NHS England and NHS Improvement

Children and Young People's Mental Health: Early Intervention and Prevention Programmes

Learning from the literature

Our Rationale and Aims

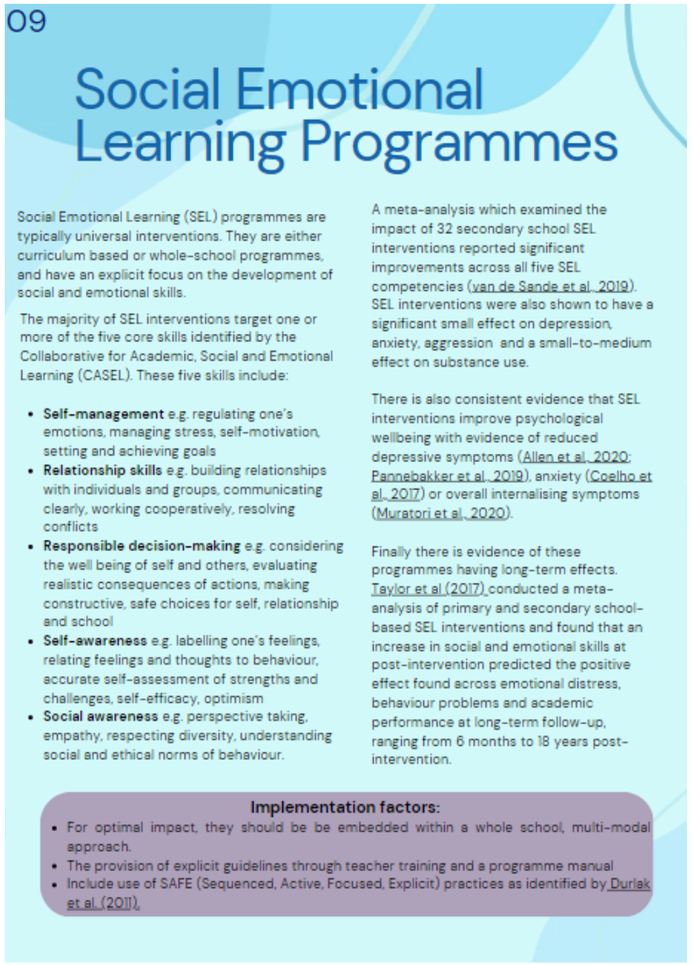
Aimed to conduct a scoping review (incl. published and grey literature) to bring together the latest evidence on:

1. Universal and targeted interventions: what works well for whom
2. Key implementation components/practical considerations for those interventions

Universal Interventions

Interventions covered include:

1. Social Emotional Learning programmes
2. Positive psychology programmes
3. Mental health literacy programmes
4. Mindfulness-based programmes
5. Positive youth development programmes



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Social Emotional Learning Programmes

Social Emotional Learning (SEL) programmes are typically universal interventions. They are either curriculum based or whole-school programmes, and have an explicit focus on the development of social and emotional skills.

The majority of SEL interventions target one or more of the five core skills identified by the Collaborative for Academic, Social and Emotional Learning (CASEL). These five skills include:

- **Self-management** e.g. regulating one's emotions, managing stress, self-motivation, setting and achieving goals
- **Relationship skills** e.g. building relationships with individuals and groups, communicating clearly, working cooperatively, resolving conflicts
- **Responsible decision-making** e.g. considering the well being of self and others, evaluating realistic consequences of actions, making constructive, safe choices for self, relationship and school
- **Self-awareness** e.g. labelling one's feelings, relating feelings and thoughts to behaviour, accurate self-assessment of strengths and challenges, self-efficacy, optimism
- **Social awareness** e.g. perspective taking, empathy, respecting diversity, understanding social and ethical norms of behaviour.

A meta-analysis which examined the impact of 32 secondary school SEL interventions reported significant improvements across all five SEL competencies (van de Sande et al., 2019). SEL interventions were also shown to have a significant small effect on depression, anxiety, aggression and a small-to-medium effect on substance use.

There is also consistent evidence that SEL interventions improve psychological wellbeing with evidence of reduced depressive symptoms (Allen et al., 2020; Pannebakker et al., 2019), anxiety (Coelho et al., 2017) or overall internalising symptoms (Muratori et al., 2020).

Finally there is evidence of these programmes having long-term effects. Taylor et al (2017) conducted a meta-analysis of primary and secondary school-based SEL interventions and found that an increase in social and emotional skills at post-intervention predicted the positive effect found across emotional distress, behaviour problems and academic performance at long-term follow-up, ranging from 6 months to 18 years post-intervention.

Implementation factors:

- For optimal impact, they should be be embedded within a whole school, multi-modal approach.
- The provision of explicit guidelines through teacher training and a programme manual
- Include use of SAFE (Sequenced, Active, Focused, Explicit) practices as identified by Durlak et al. (2011).

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Whole School Approach

Department of Education (DfE) has emphasised that a whole school and college approach to promoting good mental health is a protective factor for children and young people's mental health (Transforming children and young people's mental health provision: a Green Paper, 2017).

Public Health England (PHE) have produced guidance on implementing a whole-school approach, with 8 principles:

1. **Leadership and management** that supports and champions efforts to promote emotional health and wellbeing
2. Curriculum teaching and learning to **promote resilience and support social and emotional learning**
3. Enabling **student voice** to influence decisions
4. **Staff development** to support their own wellbeing and that of students
5. **Identifying need and monitoring impact** of interventions
6. **Working with parents and carers**
7. **Targeted support** and appropriate referral
8. **An ethos and environment** that promotes respect and values diversity

If applied consistently and comprehensively, this approach can be effective at protecting and promoting children and young people's mental health and wellbeing.

NICE guidelines:
Social, Emotional and Mental Wellbeing (Primary & Secondary School):

Whole school approach guidance:

- Adopt a whole-school approach to support positive social, emotional and mental wellbeing of staff, children and young people in primary and secondary education.
- Adopt a 'graduated response' (or 'step up–step down') approach to support (moving between universal and targeted support as relevant) as an integral part of the whole-school approach alongside broader universal approaches.
- The whole school approach should be regarded as a framework that other interventions can slot into.
- To be effective, a whole school approach should be monitored and evaluated actively.

Key implementation guidelines:

- Managed and planned by one designated individual (ideally a senior member of staff) to co-ordinate the approach.
- Involvement of families and children/young people in the planning and implementation
- Teacher and parental engagement

Targeted Interventions

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Targeted-selective interventions

Some children and young people are at greater risk of experiencing poorer mental health. For example, those who are in care, young carers, those who have had previous access to NHS CYPMHS, those living with parents or carers with a mental illness and those living in households experiencing domestic violence. Delays in identifying and meeting emotional wellbeing and mental health needs can have far reaching effects on all aspects of these children and young people's lives, including their chances of reaching their potential and leading happy and healthy lives as adults (DfE, 2017). Below are some examples of these populations and how targeted preventative interventions can benefit them.

LGBTQ+

LGBTQ+ youth may be more likely to experience identified universal risk factors for youth mental health, such as family conflict, as well as factors related to their identity status such as stigma and discrimination (Russell & Fish, 2016). A large survey in Scotland (LGBThealth.org.uk, 2018) reported that 8 in 10 YP (aged 13-25) who identified as LGBTQ+ indicated they had experienced at least one mental health problem.

McDermott et al. (2021) suggest that effective early intervention should prioritise addressing environments that marginalise YP, LGBTQ+ identities, and mental health problems. Additionally, Marraccini et al (2022) suggest that schools are well-placed to deliver these interventions, placing an emphasis on promoting positive social relationships and a safe community e.g. through universal bullying interventions.

Children in care

Care experienced young people (CEYP) are almost 4x more likely to experience poor mental health than those in the general population (NSPCC, 2015) and often their mental health issues are severe and/or complex. If left unaddressed, this can significantly increase their need for long term support from health and social care services.

NICE guidelines recommend that preventive interventions are offered to CEYP based on need, delivered in a timely manner to prevent serious mental health problems developing.

Refugees

Refugee children have been found to have an increased risk of developing psychological difficulties, such as PTSD (Tyrer et al, 2014).

The WHO (2020) recommends that selective psychosocial interventions should be offered, especially when affected by humanitarian emergencies. These interventions have been found to prevent anxiety, depression and stress-related disorders, and may be considered for reducing substance use in these populations.

There is evidence that multi-modal interventions may also be beneficial by integrating issues of psychological functioning, social/cultural difficulties, and ongoing psychosocial difficulties (Tyrer et al, 2014; Hettich et al, 2020).

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Targeted-indicated interventions

Some children and young people may already be exhibiting minimal but detectable signs or symptoms, indicating a predisposition for poor mental health. This puts them at a greater risk of developing a mental health disorder. These young people consequently may benefit from targeted indicated interventions. Below are some examples of how targeted indicated interventions can benefit certain mental health presentations.

Depression

Selective and indicated interventions have been found to be most effective at reducing symptoms of depression.

Specifically, CBT-based interventions have been found to be effective at reducing depressive symptoms in both the short and long term.

Eating Disorder

CBT-based indicated interventions have been found to be effective at reducing body dissatisfaction, and dieting/bulimic symptoms.

PTSD

CBT-based interventions have been found to be effective at preventing chronic PTSD in patients showing early acute stress symptoms after exposure to a traumatic event (Arango et al, 2018).

Conduct Disorder

Indicated interventions such as parent management training programmes have been found to prevent externalizing disorders in children with high antisocial behaviour scores (Arango et al, 2018).

Single Session Interventions (SSI's)

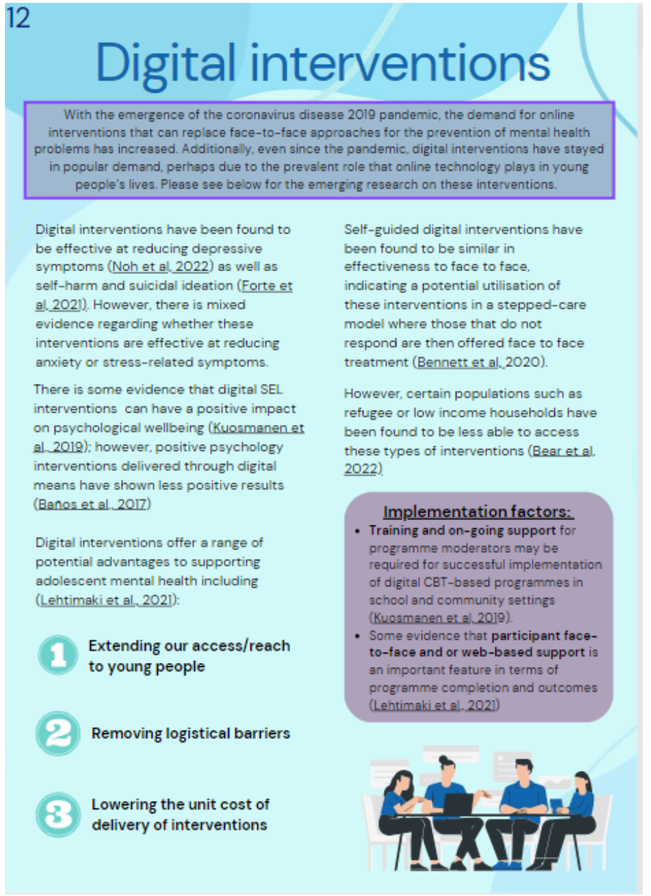
These brief interventions have been found to be effective selective or indicated interventions for the prevention of youth mental disorders.

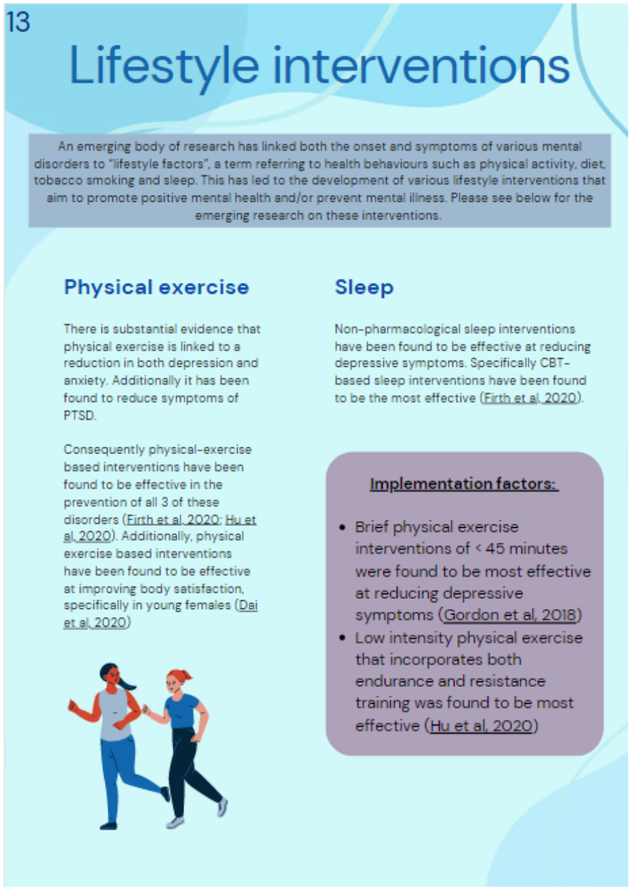
There is evidence that SSI's are effective at reducing both anxiety and conduct problems, as well as limited evidence for their effectiveness at preventing depressive and eating disorder symptoms (Schleider et al, 2017). There is also limited evidence that SSI's are most effective with younger children.

Additional intervention types

There were a handful of additional intervention types/populations that we found worth noting when scoping the literature. These include:

1. Digital interventions
2. Lifestyle-based interventions
3. Interventions for University students

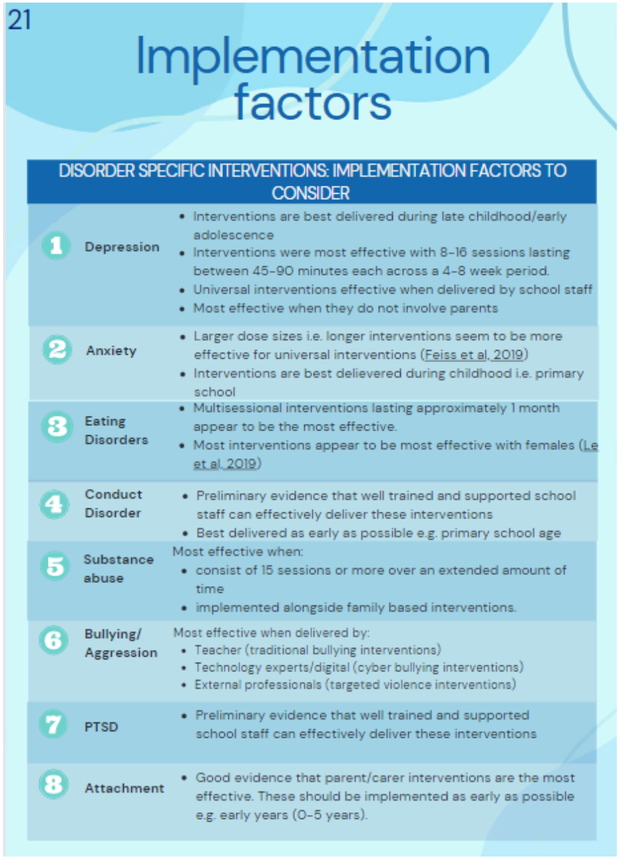




Implementing early intervention programmes

The successful implementation of early intervention programmes is crucial to their effectiveness. We included the following information to inform implementation of these programmes:

1. General guidance for universal and targeted interventions
2. Disorder-specific implementation guidance
3. Implementation planning tool



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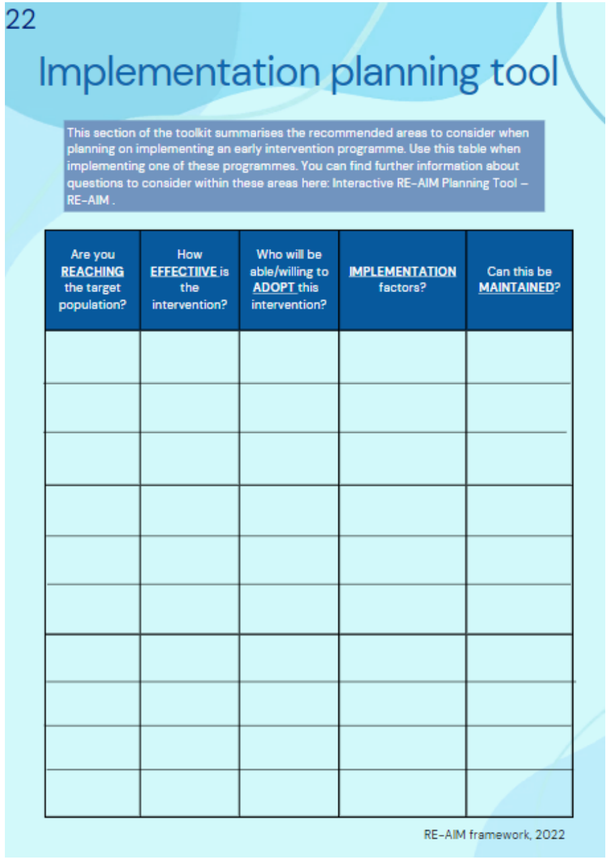
Implementation factors

DISORDER SPECIFIC INTERVENTIONS: IMPLEMENTATION FACTORS TO CONSIDER	
1 Depression	• Interventions are best delivered during late childhood/early adolescence • Interventions were most effective with 8-16 sessions lasting between 45-90 minutes each across a 4-8 week period. • Universal interventions effective when delivered by school staff • Most effective when they do not involve parents
2 Anxiety	• Larger dose sizes i.e. longer interventions seem to be more effective for universal interventions (Feiss et al. 2019) • Interventions are best delievered during childhood i.e. primary school
3 Eating Disorders	• Multisessional interventions lasting approximately 1 month appear to be the most effective. • Most interventions appear to be most effective with females (Le et al. 2019)
4 Conduct Disorder	• Preliminary evidence that well trained and supported school staff can effectively deliver these interventions • Best delivered as early as possible e.g. primary school age
5 Substance abuse	Most effective when: • consist of 15 sessions or more over an extended amount of time • implemented alongside family based interventions.
6 Bullying/ Aggression	Most effective when delivered by: • Teacher (traditional bullying interventions) • Technology experts/digital (cyber bullying interventions) • External professionals (targeted violence interventions)
7 PTSD	• Preliminary evidence that well trained and supported school staff can effectively deliver these interventions
8 Attachment	• Good evidence that parent/carer interventions are the most effective. These should be implemented as early as possible e.g. early years (0-5 years).



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Implementation planning tool

This section of the toolkit summarises the recommended areas to consider when planning on implementing an early intervention programme. Use this table when implementing one of these programmes. You can find further information about questions to consider within these areas here: Interactive RE-AIM Planning Tool – RE-AIM .

Are you REACHING the target population?	How EFFECTIVE is the intervention?	Who will be able/willing to ADOPT this intervention?	IMPLEMENTATION factors?	Can this be MAINTAINED?

RE-AIM framework, 2022

Intervention Matrix

As part of this review, we produced an implementation matrix, summarising the specific interventions that have been reported as most effective for different mental health presentations.

For each intervention, we aimed to provide the following information:

1. Brief summary of the intervention including intervention type
2. Research on its effectiveness (incl. country of origin)
3. Target population
4. Details on number of sessions, who can deliver it and the intended setting e.g. school, community
5. Implementation information including cost

FRIENDS

Brief summary

Resilience CBT based intervention aimed at reducing anxiety and promoting positive mental health for children and young people

Target population

Children aged 4+

Who can deliver?

Any allied health professional or education professional e.g. teachers and school staff.

Setting

School setting

Number of sessions

10 weekly sessions (1-hour) plus 2 optional booster sessions completed after 1 and 3 months.

Research

Higgins & O'Sullivan (2015) conducted a systematic review looking at the efficacy of the first 3 versions of FRIENDS and found that they were all effective at reducing anxiety symptoms in their targeted population. These intervention effects were also found to be maintained at 4, 6, 12 and 24 months.

Implementation considerations

- Booster intervention sessions are highly recommended
- 1 day training required to deliver the programme.
- Booster training is recommended
- License required
- Training manual and children's workbooks are provided

The Body Project

Brief summary

Cognitive dissonance-based eating disorder prevention intervention aimed at developing a healthy body image

Target population

Children aged 11-18, as well as university students (aged 18-24)

Who can deliver?

Trained facilitators

Setting

School and community settings

Number of sessions

4 or 6 sessions (dependant on program choice)

Research

Stice et al (2020) conducted a 4-year follow-up study comparing clinician-delivery, peer-educator delivery and internet delivery of the Body Project. They found that all 3 programmes were effective at reducing risk factors (body dissatisfaction, dieting, negative affect, thin ideal internalisation) and eating disorder symptoms compared to controls. These effects were found at 1 and 2 year follow up, with some effects persisting through 3 and 4 year follow up too.

Implementation considerations

- 2-day training required to deliver to females
- Train-the-trainer options available
- Training manual provided
- Bolt-on training's available for male and LGBTQ+ populations

Any Questions?