critical Appraisal Skills Programme appraisal tool for systematic reviews (Critical Appraisal Skills Programme, 2002), and awarded a score out of 16. Studies were independently assessed by two reviewers and differences were resolved through discussion. 27 systematic reviews met the criteria for inclusion.

Results
Parenting interventions
The results showed that a number of perinatal interventions are effective in improving outcomes for mothers, and infants (this current review’s main focus is on children aged 5-19, and therefore, results relating to infants and under 5 children have not been further discussed).

Group based parenting interventions
Several reviews demonstrated that group-based parenting interventions improved the emotional and behavioural adjustment of children and evidence was stronger for the children aged 3-10 (Barlow et al., 2000).

The evidence also highlighted the positive impact of programmes directed at black, or mixed ethnic origin parents (Barlow et al., 2004).

Positive effect sizes were observed for specific programme formats, such as behavioural parenting programmes (Serketich and Dumas, 1996) and parent effectiveness training (Cedar & Levant, 1990).

One systematic review identified significant improvements in children’s self-esteem (d =0.38) (Cedar & Levant, 1990).

Some finding were inconsistent in regards to the most effective format for delivery, one review showing no difference between individual and group-based programmes.
(Cedar & Levant, 1990), and another favouring group-based programmes (Barlow et al., 2000).

**Self-esteem promotion programmes**
2 reviews provided evidence of to suggest that exercise as part of a comprehensive intervention has positive short term effects on self-esteem.

Greater effect sizes for programmes that focussed on self-esteem \((d=0.57)\) than for programs that addressed other aspects of development such as behaviour or social skills.

**School programmes**
These reviews both found evidence of the effectiveness of programmes that adopted a whole-school approach, and that were aimed at the promotion of mental health as opposed to the prevention of mental illness (Wells et al., 2003; Wilson et al., 2001).

C4EO, 2010, Improving children’s and young people’s achievement, behavioural and emotional outcomes through effective support and intervention with mothers, fathers and carers of 7-19 year olds. (Goldall et al)

**Overview**
This summary is taken from the research review which identifies what works when it comes to delivering support and intervention with mothers, fathers and carers of seven to 19-year olds in order to improve children’s and young people’s attainment, behaviour, and emotional outcomes. Based on a rapid review of the research, involving systematic searching of literature and presentation of key data, the review summarises the best available evidence to enable strategic managers to improve practice and outcomes for children and young people.

The four research questions:
• What are the family support needs of parents and carers of children aged seven to 19 years?
• What is the impact of school-based initiatives and community-based initiatives that support parents in improving their children’s outcomes?
• What works in engaging parents and carers in interventions to improve child outcomes?
• Are interventions which target parents cost-effective in improving children’s outcomes?

Matrix Evidence carried out this review on behalf of the Centre for Excellence and Outcomes in Children and Young People’s Services (C4EO). The National Foundation for Educational Research (NFER) conducted the data work.

**The study**
Research literature was identified through systematic searches of relevant databases and websites, through recommendations from a group of experts on policy, research and practice on families, parents and carers, and by considering studies cited in identified literature (‘reference harvesting’).
The review team used a ‘best evidence’ approach to select literature of the greatest relevance and quality to include in the review. A systematic approach was used to critically appraise the evidence. The methods used attempt to reduce bias in the
selection of literature and the information extracted from the evidence, to ensure that the review’s findings are as objective as possible. Data contained within the data annexe was obtained by a combination of search methods but primarily via online access to known government publications and access to data published by the Office for National Statistics.

Outcomes
School-based programmes that work with parents and carers improve key outcomes including child behaviour, educational attainment, school attendance and substance misuse, as well as family relationships and stability. Fear of stigmatisation is a significant barrier to the uptake of services. The review found few cost-effectiveness studies. Some evidence suggests effective programmes for child conduct disorders and full service extended schools can be delivered at a low cost. The review did not find robust evidence of direct causal links between policy interventions designed to address family income (for example, financial incentives extended to parents to enter or increase employment) and improved child outcomes. School-based programmes are likely to minimise the fear of stigmatisation which is more often associated with referrals to specialist services. The most commonly reported needs of parents and carers are advice and emotional support. Because these needs can often be met without referral to specialist services, delivering support through schools may be more cost-effective than alternative service delivery models. Community-based programmes can work in improving child behaviour, improving child welfare, and reducing time spent in care and juvenile crime. Interventions are more likely to be effective when they are informed by the views of parents identified through a thorough needs assessment at the outset. This is particularly true of interventions with groups such as fathers (both resident and non-resident) and minority ethnic parents.

The evidence base
The review identified a number of key gaps in our understanding of parent and carer-focused support:
- A clear understanding of the needs of fathers and minority ethnic parents.
- Comparisons across intervention types to determine relative effectiveness of different service offerings.
- Evidence of child outcomes, measured using standardised questionnaires so that results from different studies can be compared more easily, or reporting outcomes from the child’s point of view.
- Studies reporting costs and evaluating programme effectiveness, so that high quality economic analysis can accurately assess the cost-effectiveness and cost-benefit of the different interventions.

Key messages
More evidence is needed on the cost-effectiveness of interventions. A greater focus on the systematic collection of robust cost and outcome data would enable policymakers to ensure resources are spent only on parental interventions with demonstrable efficacy.

Interventions that include support for parents and carers are often effective in improving outcomes for children, although rigorous evaluations are not common.
The range of support on offer to parents is diverse. It includes counselling, education, vocational training, parenting skills training, helplines and other information provision services, and financial support.

Key ingredients for effective practice in supporting families in community settings are:
• using joined-up multi-agency approaches
• having a well-trained workforce
• using media to engage hard-to-reach people
• using both practical and therapeutic interventions simultaneously.

Elements of effective school-based practice in supporting families include:
• offering a one-to-one approach to parents
• providing face-to-face support
• offering a range of services in one location
• maintaining the effects of the intervention in the long-term by, for example, running ‘reunion’ sessions for attendees at interventions.

The Children and Young People’s Mental Health Coalition (CYPMHC) Pupil premium - Policy brief 2

The Children and Young People’s Mental Health Coalition (CYPMHC) published its policy recommendations focusing on pupil premium early intervention initiatives that support the emotional resilience of children and young people. The policy brief highlighted the following problems:

1. Significant numbers of school-age children are experiencing mental health problems, even at a very young age, and half of all lifetime emotional and mental health problems are rooted in childhood.

2. Some children’s ability to benefit from education and fulfil their lifetime potential is hampered by their poor mental health and wellbeing.

3. The most disadvantaged children are those most at risk.

4. Poor mental health and wellbeing is linked to poor educational attainment, yet the wider children’s workforce, and school staff in particular, are not adequately skilled in supporting emotional resilience.

The following action points were identified as crucial to address these problems:

1. The criteria for allocating pupil premium funding should include a mental health assessment as well as financial considerations such as Free School Meals. One such option is the number of children within a school that are accessing targeted and specialist Child and Adolescent Mental Health Services (CAMHS).

2. Schools should invest a proportion of the pupil premium in:
   - whole-school initiatives aimed at promoting the mental health and wellbeing of all children and young people
   - targeted support aimed at developing the mental health and wellbeing of children facing the greatest disadvantage, to be provided by skilled
counsellors/professionals who are valued by the children, thereby improving educational attainment, behaviour and social mobility
- Supporting those children who are identified by the school as having the greatest need, and not only those who are defined as disadvantaged for the purpose of calculating the pupil premium.
3. Government guidance on how best to use the pupil premium must inform and advise on a range of evidence-based early intervention initiatives that support children’s mental health and emotional wellbeing.
4. Schools should be allowed to pool pupil premium money to purchase an emotional resilience service covering all the schools in an area.
5. Training should be provided to all school staff, including governors, on mental health awareness and the links between emotional development and behaviour in children and young people, so that they can identify and appropriately respond to children experiencing difficulties.


Overview
The paper evaluates the efficacy and acceptability of the FRIENDS programme. FRIENDS was first developed in Australia and is a universal 10 session cognitive behaviour programme designed to promote children’s emotional resilience.

Country: UK, Bath and northeast Somerset

Participants
213 Children aged 9 – 10 were selected as the target group. A total of 20 schools in three geographical areas with the highest rates of social and economic disadvantage participated in the programme. A total of 6 schools from each of the 3 geographical areas were selected as assessment schools.

Evaluation
Children’s emotional health was measured using Spence Children’s Anxiety Scale, Culture Free Self Esteem scale. The questionnaires were by psychology students during a classroom session.
A qualitative evaluation of children’s subjective views about FRIENDS was undertaken. 190 children participated in the qualitative evaluation. There was no comparable group, however, a comparison of the assessment scores of children who took part in FRIENDS during the first term and those who participated in the second term.

Results
There were significant changes in total anxiety and self-esteem by the end of the FRIENDS programme, with an increase in self-esteem and a reduction in anxiety.

Children in the “high risk” group’s average scores in self-esteem increased whilst total anxiety reduced and the status of 60% of these children in high risk group had changed at the end of the programme.
Majority of children who participated in the qualitative evaluation thought it was fun, they were listened to and reported that they had learned a new skill. 43% felt they had enough time to do the work.


Overview
Meta-analytic review that summarises the effects of depression prevention programs for children and adolescents, investigating the following potential moderators of intervention effects:

Participant features –
participant risk status
participant gender
participant ethnicity
participant age

Intervention features:
Program content
Intervention duration
Homework

Provider features
Professional interventionist

Design features
Random assignment
Interview assessment
Publication status
Incorrect unit of assessment
Follow-up duration

Literature search
46 trials met the inclusion criteria, in which 32 different depression prevention programs were evaluated (11 trials evaluated more than one program and 9 programs were evaluated in 2-8 trials), resulting in 60 effect sizes.

RCTs and quasi-experimental design studies were included.

Five procedures used to retrieve published and unpublished trials of depression prevention programs, including literature search of databases, hand searching journals, citations from other reviews and meta-analysis.

Population
The meta-analysis focused on trials that targeted children and adolescents. The average age of participants ranged from 10 – 19 years old and the majority of the programs focused on both male and females but 7 included studies solely focused on females.

Interventions
The search focused exclusively on studies on trials that were conceptualised as depression prevention programs and included a continuous measure of depressive symptoms or conducted interviews assessing the criteria for major depression. 11 programs were universal and 19 were selective or indicated and 2 programs were evaluated in both universal and selective samples.

Outcomes
Of the 32 programs evaluated in the included trials, 13 programs produced significant reductions in depressive symptoms and 4 programs produced significant reduction in risk for future depressive disorder as compared to the control groups in at least one trial.

All four participant features moderated the magnitude of intervention effects. Significantly larger effects were observed in selective trials involving high-risk participants versus universal trials.

Participant age was a significant predictor of effect size at posttest Intervention duration and homework were significant predictors of effect size; cognitive change, behavioural activation, problem solving, and social skills content were not.

Relatively shorter prevention programs produced significantly larger intervention effects than did longer prevention programs.

There were no differences in effect sizes for inventions conducted by professional interventionists versus endogenous providers for posttest effect sizes, but differences did emerge for follow-up effect sizes.


Overview
The study evaluated the effectiveness of the Promoting Alternative Thinking Strategies (PATH) curriculum on the emotional development of school-aged children. PATHS is a classroom-based programme designed to improve primary school children’s emotional literacy, self-control, social competence, positive peer relations, and interpersonal problem-solving skills. The main aim is to prevent or reduce social, emotional and behavioural problems by helping pupils become more self-aware and have a positive attitude to life and school. PATHS lessons are taught at least twice a week for a minimum of 20-30 minutes. Teachers receive training in a one day and two half-day workshops and can be supported through regular teacher support group meetings. The curriculum programme also includes information and regular homework tasks to involve parents and encourages them to use at home the strategies and vocabulary of feelings their children learn in the classroom.

Country: Seattle, USA

Participants
The study sample included 286 children (167 males and 119 females) aged between 6 and 10, who attended school in the metropolitan Seattle area and were available for both pre- and posttesting. Regular and special needs children were sampled separately. 94 children were in special education programs and 192 in regular education.

Sample comprised of 165 Caucasians, 91 African American, 11 Asian American, 7 Filipino Americans, 7 Native Americans and 1 hispanic (4 children were of unknown origin)

**Methods**

Of the 286 children, 130 received the intervention (83 regular education, 47 special education) and 156 were in control classrooms (109 regular education and 47 special education)

Classrooms for the special needs children were drawn from the Seattle, Highline and Shoreline school district. 14 teachers agreed to participate and were randomized with respect to intervention versus control status.

Regular education children were drawn from the second and third grades of four schools in the Seattle school district which were representative of the district profile with the exception of having a lower percentage of Asian-American students. Schools that agreed to participate were randomly assigned to control and intervention group.

**Outcomes**

Results showed that intervention was effective for both low- and high-risk (special needs) children in improving their range of vocabulary and fluency in discussing emotional experiences, their efficacy beliefs regarding the management of emotions, and their developmental understanding of some aspects of emotions. In some instances, greater improvement was shown in children with higher teacher ratings of psychopathology.

**Evidence grading 2-**


**Overview**

A randomized prevention trial contrasted families who took part in the Strong African American Families Program (SAAF), a preventive intervention for rural African American mothers and their 11-year-olds, with control families. SAAF is based on a model positing that regulated, communicative parenting causes changes in factors protecting youths from early alcohol use and sexual activity.

Parenting variables included involvement-vigilance, racial socialization, communication about sex, and clear expectations for alcohol use.

Youth protective factors included negative attitudes about early alcohol use and sexual activity, negative images of drinking youths, resistance efficacy, a goal-directed future orientation, and acceptance of parental influence.
Intervention-induced changes in parenting mediated the effect of intervention group influences on changes in protective factors over a 7-month period.

**Country/area:** Georgia, United States.

**Study participants**

African American mothers and their 11 year old children.

The primary caregivers in the sample work an average of 39.4 hr per week.

46.3% of the participants live below federal poverty standards; 50.4% live within 150% of the poverty threshold.

**Intervention**

SAAF aims to prevent or limit early onset of sexual activity and alcohol use, particularly among African American youth in the rural areas of the southern United States.

11 year old children and their families in a rural area were randomly assigned to either the SAAF programme or to a control group, after initial contact by members of the Center for Family Research at the University of Georgia and follow up contacts by community liaisons. Families were paid £100 at both pre and post test stages of the research.

Eight county groupings: four assigned to the intervention group, four to the control group. All families given a pre and post test surrounding the intervention; tests administered verbally by trained staff, alone with each respondent. Both tests were collected from family homes; all families who completed the tests received $100 after each test.

The participants included 150 families in the control counties and 172 families in the intervention counties.

Pre and post tests were administered by African American students and community members. The instruments and procedures were developed with a focus group of 40 African American community members, representative of the sample population. Both pre and post test data collection visits were 2 hours long per family. There was an average of 7 months between pre and post tests.

The program consists of seven consecutive weekly meetings held at community facilities, with separate parent and child skill-building curricula and a family curriculum. Each of the seven meetings includes separate, concurrent training sessions for parents and children, followed by a joint parent–child session during which the families practice the skills they learned in their separate sessions.

Concurrent and family sessions each last 1 hour and parents and youths receive 14 hours of prevention training. At the same times that the intervention families participate in the seven prevention sessions, the control families receive three
leaflets via postal mail: one describes aspects of development in early adolescence, another deals with stress management, and the other provides suggestions for encouraging children to exercise.

Parents in the prevention condition are taught involved-vigilant parenting, which includes the consistent use of nurturant-involved parenting practices along with high levels of monitoring and control, adaptive racial socialization strategies, strategies for communication about sex, and the establishment of clear expectations about alcohol use.

Children learn the importance of having and abiding by household rules, adaptive behaviours to use when encountering racism, the importance of forming goals for the future and making plans to attain them, the similarities and differences between themselves and their age mates who use alcohol, realistic estimates of the prevalence of alcohol and other substance use, and resistance efficacy strategies. Together, family members practice communication skills and engage in activities designed to increase family cohesion and the youth’s positive involvement in the family.

**Outcomes**

Rural African American families who participated in prevention programming experienced increases in regulated, communicative parenting practices and youth protective factors.

In control families, both the parent and youth outcome constructs declined.

These changes were assessed 3 months after the prevention programming concluded to provide time for any transitory immediate effects to dissipate.

Compared with control-group families, parents and youths in intervention-group families reported greater changes from pre-test to post-test in regulated, communicative parenting and youth protective factors. The significant and positive coefficients indicate that, with pre-test levels of the parent and youth intervention targeted behaviors controlled, exposure to SAAF caused the changes in the intervention group to be greater than the changes in the control group.

Additional analyses were conducted to determine whether comparisons of the control group with only those families actually attending at least one intervention session produced results similar to those of the intent-to-treat analyses on which this report primarily focused. The SEM and multilevel ANCOVA yielded the same significant results as did the primary analyses presented previously. The effect size of the SAAF intervention increased from .49 to .56 for changes in regulated, communicative parenting.

These analyses support the hypothesis that changes in youth protective factors are mediated through intervention-induced changes in regulated, communicative parenting.
References


C4EO (Centre for Excellence and Outcomes in Children and Young People's Services) Sector led research review: Narrowing the gap in educational achievement and improving emotional resilience for children and young people with additional needs.

Department for Children, Schools and Families (2010) Targeted Mental Health in Schools Grant Project (TaMHS) - Evidence-Based Guidance Booklet and Guidance on commissioning targeted mental health and emotional wellbeing services in schools. London: DCSF


Dyson A, Gallannaugh F, Humphrey N, Lendrum A & Wigelsworth M (2010) Narrowing the gap in educational achievement and improving emotional resilience for children and young people with additional needs. London: Centre for Excellence and Outcomes in Children and Young People’s Services (C4EO)


## Appendix 1

### Risk factors

<table>
<thead>
<tr>
<th>The Child</th>
<th>The Family</th>
<th>The community</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Specific learning difficulties</td>
<td>• Overt parental conflict</td>
<td>• Socio-economic disadvantage</td>
</tr>
<tr>
<td>• Communication difficulties</td>
<td>• Family breakdown</td>
<td>• Homelessness</td>
</tr>
<tr>
<td>• Specific developmental delay</td>
<td>• Inconsistent or unclear discipline</td>
<td>• Disaster</td>
</tr>
<tr>
<td>• Genetic influence</td>
<td>• Hostile or rejecting relationships</td>
<td>• Discrimination</td>
</tr>
<tr>
<td>• Difficult temperament</td>
<td>• Failure to adapt to a child’s changing needs</td>
<td>• Other significant life events</td>
</tr>
<tr>
<td>• Physical illness</td>
<td>• Physical, sexual or emotional abuse</td>
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</tr>
<tr>
<td>• Academic failure</td>
<td>• Parental psychiatric illness</td>
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<tr>
<td>• Low self-esteem</td>
<td>• Parental criminality, alcoholism, substance misuse or personality disorder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Death and loss – including loss of friendship</td>
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</tbody>
</table>

### Resilient factors

<table>
<thead>
<tr>
<th>The Child</th>
<th>The Family</th>
<th>The community</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Secure early relationships</td>
<td>• At least one good parent–child relationship</td>
<td>• Wider supportive network</td>
</tr>
<tr>
<td>• Being female</td>
<td>• Affection</td>
<td>• Good housing and high standard of living</td>
</tr>
<tr>
<td>• Higher intelligence</td>
<td>• Clear, firm and consistent discipline</td>
<td>• High morale school with positive policies for behaviour, attitudes and anti-bullying</td>
</tr>
<tr>
<td>• Easy temperament when an infant</td>
<td>• Support for education</td>
<td>• Schools with strong academic and non-academic opportunities</td>
</tr>
<tr>
<td>• Positive attitude, problem-solving approach</td>
<td>• Supportive long-term relationship/absence of severe discord</td>
<td></td>
</tr>
<tr>
<td>• Good communication skills</td>
<td></td>
<td>• Range of positive sport/leisure activities</td>
</tr>
<tr>
<td>• Planner, belief in control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Humour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Religious faith</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Capacity to reflect</td>
<td></td>
<td></td>
</tr>
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</table>
## Appendix

<table>
<thead>
<tr>
<th>Score</th>
<th>Study quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1++</td>
<td>High quality meta-analyses, systematic reviews of RCTs or RCTs with a very low risk of bias</td>
</tr>
<tr>
<td>1+</td>
<td>Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias</td>
</tr>
<tr>
<td>1-</td>
<td>Meta-analyses, systematic reviews, or RCTs with a high risk of bias</td>
</tr>
<tr>
<td>2++</td>
<td>High quality systematic reviews or case-control or cohort studies. High quality case-control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal</td>
</tr>
<tr>
<td>2+</td>
<td>Well-conducted case-control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal</td>
</tr>
<tr>
<td>2-</td>
<td>Case-control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal</td>
</tr>
<tr>
<td>3</td>
<td>Non-analytic studies</td>
</tr>
<tr>
<td>4</td>
<td>Expert opinion</td>
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Barlow et al. 2007. Systematic reviews of reviews of interventions to promote mental health and prevent mental health problems in children and young people.  

<table>
<thead>
<tr>
<th>TABLE 1: SYSTEMATIC REVIEWS OF PARENTING PROGRAMMES</th>
</tr>
</thead>
</table>
| **Objectives** | To describe the experiences of minority ethnic families taking part in parenting programmes
To address whether parenting programmes are more effective with some ethnic groups than others and whether culturally sensitive programmes are more effective than traditional parenting programmes | To establish whether group-based parenting programmes are effective in improving the emotional and behavioural adjustment of children less than 3 years of age | To evaluate whether Parent Effectiveness Training (PET) is an effective preventive intervention | To evaluate the effectiveness of Behavioural Parent Training programmes in modifying antisocial behaviour in children at home and school |
| **Number & type of studies included** | 39 quantitative (RCTs, controlled/comparative, one group & retrospective studies); 12 qualitative studies | 5 RCTs | 26 studies – all two-group designs with pre- and post-treatment measurement | 26 controlled studies (8 RCT) |
| **PARTICIPANTS** | | | | |
| **Parent(s) or children?** | Parents & children | Parents | Parents | Parents |
| **Ethnicity** | Black parents (20 studies)
Hispanic parents (8 studies)
Native Americans (2 studies) | 2 studies included multi-ethnic parents | Not stated | Not stated |
| **Age of participants** | | | | |
| 0 to 6 | X | Parents of children aged 3 or less | X | Under 6 |
| 6 to 13 | X | | X | 6-14 |
| 13 to 19 | | | | |
| **INTERVENTIONS** | | | | |
| **Level of intervention** | Universal | Population sample | Parent Effectiveness Training | Behavioural Parent Training |
| **Selective** | X | Parents of toddlers in day-care low-income communities
1 programme was directed at parents using harsh parenting strategies | X | Children displaying antisocial behaviour |
<p>| <strong>Indicated</strong> | X | | | |
| <strong>Type of</strong> | Group-based parenting programmes | Group-based parenting | Parent Effectiveness Training | Behavioural Parent Training |</p>
<table>
<thead>
<tr>
<th>Intervention(s)</th>
<th>categorised as:</th>
<th>programmes:</th>
<th>is an 8 session structured self-help intervention, which aims to alter ineffective communication patterns that rely on negative emotions between parent and child.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Traditional (n=18)</td>
<td>Videotape modelling, cognitive-behavioural parenting programmes, behavioural parenting training, and small group-based cognitive-behavioural parenting programme for parents at risk of using harsh parenting strategies.</td>
<td>(BPT): Training of parents/caregivers in the use of differential reinforcement and/or time-out procedure. Studies were included if</td>
</tr>
<tr>
<td></td>
<td>• Translated (n=4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Adapted (n=7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Culturally-specific (n=7)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Results

**Overall effectiveness of parenting programmes**

**Black Families**
- The 6 most reliable studies showed a range of positive outcomes
- Two small studies produced negative results, 4 larger studies showed effectiveness for traditional, translated & culturally-specific programmes (improvements in both parent & independent assessment of children’s emotional & behavioural adjustment, intellectual development, problem-solving ability & play, parenting attitudes & behaviour (including use of harsh/inconsistent discipline)
- All studies showed evidence of no effect for some outcomes

**Ethnically-mixed programmes**
- In the 2 studies that used a control group, there was evidence of some improvement in children’s emotional & behavioural adjustment & learning problems
- There was also evidence of some improvement in parenting attitudes &

| All outcomes - parental reports | d= -0.29 (CI: -0.55 to -0.02) in favour of intervention group |
| All outcomes - independent observation of children’s behaviour | d= -0.54 (CI: -0.84 to -0.23) in favour of intervention group |
| All outcomes - follow-up data | d= -0.24 (CI: -0.56 to 0.09) |

**Overall mean effect size of PET**

**Parents’ course knowledge**

**Parental attitudes (towards parenting)**

**Parental behaviour (towards children)**

**Child self-esteem**

**Child attitudes**

**Child behaviour**

**Overall child outcome**

**Child outcome (parental report)**

**Child outcome (observer report)**

**Teacher report**

**Parental adjustment**

<table>
<thead>
<tr>
<th>Overall outcomes</th>
<th>d</th>
<th>CI</th>
<th>Overall</th>
<th>d</th>
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<tbody>
<tr>
<td>PET</td>
<td>0.33</td>
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<tr>
<td>Parents’ course knowledge</td>
<td>1.10</td>
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<td></td>
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<tr>
<td>Parental attitudes (towards parenting)</td>
<td>0.41</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Parental behaviour (towards children)</td>
<td>0.37</td>
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<tr>
<td>Child self-esteem</td>
<td>0.38</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Child attitudes</td>
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<td></td>
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<tr>
<td>Child behaviour</td>
<td>0.03</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child outcome (parental report)</td>
<td>0.86</td>
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<td></td>
<td></td>
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<tr>
<td>Child outcome (observer report)</td>
<td>0.84</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Teacher report</td>
<td>0.73</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental adjustment</td>
<td>0.44</td>
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</tbody>
</table>
Relative effectiveness of parenting programmes with different ethnic groups

- In one study, white parents reported negligible outcomes for child conduct and social competence and black parents reported negligible improvement in social competence but not child conduct.
- Independent observation of child behaviour showed moderate improvements in conduct and measures of deviance, but negligible improvement in positive affect. African-American children showed small improvements in combined measure of deviance.
- One study showed small improvements in (self-reported) involvement but negligible improvements in the use of harsh/inconsistent discipline practices (white parents showed moderate improvements in use of harsh/ inconsistent discipline but negligible improvements in involvement with their child).
- Independent observation of harsh/ critical parenting, competent and positive parenting and parent commands showed moderate to large improvements in all areas except parent commands: white parents showed small to moderate improvements on all outcomes except harsh parenting.

Relative effectiveness of traditional programmes compared with culturally sensitive programmes

- Lack of reliable evidence from comparative
Studies
• Results of individual programmes (n=30) suggest that traditional or translated programmes show clear evidence of effectiveness across a range of outcomes
• Six culturally specific programmes (all ethnic groups) showed mixed results (4 showed improvements in most child outcomes, 2 did not), although all showed significant improvements in at least half of the parent outcomes measured
• This finding may be explained by the methodological weakness of these studies (small sample size, limited number of outcomes)
• Evidence from qualitative studies shows a range of benefits not identified by quantitative evidence

<p>| Authors’ conclusions | There is evidence of beneficial outcomes of parenting programmes for both children and their parents (Black or mixed ethnic origin) | Parenting programmes can be effective in improving the short-term emotional and behavioural adjustment of children under | PET has positive effects on parent’s knowledge, attitudes and behaviour and on | Children and parents who participated in BPT were better adjusted on all measures |</p>
<table>
<thead>
<tr>
<th><strong>TABLE 2: SYSTEMATIC REVIEWS OF SELF-ESTEEM PROGRAMMES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
</tr>
<tr>
<td><strong>Number and type of studies</strong></td>
</tr>
<tr>
<td><strong>Participant details</strong></td>
</tr>
<tr>
<td><strong>Parent(s) or children?</strong></td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>Age of participants</strong></td>
</tr>
<tr>
<td>0 to 6</td>
</tr>
<tr>
<td>6 to 13</td>
</tr>
<tr>
<td>13 to 19</td>
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<tr>
<td><strong>INTERVENTIONS</strong></td>
</tr>
<tr>
<td><strong>Level of intervention</strong></td>
</tr>
<tr>
<td><strong>Universal</strong></td>
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<tr>
<td><strong>Indicated</strong></td>
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<tr>
<td><strong>Type of Intervention(s)</strong></td>
</tr>
<tr>
<td><strong>Results</strong></td>
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<td></td>
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<td></td>
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<td>-----------------------------</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Healthy children</td>
</tr>
<tr>
<td>Children at risk/ with defined problems</td>
</tr>
<tr>
<td>Exercise as part of a comprehensive intervention vs No intervention:</td>
</tr>
<tr>
<td>All children</td>
</tr>
</tbody>
</table>

**Authors' Conclusions**

- Exercise has positive short-term effects on self-esteem in children and young people
- Programmes that included only exercise showed similar effects to programmes that included exercise as part of a wider programme. However, these results need to be interpreted with caution as interventions that included exercise as part of a wider programme covered a broad range of very different types of intervention
- Improving children and adolescent self esteem and/ or self-confidence can be achieved
- Programmes that specifically focus on SE/SC are more likely to be effective than interventions that target other goals
- Programmes appear to be more effective with children and adolescents with presenting problems, particularly those with internalising problems

**Reviewers' conclusions**

- This is a high quality review, which included only randomised and quasi-randomised controlled trials
- As the authors note, the conclusions are based on a small number of trials and the results should therefore be treated with caution
- This is a moderate quality review: the reliability of the findings may be compromised because non-randomised trials were included

<table>
<thead>
<tr>
<th>Quality Score</th>
<th>14</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>To assess whether school-based mental health promotion interventions that take a universal approach have shown in controlled trials to improve children’s mental health. To identify attributes that are common to successful school-based mental health promoting interventions adopting a universal approach.</td>
<td>To evaluate the effectiveness of school-based prevention programmes in reducing crime, substance use, dropout/non-attendance and other conduct problems, and to examine the features of effective programme.</td>
</tr>
<tr>
<td><strong>Number &amp; type of studies</strong></td>
<td>17 controlled studies</td>
<td>165 controlled studies</td>
</tr>
<tr>
<td><strong>PARTICIPANT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent(s) or children?</td>
<td>Children</td>
<td>Children</td>
</tr>
<tr>
<td>Ethnicity</td>
<td><strong>Many schools had a high proportion of children from ethnic minority groups</strong></td>
<td><strong>Around 50% of participants were from minority ethnic groups</strong></td>
</tr>
<tr>
<td><strong>Age of participants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 to 6</td>
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<td>6 to 13</td>
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<td>X</td>
</tr>
<tr>
<td>13 to 19</td>
<td>Up to 18 years</td>
<td>Up to 18 years</td>
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<tr>
<td><strong>INTERVENTIONS</strong></td>
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</tr>
<tr>
<td>Level of intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Selective</td>
<td><strong>The majority of schools studied were in socio-economically deprived areas</strong></td>
<td><strong>28% of the study samples had been identified as high-risk for problem behaviours or delinquency</strong></td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Intervention(s)</td>
<td>3 <strong>types of intervention:</strong> 1. Interventions adopting a whole-school approach that involved all teachers and students, in addition to changing some aspects of the social environment of the school and involving the wider community. 2. Interventions with a classroom-based approach that were confined to changes in the curriculum or changes in the classrooms teacher’s.</td>
<td><strong>Environmentally focused interventions:</strong> Establish norms or expectations for behaviour, classroom or instructional management, school and discipline management interventions. <strong>Individually focused interventions:</strong> Self-control or social competency, with or without cognitive-</td>
</tr>
</tbody>
</table>
### Results

Of all the studies, only 3 reached more than 70% of positive outcomes measured. The two interventions specifically designed to promote mental health showed a higher proportion of positive outcomes than other programmes, including programmes to prevent mental health problems. The two programmes that adopted a whole-school approach or a beyond school approach showed a higher percentage of positive results (95% and 100%)

<table>
<thead>
<tr>
<th>Mean effect size (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delinquency</strong></td>
</tr>
<tr>
<td>$d=0.04$ (-0.03 to 0.11)</td>
</tr>
<tr>
<td><strong>Dropout/non-attendance</strong></td>
</tr>
<tr>
<td>$d= 0.16$ (0.05 to 0.27)</td>
</tr>
<tr>
<td><strong>Other problem behaviours</strong></td>
</tr>
<tr>
<td>$d=0.17$ (0.09 to 0.25)</td>
</tr>
</tbody>
</table>

### Authors' conclusions

- There is positive evidence of the effectiveness of programmes that take a whole-school approach, aimed at the promotion of mental health as opposed to the prevention of mental illness.
- The included reviews provide evidence that universal school mental health promotion programmes can be effective and suggest that long-term interventions promoting the positive mental health of all pupils and involving changes to the school climate are likely to be more successful than brief classroom-based mental illness prevention programmes.

### Reviewers' conclusions

- This review shows that school-based prevention practices appear to be effective in reducing alcohol and drug use, dropout and non-attendance, and other conduct problems.
- However, the size of the average effects for each outcome is small and there is considerable heterogeneity across studies.

### Quality score

- **10**
- **11**
<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>To evaluate the efficacy of prevention programmes for aggressive behaviour among preschoolers with otherwise normal development</td>
<td>To evaluate the effectiveness of family-based prevention programmes in reducing offending and antisocial behaviour in children and adolescents</td>
<td>To evaluate the effectiveness of child skills training in preventing antisocial behaviour in children and youth</td>
<td>To quantify the effectiveness of school-based violence prevention programmes for children identified as at risk for aggressive behaviour</td>
<td>To assess the effect of social-skills training for students with emotional or behavioural disorders</td>
<td>To assess the effectiveness of mainstream service programmes for minority juvenile delinquents relative to White delinquents</td>
</tr>
<tr>
<td><strong>Number &amp; type of studies</strong></td>
<td>17 studies (any design)</td>
<td>40 studies, mostly RCTs</td>
<td>84 RCTs</td>
<td>44 RCTs</td>
<td>35 studies</td>
<td>305 studies with an experimental or quasi experimental comparison of at least one treatment and one control group</td>
</tr>
<tr>
<td><strong>PARTICIPANTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent(s) or children?</td>
<td>Preschool aged children and also parents of preschoolers</td>
<td>Parents and children</td>
<td>Children and youth</td>
<td>Children</td>
<td>Children</td>
<td>Youth</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Predominantly White 2 studies included ethnic minority families</td>
<td>Not stated</td>
<td>Not stated</td>
<td>Not stated</td>
<td>Not stated</td>
<td>Youth from ethnic minority groups</td>
</tr>
<tr>
<td>Age of participants</td>
<td>0 to 6</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 to 13</td>
<td>Up to 8 years</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Average age of participants: 11.5 years 12 to 21</td>
</tr>
<tr>
<td></td>
<td>13 to 19</td>
<td>Up to 17 years</td>
<td>Up to 18 years</td>
<td>Up to 18</td>
<td></td>
<td>12 to 21</td>
</tr>
<tr>
<td><strong>INTERVENTIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of intervention</td>
<td>Universal</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>2 studies included</td>
<td>Children that belong to X</td>
<td>Children at risk of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td>Type of Intervention(s)</td>
<td>Results</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------</td>
<td>---------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preschoolers with aggressive and disruptive behaviour.</td>
<td><strong>Parent focused:</strong> Grouped into 4 broad types: Behavioural parent training, Functional assessment, Videotapes and Relationship-focused interventions</td>
<td>• Effects of programmes for preventing aggressive behaviour in preschoolers are</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Primary, secondary and tertiary family-based prevention programmes: home visiting, day care/preschool programmes, school-based programmes, home/community programmes and multi systemic therapy programmes.</td>
<td>Mean effect size All outcomes =0.223</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Child skills training programmes focused on prevention of antisocial behaviour</td>
<td>Mean effect size All outcomes =0.38 (post-intervention) =0.28 (at follow-up)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>School based interventions designed to reduce aggression and violence: training in skills of non-response, training to improve relationship skills</td>
<td>Mean effect size (95%CI) Aggressive behaviours =-0.36 (-0.54 to -0.18)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children with emotional or behavioural disorders.</td>
<td><strong>Social skills training interventions:</strong> 22 studies included comprehensive, multimodal and multi-content training procedures such as direct instruction, modelling, role-playing, rehearsal, group discussion and feedback</td>
<td>Mean effect size All outcomes = 0.199 (in favour of the intervention)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth identified as delinquent or displaying antisocial behaviour.</td>
<td><strong>Institutional and non-institutional counselling and casework or service brokerage type services</strong></td>
<td>Mean effect size Delinquency outcomes across all treatment modalities Minority youths</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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50
modest
• 8 studies used a primarily behavioural approach and 8 included cognitive behavioural principles or psychosocial interactional approaches as well.
• Both types of studies showed equally positive results
• Imaginative play training significantly affected several play behaviours, but not aggression. Positive social play alone does not therefore appear to be effective in reducing aggression.
• The magnitude of the results were not related to the duration of treatment which varied widely

<table>
<thead>
<tr>
<th></th>
<th>=0.321</th>
<th>Delinquency/ police contact</th>
<th>0.19</th>
<th>Majority youths = 0.11</th>
</tr>
</thead>
<tbody>
<tr>
<td>All antisocial behaviour outcomes</td>
<td>=0.196</td>
<td>=0.16 (p&lt;.05)</td>
<td>(in favour of a reduction of aggression with the intervention)</td>
<td>(in favour of a reduction in school or agency actions with intervention)</td>
</tr>
<tr>
<td></td>
<td>All antisocial behaviour outcomes</td>
<td>Effects were smaller for changes in antisocial behaviour than on related social and cognitive measures.</td>
<td>School /agency responses</td>
<td>=-0.59 (-1.18 to 0.01)</td>
</tr>
</tbody>
</table>

Author's conclusion
• Scant treatment literature for aggression and disruptive behaviour of preschoolers shows
• Family-based programmes have a positive effect in reducing delinquency and
• Studies demonstrate a small, positive overall effect in the efficacy of social skills training in preventing
• School-based violence prevention programmes produce modest reductions in
• Social skills programmes only have a small effect on outcomes for students with
• Mainstream service programmes for ethnic minority juvenile delinquents without cultural tailoring showed
<table>
<thead>
<tr>
<th>Reviewers’ conclusion</th>
<th>very modest results even for lengthy interventions. However methodological and design factors temper this conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Studies that show a positive effect are likely to include behavioural interventions</td>
<td>ant-social child behaviour</td>
</tr>
<tr>
<td>• This review includes a wide range of study designs and no quantitative data is</td>
<td>antisocial behaviour in childhood and youth</td>
</tr>
<tr>
<td>presented, making it difficult to assess the quality and reliability of the authors’ conclusions.</td>
<td></td>
</tr>
<tr>
<td>• The principal conclusion that can be drawn from the study is that there appears to be less evidence about programmes for this age group.</td>
<td>aggressive and violent behaviour, and reductions in school and agency actions in response to such behaviours</td>
</tr>
<tr>
<td>• This review relied on hand searching and contacting experts in the field and did not include searching of electronic databases. This carries a substantial risk of bias, which undermines the conclusions of this review</td>
<td>emotional or behavioural disorders</td>
</tr>
<tr>
<td>• The review describes a number of individual family-based programmes that have been shown to be</td>
<td>positive overall effects on delinquent behaviour, school participation, peer relations, academic achievement, behaviour problems, psychological adjustment and attitudes</td>
</tr>
<tr>
<td>• This is a good quality study drawing on a large number of high-grade trials</td>
<td></td>
</tr>
<tr>
<td>• The authors’ conclusion that studies show a small, positive effect is based on longer-term follow-up data on recidivism, contact with police as well as interim outcomes such as changes in social skills (which show larger effect sizes)</td>
<td></td>
</tr>
<tr>
<td>• The review provides good evidence of positive changes in aggressive behaviour, particularly for programmes aimed at improving</td>
<td></td>
</tr>
<tr>
<td>• Limitations in terms of the amount of data presented in this review have resulted in a relatively low quality score: the data presented appears to support the authors’ conclusion that social skills training programmes for children already exhibiting problem behaviours have</td>
<td></td>
</tr>
<tr>
<td>• The purpose of this review was to establish whether mainstream programmes to tackle juvenile delinquency are more or less effective with majority or minority youth</td>
<td></td>
</tr>
<tr>
<td>• The authors’ conclusions that overall effects for all programmes combined are small and that similar results are observed in minority &amp; majority youth reflects the data presented in their meta-analysis. However, the lack of a</td>
<td></td>
</tr>
</tbody>
</table>
Effective in reducing delinquency & anti-social child behaviour (see examples of successful programmes) but other findings should be treated with caution.

- There is evidence from a small number of studies that these effects are maintained at 1 year.
- Secondary school-based interventions appear to be more effective than primary school-based interventions although this may be due to the small number of studies in the latter category.
- The publication bias may mean that this study over-estimates the positive results obtained.

- Only a limited effect on disruptive behaviour and aggression.
- Other data presented in the report point to more positive results for interim outcomes such as anxiety and social relations & social behaviour.

<p>| Quality Score | 9 | 8 | 11 | 13 | 8 | 9 |</p>
<table>
<thead>
<tr>
<th>Author/ year</th>
<th>Objectives</th>
<th>Number &amp; type of studies</th>
<th>Participates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrews &amp; Wilkinson (2002)</td>
<td>To establish the value of risk-factor reduction or enhanced coping strategies in preventing the onset of anxiety, affective or substance-use disorders</td>
<td>20 RCTs</td>
<td>Children and adolescents</td>
</tr>
<tr>
<td>Dubois et al (2002)</td>
<td>To assess the effects of mentoring programmes on youth</td>
<td>55 controlled studies</td>
<td>Not stated</td>
</tr>
<tr>
<td>Durlak &amp; Wells (1997)</td>
<td>To review the effectiveness of interventions to reduce the future incidence of adjustment problems in under 18s</td>
<td>177 controlled studies</td>
<td>Not stated</td>
</tr>
<tr>
<td>Durlak &amp; Wells (1998)</td>
<td>To evaluate the effectiveness of indicated preventive mental health interventions for children and adolescents</td>
<td>121 controlled studies</td>
<td>Not stated</td>
</tr>
<tr>
<td>Greenberg et al. (2001)</td>
<td>To review prevention programmes found to produce improvements in psychological symptomology or in factors associated with increased risk of child mental disorders</td>
<td>34 studies using randomized-trial design/ quasi-experimental design</td>
<td>Not stated</td>
</tr>
<tr>
<td>Kulic &amp; Horne (2004)</td>
<td>To identify effective group approaches to prevention with adolescents and children</td>
<td>80 quasi-experimental or experimental studies</td>
<td>Mixed</td>
</tr>
<tr>
<td>Nelson et al. (2003)</td>
<td>To determine the effectiveness of preschool prevention programmes for disadvantaged children’s cognitive and social development</td>
<td>34 studies with a prospective design and a control group.</td>
<td>More than half of the interventions targeted African-American children.</td>
</tr>
</tbody>
</table>

**PARTICIPANTS**

- **Parent(s) or children?**
  - Children and adolescents
  - Children and adolescents
  - Children and adolescents
  - Children and adolescents
  - Children and adolescents
  - Children and adolescents
  - Children

- **Ethnicity**
  - Not stated
  - Not stated
  - Not stated
  - Not stated
  - Not stated
  - Mixed
  - More than half of the interventions targeted African-American children.

- **Age of participants**
  - 0 to 6
  - 6 to 13
  - 13 to 19

- **INTERVENTIONS**
  - **Level of intervention**
    - Universal
      - Normal populations
      - Children who did not
### Selective

| Type of intervention(s) | Interventions | Children with sub-clinical problems (internalising, externalising, mixed adjustment problems, poor peer relations and low levels of academic performance) | X | X | X | X

| Indicated | Predominantly cognitive behavioural therapy interventions, delivered by teachers, clinicians or psychologists | One-to-one mentoring programmes delivered in school & community settings | Person-centred Affective education, problem-solving Environment-centred School programmes: changes in classroom setting, school, classroom social skills training. Parenting programmes: home visiting, parent training. Transition School-transition, | Combined-behavioural Reinforcement, modelling, desensitisation Cognitive-behavioural Self-instructional training, using cognitive processes to modify behaviour Non-behavioural Rogerian/Adlerian | Universal preventive programmes Violence prevention, social/cognitive skill-building programs, school-transition Externalising behaviours (selected or indicated) Child-focused, adult-support/mentoring, multi-component | Interventions included psycho-educational groups, counselling/ interpersonal problem solving, self-esteem programmes 80% of programmes were delivered in schools | Universal or selected pre-school prevention programs to promote children’s competence and well-being and/or prevent negative outcomes for children. Most frequently provided programme component was home visitation, parent training, and pre-school education. 79% of programmes offered more than one component. |
| Results | CBT to prevent depressive disorders may be effective in both universal and targeted groups and in preventing anxiety disorders in children identified as being at risk | **Overall effect of youth mentoring programmes:** d=0.18  
Programmes that included structured activities and ongoing training were more effective than those without, as were programmes that involved parents  
**Environment centred**  
School-based d=0.35 (CI: 0.30 to 0.43)  
Parent-training d=0.16 (CI: -0.04 to 0.36)  
**Transition**  
School entry d=0.39 (CI: 0.27 to 0.58)  
**Person-centered**  
**Affective education**  
Aged 2-7 d=0.70 (CI: 0.49 to 0.91)  
Aged 7-11 d=0.24 (CI: 0.18 to 0.31)  
Over 11 d=0.33 (CI: 0.18 to 0.48)  
**Treatment type**  
**Behavioural treatment group**  
d= 0.51 (CI: 0.41 to 0.60)  
**Cognitive-behavioural treatment group**  
d= 0.53 (CI: 0.42 to 0.64)  
**Presenting problem**  
**Externalising**  
d= 0.72 (CI: 0.52-0.92)  
**Internalising**  
d=0.49 (CI: 0.39-0.60)  
No formal results given: individual qualitative descriptions of each programme but no summary of results across the three programme categories. Only studies with positive effects were included in the review.  
No data reported on outcomes: paper describes characteristics of studies (methodological characteristics & change agent characteristics) but without reference to overall effect of interventions  
Cognitive impacts (all programmes) greatest during the pre-school period (d=0.52) but were still evident during kindergarten to Grade 8 (d=0.3). Social-emotional impacts on children were similar up to Grade 8 (d=0.27) and high school and beyond (d=0.33) as were parent-family wellness impacts at preschool (d=0.33) and up to Grade 8 (d=0.30). |
**Interpersonal problem solving**
Children 2-7
d=0.93 (CI: 0.66 to 1.19)
Children 7-11
d=0.36 (CI: 0.24 to 0.48)

**Other person centred programmes**
Behavioural approach
d=0.49 (CI: 0.38 to 0.59)
Non-behavioural approach
d=0.25 (CI: 0.06 to 0.44)

Authors’ conclusions

- Evidence that some anxiety, affective and substance-use disorders can be prevented.
- Trials show that interventions are efficacious but there is limited evidence about effectiveness in
- Some evidence of the effectiveness of youth mentoring programmes. However, the average estimated effect size of 0.14 is consistent with only a small effect

Most types of primary prevention achieved significant positive effects in both reducing problems and increasing competencies and problem-solving skills, with the exception of parent-training (which did not reach significance).

- Indicated prevention produces positive effects that are statistically and practically significant
- Mean effects achieved by cognitive-behavioural or behavioural programmes are

- There is a growing number of programmes with documented evidence of beneficial impact on the reduction of psychiatric symptomology
- More work is needed to evaluate the

See below

- Pre-school prevention programmes have positive short, medium and long-term impacts on children’s cognitive, social-emotional functioning and family wellness that last up to 9 years of age.
- Effect sizes are in the
| Reviewers’ conclusions | • This is a poor quality review that does not appear to have used a systematic search • The review identifies a number of successful programmes but the serious design flaws in the study mean that its conclusions should be treated with caution | • This is a reasonably high quality review which uses meta-analysis to compare the overall effectiveness of youth mentoring programmes • The authors present evidence from meta-analysis to support their conclusions • The review includes some non-randomised control trials and should therefore be treated with caution. | See Durlak & Wells (1997) • The purpose of this review is to identify successful programmes only. This means that it is not possible to draw any conclusions about the overall effectiveness of different programmes or programme types • This poor quality review is primarily focused on the methodological characteristics of included studies and does not present data on the relative effectiveness of different interventions • The review discusses some of the factors that appear to influence programme effectiveness (see | • This is a reasonable quality review providing evidence from controlled studies that pre-school prevention programmes for disadvantaged children have beneficial effects on both cognitive and social-emotional, with the greatest benefit on cognition • A small number of studies show that these benefits are maintained over time |

| routine practice | moderately high in magnitude • The highest overall mean effect was found for participants presenting with externalising disorders | implementation process and impact of widely disseminated programme models | small to moderate range. |
| TABLE 6: SYSTEMATIC REVIEWS OF ANXIETY & DEPRESSION PREVENTION PROGRAMMES |
|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------|
| **Author/year**                                 | **Andrews & Wilkinson (2002)**                   | **Jane-Lluis et al. (2003)**                      |
| **Objectives**                                  | To establish the value of risk-factor reduction or enhanced coping strategies in preventing the onset of anxiety, affective or substance-use disorders | To identify potential predictors of outcome in prevention programmes |
| **Number & type of studies**                    | 20 RCTs                                          | 54 RCTs/controlled trials                        |
| **PARTICIPANTS**                                |                                                  |                                                  |
| **Parent(s) or children?**                      | Children and adolescents                        | Children and adolescents                        |
| **Ethnicity**                                   | Mixed                                            | Not stated                                       |
| **Age of participants**                         |                                                  |                                                  |
| 0 to 6                                          | X                                                | X                                                |
| 6 to 13                                         | X                                                | X                                                |
| 13 to 19                                        | Young people under 19                            | X                                                |
| **INTERVENTIONS**                               |                                                  |                                                  |
| **Level of intervention**                       |                                                  |                                                  |
| Universal                                       | X                                                | X                                                |
| Selected                                        | X                                                | X                                                |
| Indicated                                       | X                                                |                                                  |
| **Type of Intervention(s)**                     | Predominantly cognitive behavioural therapy interventions, delivered by teachers, clinicians or psychologists | **5 broad categories of intervention:** |
|                                                 | • Behavioural (behaviour change, modelling)    | • Behavioural (behaviour change, modelling) |
|                                                 | • Cognitive (cognitive restructuring, counselling, explanatory style training) | • Cognitive (cognitive restructuring, counselling, explanatory style training) |
|                                                 | • Competence-based (broad skill training, social resistance skills) | • Competence-based (broad skill training, social resistance skills) |
|                                                 | • Educational (direct instruction, lectures & workshops) | • Educational (direct instruction, lectures & workshops) |
|                                                 | • Social support (network building,             | • Social support (network building,             |
|                                                 |                                                 |                                                 |
|                                                 | **Psychological interventions:** 18 studies using cognitive behaviour to combat stress, build resilience or improve problem solving skip programmes, 8 targeted programmes for young people with elevated scores | **Psychological interventions:** 18 studies using cognitive behaviour to combat stress, build resilience or improve problem solving skip programmes, 8 targeted programmes for young people with elevated scores |
|                                                 | **Educational intervention:** 1 study (using three 50-minute manual | **Educational intervention:** 1 study (using three 50-minute manual |
|                                                 | **Psycho-educational:** 2 studies (16-session intervention to students’ depression scores, given by psychologists/clinically trained graduate students and | **Psycho-educational:** 2 studies (16-session intervention to students’ depression scores, given by psychologists/clinically trained graduate students and |

| Quality Score | 5 | 9 | 9 | 9 | 4 | 4 | 8 |
| Results | CBT to prevent depressive disorders may be effective in both universal and targeted groups and in preventing anxiety disorders in children identified as being at risk | **All outcomes**
*Children (0 – 14yrs) (n=16)*
\[d=0.\]

*Adolescents (15 – 18yrs) (n=9)*
\[d=0.19 \text{ (CI: 0.070 to 0.38)}\]

*All ages (adults included)*
\[d=0.22 \text{ (CI: 0.14 to 0.30)}\]

- Programmes with larger effect sizes were: multi-component
- included competence techniques
- had more than 8 sessions
- had sessions 60-90 minutes long
- were delivered by a health care provider, with or without lay support

**Psychological interventions vs. non-intervention**
*Immediately post-intervention*

**Depression scores**
\[d=-0.26 \text{ (CI: -0.40 to -0.13)}\] in favour of intervention

**Targeted vs. universal (immediately post-intervention)**

**Depression scores (SMD)**

*Targeted interventions*
\[d=-0.26 \text{ (CI: -0.40 to -0.13)}\]

*Universal interventions*
\[d=-0.21 \text{ (CI: -0.48 to 0.06)}\]

*All interventions*
\[d=-0.26 \text{ (CI: -0.36 to -0.15)}\]

Pooled data showed no significant effect for either universal or targeted at any other time point, except at 36 months for 1 study \[d=-0.29 \text{ (CI: -0.24 to -0.01)}\].

**Depression diagnosis (Risk Difference)**

*Targeted (n=3)*
\[RD=-0.13 \text{ (CI: -0.22 to -0.05)}\]

*Universal (n=2)*
\[RD=-0.08 \text{ (CI: -0.15 to -0.01)}\]

*Both (n=5)*
\[RD=-0.10 \text{ (CI: -0.15 to -0.05)}\]

Pooling targeted and universal interventions at 12 months showed no oAlthough at 12 months 2 studies of targeted interventions reported a diagnosis of depressive disorder
\[RD =-0.12 \text{ (CI: -0.24 to -0.01)}\].

**Educational vs. psychological**

No evidence of the effectiveness of educational interventions.

| Author’s conclusions | Evidence that some anxiety, affective and substance-use disorders can be prevented. | An 11% improvement in depressive symptoms can be achieved using prevention programmes | • There is insufficient evidence to merit the introduction of depression programmes although results suggest that |
Trials show that interventions are efficacious but there is limited evidence about effectiveness in routine practice. Further study would be:
- Most studies have focused on psychological interventions and the educational interventions has not been fully investigated.

**Reviewer’s conclusions**
- This is a poor quality review that does not appear to have used a systematic search.
- This review points to moderate effects of depression prevention programmes across all outcomes (combined).
- Results should be interpreted with caution due to the relatively low quality of the review.
- This is a methodologically sound Cochrane review that draws on. The conclusions drawn reached by the authors are therefore likely.

<table>
<thead>
<tr>
<th>Quality Score</th>
<th>5</th>
<th>9</th>
<th>15</th>
</tr>
</thead>
</table>