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**Literature Review:
The Emotional Harm and Well-being of Children**

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1. Definitions

Definition of emotional well-being

In 1998, the Health Education Authority defined 'mental health' as:

'... the emotional and spiritual resilience which enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own and others' worth.'

In relation to children, the concept of 'mental health' has been shaped in recent years by two key publications. The first was the NHS Advisory Service's report (1995) '*Together we stand*', concerning the commissioning role and management of child and adolescent mental health services. That definition was extended by the Mental Health Foundation in its publication '*Bright Futures*' (MHF, 1999). This specifically refers to the mental health of children in terms of a number of abilities. These include the ability to:

- develop psychologically, emotionally, intellectually and spiritually;
- initiate, develop and sustain mutually satisfying personal relationships;
- use and enjoy solitude;
- become aware of others and to empathise with them;
- play and learn;
- develop a sense of right and wrong;
- face problems and setbacks and learn from them, in ways appropriate for the child's age.

This definition of mental health has been criticised for being cultural-specific (within a Western perspective), and for failing to take account of the diversity of abilities and human responses to experiences (e.g. Dogra et al, 2002). Despite its limitations, this definition forms a useful starting point for considering children's emotional well-being and emotional harm. It is clear, for example, that mental health involves more than just the absence of emotional difficulties. It involves the presence of a number of abilities which develop from infancy, through childhood and adolescence, and which have implications for adjustment and well-being in adulthood.

Although the present discussion focuses on mental health and emotional well-being, the interdependence of emotional well-being with other areas of well-being such as physical well-being needs to be acknowledged. Thus, for example, a child who is chronically ill or has experienced a traumatic accident may experience difficulty in playing and learning, or in developing relationships, which is likely to be detrimental to their emotional well-being.

The interrelatedness of emotional well-being with other domains of a child's life is also reflected in the five outcomes identified for all children, as set out in the Children Act (2004):

- Be healthy: enjoying good physical and mental health and living a healthy lifestyle;
- Stay safe: being protected from harm and neglect and growing up able to look after themselves;
- Enjoy and achieve: getting the most out of life and developing broad skills for adulthood;
- Making a positive contribution: to the community and to society and not engaging in anti-social or offending behaviour;
- Achieve economic well-being: engage in further education or employment and live in decent homes and communities.

Embedded within these five outcomes to varying degrees are the abilities covered within the Mental Health Foundation's definition of child mental health. For example, a child with good mental health according to the Mental Health Foundation definition is likely to develop a sense of right and wrong, to be aware of others and to empathise with them, and is therefore likely to be better equipped to achieve the outcome of 'making a positive contribution'. Hence, enhancing children's emotional well-being is likely to lead to improvements for children on these five outcomes, and as such should be a priority for service planners and providers. All local authorities are obliged to provide services that work towards improving these outcomes for children as a means of enhancing their emotional well-being.

Definition of emotional harm

In the government's *'National Service Framework for Children, Young People and Maternity Services'* (NSF, DH 2004), which sets out a ten year strategy for the development of services to support children and young people, mental health problems in children and young people are defined as:

'abnormalities of emotions, behaviour or social relationships sufficiently marked or prolonged to cause suffering or risk to optimal development in the child or distress or disturbance in the family or community.'

The NSF also defines mental health difficulties in relation to their impact on a child's abilities, abilities which relate to those identified in the Mental Health Foundation's definition of child mental health described earlier:

'mental health problems may be reflected in difficulties and/or disabilities in the realm of personal relationships, psychological development, the capacity for play and learning and in distress and maladaptive behaviour. They are relatively common, and may or may not be persistent.'

There are many other terms used to describe the difficulties that children may experience in relation to their emotional well-being and mental health. Definitions can vary from the non-specific to the highly categorised, depending on the professional context of the person describing the issue. Teachers and other education professionals, for example, may describe children as having 'emotional and behavioural difficulties' (EBD) if they appear

anxious or withdrawn or if their behaviour is impeding their (and others) ability to sit and concentrate. When such difficulties become persistent, severe, or affect daily functioning, they may reach a threshold for definition as a mental disorder, classified within a psychiatric classification system such as ICD-10 (World Health Organisation, 1992) or DSM-IV (American Psychiatric Association, 1994). For children, these disorders are defined in terms of the following:

- emotional disorders - e.g. phobias, anxiety states and depression; these may manifest themselves in physical symptoms
- conduct disorders - e.g. stealing, fire-setting and anti-social behaviour.
- hyperkinetic disorders - e.g. disturbances of activity or attention
- developmental disorders - e.g. delay in acquiring skill such as speech; may affect primarily one area or pervade a number of areas, for example in autism
- eating disorders - e.g. pre-school eating problems, anorexia nervosa and bulimia nervosa
- habit disorders - e.g. tics, sleep problems, enuresis/encopresis
- post traumatic syndromes - e.g., post traumatic stress disorder
- somatic disorders - e.g. chronic fatigue syndrome
- psychotic disorders - e.g. schizophrenia, manic depressive disorder, drug-induced psychoses.

NHS Health Advisory Service (1995)

The distinctions between 'normal' child behaviour, mental health problems and mental disorders are often a question of degree and persistence of the problem, as well as age and timing. For example, the occasional temper tantrum by a two year old could be viewed as a 'normal' behaviour pattern, but if the same behaviour was frequent, severe, or persisted into school years, it would be considered indicative of an emotional and behavioural problem, and potentially a mental health disorder.

As well as the different labels and methods of classifying mental health problems and disorders, the conceptual relationship between emotional well-being and emotional harm also varies. The two can be seen as quite separate, independent categories, or as lying on opposing ends of a spectrum. Each has implications for the design and implementation of interventions in terms of who is targeted and what risk or protective factors are targeted.

The variety of ways in which children's emotional and mental health problems are defined raises several issues for the policy and provision of services aimed at intervention and prevention. Agencies working in this area need to develop a consensus regarding definitions and thresholds to enable interdisciplinary communication and the development of co-ordinated policy and strategy for intervening to enhance children's emotional well-being and reduce emotional harm.

2. Prevalence of mental health problems

Differences in definitions and thresholds for defining emotional or mental health problems lead to variations in reported prevalence for mental health problems and disorders. For example, statistics from the US report that as many as 21% of US children age 9 to 17 years have a mental health problem causing at least 'minimal impairment'. When the higher threshold of 'significant impairment' is applied however, this rate reduces to 11% (Shaffer et al, 1996).

A recent survey of almost 8000 children and adolescents in Great Britain carried out by the Office for National Statistics (ONS, Green et al, 2005) showed that around one in ten children have a mental health disorder to clinically significant levels (as assessed by children, parent and teacher reports using ICD-10 criteria). Summary statistics from the survey are provided in table 1.

Table 1. Prevalence of mental disorders by age and sex for children and adolescence in Great Britain, 2004 (Green et al, 2005)

	5 - 10 year olds (% of children)			11 – 16 year olds (% of children)			All children (% of children)		
	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All
Type of disorder									
Emotional disorders	2.2	2.5	2.4	4.0	6.1	5.0	3.1	4.3	3.7
Conduct disorders	6.9	2.8	4.9	8.1	5.1	6.6	7.5	3.9	5.8
Hyperkinetic disorders	2.7	0.4	1.6	2.4	0.4	1.4	2.6	0.4	1.5
Less common disorders	2.2	0.4	1.3	1.6	1.1	1.4	1.9	0.8	1.3
Any disorder	10.2	5.1	7.7	12.6	10.3	11.5	11.4	7.8	9.6

These figures show that rates for disorders are higher in adolescents than in younger children (11.5% compared with 7.7%). Across the 5 to 15 years age range there are overall slightly higher rates for disorders among boys compared to girls, with boys experiencing higher rates of conduct disorders, and girls experiencing higher rates of emotional disorders.

Less information is available concerning rates of mental health problems in older groups (age 16-18 years) or in very young children in the UK. A study carried out in 1975 in Inner London by Rickman and colleagues reported

moderate to severe disorders in 7% of three year olds and mild disorders in 15% (Rickman cited in DfES, 2004). A more recent study of children aged 18 months who formed part of the Copenhagen Child Cohort reported rates for diagnosable disorders in the 16 to 18% range (Skovgaard et al, 2007).

In order to illustrate the overall prevalence rate of 10% for disorders as reported in the ONS survey, Young Minds (1999) provide the following picture of mental health when this figure is applied to populations in various contexts:

In a town the size of Derby:

- about 5,000 children will be suffering from a mental health problem

In a primary school with 250 pupils:

- 3 children will be seriously depressed
- a further 11 children will be suffering significant distress
- 12 children will be affected by phobias
- 15 children will have a conduct disorder

In a secondary school with 1000 pupils:

- at any one time around 50 pupils will be seriously depressed
- a further 100 will be suffering significant distress
- between 5 and 10 girls at the school will be affected by eating disorders
- 10 to 20 pupils will have an obsessive compulsive disorder

The ONS study also reported that one in five children diagnosed with a disorder had more than one disorder, with the most common overlap occurring between emotional disorders, conduct disorders, and hyperkinetic disorders. Almost three-quarters (72%) of children with multiple disorders were boys, reflecting the high degree of overlap between conduct disorders and other disorders.

In terms of the effects that these disorders have on children's lives, among those with emotional disorders, 44% were behind at school and the figure for conduct disorders was 59%. Their ability to make friends was also affected, with 35% of those with emotional disorders and 33% with conduct disorders reporting difficulties in this area. Around a quarter of those with an emotional or conduct disorder were suicidal. Information from a variety of sources indicates that the numbers of children and adolescents experiencing mental health problems is on the increase (Mental Health Foundation, 1999; Rutter and Smith, 1995).

3. Causes of emotional harm

Understanding the causes of children's emotional problems is important for informing the design of interventions to enhance well-being. Research in this

area has focused on the identification of risk factors and protective factors. Risk factors are factors that increase the chance of an undesirable outcome affecting the child, while protective factors are those that moderate the effects of the risk factor (Garmezy, 1983). Information about risk and protective factors is essential for knowing who to intervene with, what factors to target for intervention and at what stage in the developmental trajectory of children's lives to intervene. Many mental health problems share the same risk factors. Hence targeting these factors can lead to positive outcomes influencing a range of dimensions of well-being. Risks factors can be present in different contexts specific to the child, family, or community. The risk factors known to adversely affect children's mental health are set out in box 1.

The impact of risk factors on children's emotional well-being may be offset by the presence of protective factors. Resiliency refers to positive adaptation in the face of severe adversity (Rutter, 1987). A resilient child is less likely to succumb to the effects of a stressor, and is likely to cope more successfully with traumatic events (Newman, 2004). Hence these factors have important implications for interventions aimed at enhancing children's emotional well-being. Like risk factors, factors identified as enhancing resilience have been located within the child, family and community, as shown in box 2.

Box 1. Risk factors for child mental health

Risk factors in the child:

- Specific learning difficulties
- Communication difficulties
- Specific developmental delay
- Genetic influence
- Difficult temperament
- Physical illness especially if chronic and/or neurological
- Academic failure
- Low self-esteem

Risk factors in the family:

- Overt parental conflict
- Family breakdown
- Inconsistent or unclear discipline
- Hostile or rejecting relationships
- Failure to adapt to a child's changing needs
- Physical, sexual or emotional abuse
- Parental psychiatric diagnosis
- Parental criminality, alcoholism or personality disorder
- Death and loss – including loss of friendship

Risk factors in the community:

- Socio-economic disadvantage
- Homelessness
- Disaster
- Discrimination
- Other significant life events

DfEE (2001)

Box 2. Resilience factors for child mental health

Resilience factors in the child:

- Secure early relationships
- Being female
- Higher intelligence
- Easy temperament when an infant
- Positive attitude, problem solving approach
- Good communication skills
- Planner, belief in control
- Humour
- Religious faith
- Capacity to reflect

Resilience factors in the family:

- At least one good parent-child relationship
- Affection
- Clear, firm and consistent discipline
- Support for education
- Supportive long-term relationship/absence of severe discord

Resilience factors in the community:

- Wider social network
- Good housing
- High standard of living
- High morale school with positive policies for behaviour, attitudes and anti-bullying
- Range of positive port/leisure activities

DfEE (2001)

The link between risk factors and outcomes

Figures from the ONS survey described earlier show variations in prevalence rates for disorders in relation to a number of risk factors. (Green et al, 2005). Prevalence rates for disorders are higher among children in certain socio-economic and family circumstances:

- In lone parent households (16%) compared with two-parent families (8%)
- In reconstituted families (14%) compared with those containing no stepchildren (9%)
- In families with a parent with no educational qualifications (17%) compared with those who had a degree level qualification (4%)
- In families with neither parent working (20%) compared with those in which both parents worked (8%)
- In families with a gross weekly household income of less than £100 (16%) compared with those with an income of £600 or more (5%)

- In families where the householder was in a routine occupational group such as unskilled manual worker (15%) compared with those with the householder in a higher professional group, for example doctors and lawyers (4%)
- Living in social or privately rented housing (17% and 14%) compared with those who owned their own accommodation (7%)
- Living in low income, high unemployment areas (15%) compared with affluent areas (7%)

Accumulation of risk

The effect of risk factors is cumulative. A child with a single risk factor present in their life is thought to have a 1 - 2% chance of developing a mental health problem, whereas for a child with three risk factors the chance is 8%, and with four or more risk factors the chance is 20% (DfEE, 2001). Early intervention to halt the accumulation of risk is therefore recommended (Rutter et al, 1998).

There are circumstances in which children are at greater risk of exposure to multiple risk factors, and these circumstances therefore make emotional harm more likely. These include situations involving loss and separation resulting from death, parental separation or divorce, hospitalisation, loss of friendships; life changes such as moving schools or moving house; and traumatic events such as abuse, violence, accidents, injuries, war or natural disaster. Some groups of children are more likely to be exposed to these events and, therefore, will be at greater risk for mental health problems through the accumulation of multiple risk factors. These include looked after children, children of divorcing parents, young carers, runaways, teenage parents, children with special needs or disabilities, unaccompanied asylum seeking children, children exposed to domestic violence, and children with mentally ill parents or substance misusing parents.

Risk factors and the developmental perspective

The impact of risk factors also needs to be understood in terms of the developmental trajectory of the child. What may constitute a significant risk factor at a particular age may constitute a less significant risk at another age. Hence risks need to be understood in terms of stages of child development and the changing needs of the child. There are several developmental theories that have informed understanding of risks include Bowlby, Freud, Erikson, Piaget and Maslow. Bowlby's attachment theory, for example, highlights the significance of secure attachment in infancy for a child's emotional well-being in later years (Bowlby, 1969). The first two years of life are a time of particularly rapid brain growth and development, and experiences in this period are especially likely to influence brain development in ways that shape well-being and mental health in later years (Sander, 2000). The quality of the relationship with the primary carer is one of the most significant factors influencing such development in infancy. This clearly has implications for intervention at the earliest stages of development, beginning at birth or pre-natally. Safeguarding infants from experiences such as inconsistent, unresponsive, neglectful or abusive parenting, or loss can enhance development of secure attachment, which acts as a protective factor

for the child's emotional well-being and long-term adjustment. Interventions need a theoretical basis such as this to provide an understanding of how risk factors operate, and to inform the design and timing of interventions across a child's life.

4. Indicators of emotional harm

There is great variation in the way that emotional harm can show itself among children. It may have physiological, physical, emotional and social effects, which vary for each child and across age ranges also. Some indicators can mirror 'normal' developmental behaviours. 'Naughtiness' for example, might be within the normal range, but may escalate to become a more persistent behavioural problem. Some signs of mental health problems can also be similar across different disorders, and there can be co-morbidity of disorders (i.e. more than one type of difficulty present at a time). Young children often cannot articulate their distress, and the signs may be masked, since children do not necessarily show signs in the way that adults do. For example, passivity and lethargy might be indicators of depression in adults, but acting out and aggression might be signs of the same disorder within a young child.

Indicators in infants and toddlers

The expression of emotional harm within babies is not well understood, but is thought to be demonstrated by poor sleep patterns, difficulties with feeding, restlessness and gastric disturbances (Young Minds, 2007). For older infants and toddlers, emotional harm may show itself in terms of a loss of previously acquired developmental skills, or developmental regression. This can include difficulty falling asleep on their own, difficulty separating from a parent at nursery, loss of speech or toileting skills. Other responses may include: increased crying, increased clinginess, increased anxiety and fear, irritability, head banging, increased sleep difficulties (such as nightmares, night terrors, or fear of going to sleep), increased feeding problems, falling off growth curves, developmental delay, limited speech, and limited social interaction. Preschool age children may also show: uncontrollable behaviour, hyperactivity, tantrums, breath-holding, biting, kicking, scratching, nightmares, and toileting problems (refusal, withholding, smearing, bedwetting, increased 'accidents').

Indicators in school age and older children

In school age children, indicators of emotional harm may include a worsening of school performance, difficulty concentrating, increasing school and homework resistance, physical complaints (such as headaches, tummy aches, respiratory complaints, muscle tension, fatigue), altered sleeping or eating patterns, lack of motivation, anxiety, lack of empathy with others, heightened sensitivity to others who are upset or stressed, loss of capacity to experience curiosity or joy, poor self-esteem, withdrawn, difficulty maintaining friendships, difficulty asking for help, a desperate need to please and need for popularity, defiance, extreme rage, and increased lying and stealing. In addition, in older school-aged children, signs may include: school failure,

promiscuity, aggression, delinquent behaviour, increased aches and pains, substance misuse, self-harm, suicidal thoughts or attempts, and other symptoms that are more like adult depression.

The point at which such behaviours reach a threshold for intervention by a mental health professional typically includes consideration of the persistence, increasing intensity or frequency of the symptoms, and whether it interferes significantly with daily functioning, or presents a danger to the child or to others.

5. Effective interventions

Policy guidance on intervention

'Every Child Matters: Change for Children' sets out a framework for national and local change aimed at improving the five outcomes for children and young people set out under the Children Act (2004). The principles it sets out concerning services are:

- The needs of children, young people and their families must be at the heart of all service planning and delivery.
- Organisations working with children, young people and their families must work together more effectively to provide integrated and accessible services that meet these needs.
- Identifying problems and intervening before children reach crisis point and protecting children from harm.
- Establishing a voice for children, young people and their families when developing services.
- Improved outcomes for all children and young people.

In relation to children's mental health services in particular, The National Service Framework (NSF; DH, 2004) states such services should be local and accessible, planned in conjunction with service users and carers, with emphasis on early intervention and detection and parenting support with clearer access to specialist services. Specific guidance concerning the way in which agencies must work together to achieve these aims is also set out within the 'Every Child Matters: Change for children' framework (DfES, 2005).

Definitions of prevention

The UK policy emphasis is firmly placed on early intervention, but the definition of early can vary. 'Early' interventions may not only refer to those that target children at a young age, but also those that target children preventatively, prior to the onset of a difficulty, regardless of the child's age (Little and Mount, 1999). Traditionally, interventions have been described as primary, secondary and tertiary depending on the point at which they are implemented in the development of mental health problems and disorders. In 1994, the US Institute of Medicine Committee on the Prevention of Mental Disorders reviewed this classification of interventions and produced a framework called the Mental Health Intervention Spectrum for Mental

Disorders (Mrazek and Haggerty, 1994). This classified interventions in the following way:

- Prevention: Universal
Selective
Indicated
- Treatment: Case identification
Standard treatment for known disorders
- Maintenance: Compliance with long-term treatment (reduction in relapse)
- After care (rehabilitation)

Within this framework, prevention is used to refer to interventions that occur **before** the initial onset of a mental health disorder, as defined by psychiatric classification systems such as DSM-IV and ICD-10. Universal preventative interventions target the entire general public, such as maternal prenatal care. Selective preventative interventions target part of the population with a higher than average risk, for example, low birth weight babies. Indicated preventative programmes target high risk individuals who do not meet the formal diagnostic criteria for a mental health disorder, but are nevertheless experiencing significant difficulties. A mix of universal, selective and indicated programmes for child mental health is recommended (Offord et al, 1998). The present report focuses on preventative programmes rather than treatment and maintenance of mental health disorders.

Effective intervention approaches

An enormous range of interventions have been devised to enhance children's emotional well-being, covering a wide range of theoretical approaches, intervention contexts, age groups, and targeted recipients (e.g. children, parents, and high-need families). The types of intervention programmes that have shown effectiveness in changing outcomes for children's emotional well-being across risk targets are broadly described as (DfES, 2004):

- Relational-based family interventions
- Attachment-based interventions
- Parent training
- Emotional education programmes

For the purposes of this review, we are summarising the above types of interventions into two broad categories. The first category is parenting education and support, which encompasses the first three types of programme on the above list. The second category is school-based interventions, which covers the last type of intervention on this list, although emotional training programmes can take place in other settings. There may be

some overlap between these two categories in some instances, for example, when parent training is run in partnership with a school. Most preventative interventions, but not all, fall within these two broad categories since family and school are the contexts in which children spend most of their lives, which form significant influences on development and outcomes.

Principles of effective parent education and support services

Given the significance of parents or primary carers in a child's life, supporting and enabling parents to carry out their role is seen as an important area for intervention for enhancing emotional well-being among children. Hence there has been a large growth in recent years in the provision of parenting support and training (Moran and Ghate, 2005). Parent training and support programmes generally aim to change the way that parents interact with their infants and children. They involve working directly with parents (typically mothers) and many also involve direct work with children or with parents and children together. They can involve home visits, group training and information sessions, parent-school partnerships, and other programme formats run from other community settings. A recent review of international evidence regarding what works in parenting support identified a number of characteristics of parenting interventions that have been effective in improving outcomes for children, including emotional well-being (Moran et al, 2004). These are set out in box 3.

Many of the factors listed in box 3 also appear in a report concerning '*What works in promoting children's mental health*', which summarises research evidence in this area and sets out the implications for Sure Start local programmes (DfES, 2004). That report specifies particular features of programmes that relate to effectiveness:

- Comprehensiveness – programmes should including multiple components because no single component can prevent multiple high-risk behaviours.
- System orientated – interventions should be aimed at changing institutional environments as well as individuals.
- Relatively high intensity and duration – successful programmes are rarely brief. Multi-year programmes tend to have an impact on more risk factors and have more lasting effects.
- Structured curriculum – there is no clear indication as to the 'ideal' curriculum, but interventions should be directed at risk and protective factors rather than problem behaviours so that multiple adverse outcomes may be addressed within a single programme.
- Early commencement – this has been shown to be essential and intervention during pregnancy brings additional benefits.
- Specific to particular risk factors – generic preventative intervention cannot tackle all risk factors. Prevention needs to address risks for specific problems or disorders within a specific context and with a specific objective.

- Specific training – there is less consistency in finds regarding the level of qualifications required to carry out preventative work. Most UK interventions involve health visitors who have a statutory obligation to visit young families.
- Attention to maintaining attendance – families with high level needs are likely to need a great deal of support to engage with an intervention as they are the most likely to drop out.

Adapted from 'What works in promoting children's mental health'
DfES, 2004

Box 3. What works in parenting support

- Both early intervention and later intervention; early interventions report better and more durable outcomes for children; but late intervention is better than none and may help parents deal with parenting under stress
- Interventions with a strong theory-base and clearly articulated model of the predicted mechanism of change: services need to know both where they want to go, and how they propose to get there
- Interventions that have measurable, concrete objectives as well as overarching aims
- Universal interventions (aimed at primary prevention amongst whole communities) for parenting problems and needs at the less severe end of the spectrum of common parenting difficulties - though some types of universal services require more evaluation to determine their effectiveness
- Targeted interventions (aimed at specific populations or individuals deemed to be at risk for parenting difficulties) to tackle more complex types of parenting difficulties
- Interventions that pay close attention to implementation factors for 'getting', 'keeping' and 'engaging' parents (practical, relational, cultural/contextual, strategic and structural; see Section Four)
- Services that allow multiple routes in for families (i.e. a variety of referral routes)
- Interventions using more than one method of delivery (i.e., multi-component interventions)
- Group work, where the issues involved are suitable to be addressed in a 'public' format, and where parents can benefit from the social aspect of working in groups of peers
- Individual work, where problems are severe or entrenched or parents are not ready/able to work in a group, often including an element of Home Visiting, as part of a multi component service, providing one-to-one, tailored support

- Interventions that have manualised programmes where the core programme (i.e., what is delivered) is carefully structured and controlled to maintain 'programme integrity'
 - Interventions delivered by appropriately trained and skilled staff, backed up by good management, support and supervision
 - Interventions of longer duration, with follow-up/booster sessions, for problems of greater severity or for higher risk groups of parents
 - Short, low level interventions for delivering factual information and fact-based advice to parents, increasing knowledge of child development and encouraging change in 'simple' behaviours
 - Behavioural interventions that focus on specific parenting skills and practical 'take-home tips' for changing more complex parenting behaviours and impacting on child behaviours
 - 'Cognitive' interventions for changing beliefs, attitudes and self-perceptions about parenting
 - Interventions that work in parallel (though not necessarily at the same time) with parents, families and children
- Moran et al (2004)

Specific parent education and support interventions

Examples of effective programmes that involve parent education and support are described in Appendix 1. These descriptions have been extracted from a recent review of what works in parenting support (Moran et al, 2004). The specific interventions have been chosen on the basis that there is robust research evidence showing that these interventions are effective in changing outcomes for children. Since the U.S. has a longer tradition of carrying out methodologically robust evaluations of such interventions, the best evidence of what works comes predominantly from the US. However, we have included some UK interventions where sufficient evidence of effectiveness has been shown. (More detailed information concerning these interventions is available from the original report from which the descriptions were extracted). The descriptions of interventions show that, although they cover a range of intervention types and age range of children, they embody many of the principles summarised above.

Principles of effective school-based approaches

The school-based interventions are those that aim to change the school 'environment' in its broadest sense. The significance of schools as a site for intervention is highlighted by the recent finding that teachers are the most popular source of formal support among 15 year old school pupils (Moran, 2007). There are a number of ways in which schools can influence children's emotional well-being, including universal, whole-school approaches as well as targeted interventions, described below.

Whole-school approaches

A range of terminology is used to describe 'whole school' approaches, including 'holistic', 'healthy schools', 'health promoting schools' and 'universal'. These approaches involve changing the total emotional and social context of the classroom and school. In the UK, the government's 'National Healthy Schools' initiative sets out to promote physical and emotional well-being using a whole school approach (NHS Health Development Agency, 2004).

A review by Wells et al (2003) concludes that whole school approaches lasting at least a year can be effective, including changing outcomes for those with emotional and behavioural problems. One of the benefits of these types of approaches is that they are non-stigmatising, and those with problems are more likely to feel positive about them rather than feeling singled out. Weare and Gray (2003) describe the components of an effective holistic/whole school approach:

- It would look at several aspects of the school, not just one, and certainly not the curriculum only. Other important aspects include management, ethos, relationships, communication, policies, physical environment, relations with parents and relations with community.
- It would look at the underlying environmental determinants of emotional wellbeing and competence, not just it's learning or behavioural outcomes.
- It would work with all relevant parties and at all levels, for example government, LEAs and schools, and with everyone in the school or community, not just those with special needs or those families identified as having problems.
- It would include the care-givers (for example teachers) as well as the recipients (for example pupils).
- It would ensure congruence between the various parts, so that one part of the picture is not undermining work that is being carried out somewhere else (for example messages from LEAs conflicting with what is happening in schools).
- It would promote coherence, teamwork, 'joined up thinking' and multi professional working. It would take a positive approach, which starts from the widest possible perspective of wellbeing, and includes problems within it, not starting with a narrow, problem centred, deficit model.

Targeting within a whole school approach

In addition to whole school approaches, early identification and assessment of children is needed in order to provide more targeted support for those experiencing emotional and behavioural difficulties. Intervening early is seen as critical in order to prevent the escalation of risk that leads to long-term difficulties, and is one of the aims behind Behaviour and Education Support Teams (BESTs). Such teams aim to promote the emotional well-being of children and are based on evidence of what works in early intervention.

Learning Support Units (LSUs) have also been introduced as a form of in-school support for children with behavioural problems. They are best used as a form of short-term support, using the same clear classroom management strategies as the mainstream classes to which pupils return, so that there are consistent messages regarding expectations and boundaries (Weare and Gay, 2003).

Where the introduction of specific programmes is concerned, there is clear evidence that programmes need to take a long-term, developmental approach. Programmes that have been successful in enhancing children's emotional development typically show that they are more successful the longer they are in place, which can be for many years.

In a review of school-based programmes, Weave and Gray (2003) set out the principles of programme design that have been shown to be effective in relation improving emotional well-being of school children:

- **Teach skills as well as knowledge and attitudes** – programmes need to include extensive, routinised, regular and predictable work to develop specific skills (such as social skills) across the curriculum, and reinforce these skills by pupils' real life experience across the school.
- **Use a step by step approach** – problem solving approaches that involve progression through stages is useful, e.g. problem clarification, identification of possible solutions, assessing pros and cons, reflecting on outcomes, etc. Stepwise 'thinking strategies' have formed a component of several successful interventions, and can involve acronyms or visual mnemonics as prompts.
- **Help learners generalise to real life** – programmes tend to be more effective when they teach young people sufficiently generic, basic, foundation competencies that can be generalised across risk situations.
- **Use positive techniques** – programmes are more effective in changing behaviour when they focus on positive behaviour rather than punishing negative behaviour.
- **Use active methods, such as co-operative group work** – programmes that are effective often involve active, participatory elements such as group work, role play, games, simulations and class discussion.
- **Use peer education** – peer tutoring in various forms can have beneficial effects on self-concept, learning, social relationships and classroom behaviour, especially for those with behavioural and emotional problems.
- **Be congruent with what happens across the rest of the school** – in keeping with the 'whole-school' approach, programmes are more effective if they are congruent with the rest of the school, as reflected for example in teachers modelling of respectfulness and warmth, and in routines and practices across all lessons.

Specific schools-based interventions

As with parenting interventions, the most robust evaluations of schools based programmes are from the US, and results do not necessarily transfer to a UK context. Programmes that have demonstrated effectiveness are summarised in Appendix 1. In terms of programmes and initiatives within the UK context, the general lack of rigorous evaluation means that all that we can conclude regarding various approaches is that at best they are 'promising'. 'Promising' approaches in the UK context include peer support schemes, such as peer listening, peer mentoring, peer counselling, and approaches that consider building self-esteem and also emotional literacy, or combinations of several of these factors (Sutton et al, 2005). Case study examples of various approaches that are promising, from the whole-school approach to targeted, can be found in the DfEE (2001) guidance *'Promoting children's mental health within early years and school settings'* and also in the DfES (2002) guidance *'Intervening early: A snapshot of approaches primary schools can use to help children get the best from school'*. The promising approaches covered in the guidance include circle time, the 'You Can Do It!' Programme, nurture groups, the National Pyramid Trust, The Place To Be, and mentors.

6. Conclusions

Enhancing the emotional well-being of children is important for many reasons, not least to improve the quality of children's day to day experience, but also to improve their chances of experiencing emotional well-being in the long-term. We know that emotional harm is common, with as many as one in ten children experiencing such harm to clinically significant levels. We also know that rates are rising.

Research evidence suggests that children's mental health difficulties can often be identified early, and that they are best tackled when they are still relatively mild (Rutter et al, 1998). Early intervention is therefore an important strategy for enhancing emotional well-being, and is a priority in terms of current government policy. There is now a considerable amount that we know about 'what works' in designing interventions and services to improve children's well-being, although much of this evidence is derived from the US. We know that working with parents and schools to change the environments (in the broadest sense of the word) in which children develop can significantly alter a child's trajectory in terms of their well-being across the lifespan. What is less clear is how far these results can be replicated within the UK context, although promising results are beginning to emerge.

Appendix 1: Specific intervention programmes

Programmes listed below are those that have been shown to be effective in methodologically rigorous research studies. They involve both US-based and UK-based interventions, and are set out in terms of two broad categories: first, parent education and support programmes, and second, school-based programmes. Their US or UK origins are indicated. The parent education and support programmes are also set out in terms of the age range of the children that they are designed to improve outcomes for, starting with the youngest. Information about parent education and support programmes has been extracted from *'What works in parenting support: A review of the International evidence'* (Moran et al, 2004). Most of the information about school-based interventions has been extracted from *'What works in developing children's emotional and social competence and well-being'* (Weare and Gray, 2003).

Parenting Interventions: For parents of infants and pre-school children

US: Brazelton Neonatal Behavioural Assessment Scale

An example of an intervention with newborns is the Brazelton Neonatal Behavioural Assessment Scale (BNBAS; Brazelton, 1973). Although originally devised as an assessment tool for newborns, the BNBAS has been used as a means of enhancing parent-infant interaction and attachment in high and low risk families by increasing parental awareness of the infant's individuality and capabilities. It involves eliciting a number of responses from the infant to assess neurological condition, demonstration of which to parents is believed to increase parental awareness and responsiveness to infant behaviour as well as enhance feelings of nurturance towards the baby.

A meta-analysis of BNBAS-based interventions with newborns concluded that there was a small to moderate beneficial effect on parental behaviour in relation to reciprocity, sensitivity and responsiveness to infant cues (i.e. parents' ability to read and respond in interactions with infants (Das Eiden and Reifman, 1996). Several factors have been suggested as potentially increasing or lowering the effectiveness of the intervention. These include the intensity of the sessions (in terms of the number of repetitions of the procedure required to bring about and sustain change) and the interaction of this with maternal risk factors for poor outcomes such as low socioeconomic status. Passive observation of the procedure versus parental administration of the BNBAS may also affect its impact, although results of trials in this area have produced mixed results. Further research into these moderating factors is required to produce more consistent findings regarding effectiveness. Long-term follow-ups are also required to assess whether the initial short-term enhancement of parental sensitivity leads to more positive parent-infant interactions, and indirectly to other positive outcomes in the longer-term. It has been suggested that the BNBAS should not be viewed in isolation, but seen as an initial component of a longer-term or more intensive intervention.

US: Prenatal/Early Infancy Project (PEIP)

The Elmira Prenatal/Early Infancy Project (PEIP, Olds 1997), also known as the Nurse-Family Partnership, provides parent education and enhanced family support and access to services via an intensive programme of home visits from a trained nurse for the first two years of the child's life. It is aimed at first time mothers from low-income homes, and sets out to prevent early parenting problems that are likely to contribute to emotional harm including anti-social behaviour among children. The programme begins as soon as possible after the beginning of pregnancy, and visits are structured around the changing developmental needs of the child. Mothers are encouraged to reduce potentially harmful health-related behaviours during pregnancy, such as smoking and drinking alcohol; are encouraged to build supportive relationships and friendships; and use other support services and keep appointments for children's health care checks. The originators of the programme stress the importance of programme fidelity in bringing about successful outcomes and that 'watering down' the intervention will reduce the chances of success.

The programme has been running for over twenty years, and has shown to be effective in changing outcomes for mothers and children. Mothers report improved health, greater informal support, greater likelihood of employment, fewer pre-term babies, and heavier babies at birth. For children, outcomes include lower rates of neglect and abuse, fewer arrests by the age of 15 years, less running away, and homes more conducive to positive child development.

US: Perry Preschool Project

The Perry Preschool Project targets low-income families with pre-school aged children at risk of school failure. It takes the form of a structured classroom-based programme that focuses on language, literacy and numeric and social development, with the aim of promoting school readiness in high-risk populations. The programme runs for a minimum of twelve-and-a-half hours per week, and relies on a 'plan-do-review' routine which encourages child-initiated learning activities. Active learning is promoted by providing children with a supportive adult, who prompts and guides child learning activities, and a materials-rich environment. Teachers use as a framework a set of active learning 'key experiences' drawn from child development theory to encourage children to engage in play activities that facilitate decision-making and problem-solving, or otherwise stimulate intellectual, social and physical development. Teachers also offer weekly one-and-a-half hour home-visits to parents, providing an opportunity for discussion and modelling of child activities in the classroom to support child development at home. In addition, the intervention includes monthly parent group meetings.

A randomised controlled trial assessing the long-term effectiveness of the Perry Preschool Project demonstrated enhanced school readiness at age seven years; significantly higher achievement scores on reading, language and mathematics test at age fourteen years; better literacy skills at age nineteen years; and higher education and earnings, and fewer arrests at age

twenty-seven years when compared to the no-intervention control group (Schweinhart et al., 1993). Another longitudinal study with follow-ups at ages fourteen to fifteen, nineteen and twenty-seven years produced similar results. The intervention group had significantly higher monthly earnings, higher percentages of home ownerships, higher levels of schooling, lower percentages of social services intervention, fewer arrests, and higher I.Q. and achievement scores than the no-intervention control group (Schweinhart et al., 1993).

UK: Parent Advisor Service

The Parent Advisor Service is based on a non-directive parent counselling model. The intervention addresses the psychosocial needs of the family as a whole rather than focusing on behaviour of the child. Specifically it aims to empower parents to use their own resources to manage difficulties while preventing them from feeling stigmatised or belittled, and to be with them and support them in the process. Parent Advisors, who are typically health professionals such as health visitors, are required to train on a manualised course in order to acquire the basic skills for counselling families with pre-school children. Families are usually seen at home for an hour at a time, typically on a weekly basis initially, and then on a less frequent basis depending on their needs. The number of sessions is unlimited, but is in practice restrained by the pressure from further referrals.

The scheme has been evaluated within a variety of contexts including child mental health services for treatment of behavioural and emotional difficulties (Davis and Spurr, 1998), families with preterm infants (Marlow and Avon Premature Infant Project), and (in its original context) families of children with disabilities (Davis and Rushton, 1991). Results have been largely positive, although its benefits for use with parents of preterm infants were limited. Parents report less stress, reduced severity of problems and distress in relation to parenting, decreased anxiety and depression, and improved self-esteem, more positive attitudes towards their children, and improvements in their child's behaviour (Davis and Spurr, 1998). These outcomes were assessed at four months post recruitment, and longer-term outcomes are not known.

Parenting interventions: For parents of school-age children

UK: SPOKES (Supporting Parents on Kids Education)

SPOKES aims to facilitate parental support of child learning (particularly improving literacy), and develop effective child behaviour management strategies. More specifically, SPOKES aims to reduce parental stress and the use of physical punishment, increase parental involvement in constructive learning at home, increase parents' involvement in children's school activities and progress, improve child attainment in literacy and attitudes towards reading, and reduce child aggression and anti-social behaviour.

It was developed by Oxford University and the Institute of Psychiatry, London, and includes two distinct components. The first consists of a twelve-week parenting programme that focuses on fostering positive child play behaviours, negative reinforcement of negative or undesirable child behaviours, and positive reinforcement of appropriate or prosocial behaviour. The second part of the intervention includes ten weekly sessions which provide information about child reading, and teaches parents how to effectively support children's literacy development at home. At each session a library of books and literacy activities is provided, and parents are encouraged to borrow books and games for use at home.

Recent evaluation of the programme has shown it to be effective in reducing antisocial behaviour and improving reading ability (Scott and Sylva, 2003). Its success has been attributed to several factors including: use of a strong theory-based parenting programme (i.e. Webster-Stratton), using a collaborative approach where partnership with parents to identify their needs, combining a literacy element to increase attractiveness, pitching the programme as being universally relevant rather than for 'failing' parents, establishing close partnership with the schools in which the scheme was based, and good supervision of group leaders.

US: Fast Track

Fast Track is a long-term, multi-site, multi-component preventative intervention for school-age children that addresses multiple risk factors (including classroom, school, individual child and family risk factors) associated with persistent anti-social behaviour. It comprises a universal component (curriculum delivered in classrooms) and selective components (parent groups, child social skills training, parent-child sharing time, home visiting, child peer pairing and academic tutoring).

The universal component of the programme is delivered by classroom teachers, and covers four domains of skills: skills for emotional understanding and communication, friendship skills, self-control skills, and social problem-solving skills. The selective interventions were offered to 'high-risk' children and their parents, and consists of extra-curricular 'enrichment programmes', delivered by counsellors and social workers. The parent skills training focused on establishing positive family-school relationships, building parental self-control, promoting developmentally appropriate expectations for child behaviour, and improving parent-child interaction. The child social skills training includes 'friendship' groups, focused on reviewing and practicing skills in emotional understanding and communication, friendship building, self-control, and social problem-solving. In addition to the 'enrichment programmes', individual, in-home support, child 'peer-pairing' (both of the latter designed to assist parents and children in generalising or consolidating their acquired skills to other settings), and child academic tutoring (primarily promoting reading skills) were provided by paraprofessionals.

Two evaluations of Fast Track (both randomised controlled trials) suggest high effectiveness (Conduct Problems Prevention Research Group, 1999,

2002). Parents in the intervention group decreased their reported use of physical punishment, displayed more warmth and positive involvement, more appropriate and consistent discipline, and reported increases in parental satisfaction. These changes were maintained over time. In addition, positive changes in almost all the targeted areas of skills-acquisition for children were found one year post-intervention, including increases in emotional and social coping skills, reading skills, peer relations, and school grades. The results of a later evaluation provide evidence that the intervention also contributed directly to a reduction in conduct problems in high-risk children.

US: Strengthening Families Programme (SFP)

SFP is a 14-session family skills training programme designed to reduce risk factors for substance abuse, depression, aggression, delinquency, violence and school failure in 6 to 12 year-old children of substance abusers, although it has been used successfully with non-substance abusing parents also. The programme involves three components: Parent Skills Training, Children's Skills Training and Family Life Skills Training. The Parent Skills Training teaches parents to communicate clearly, use effective discipline and limit-setting. It also targets parental problem-solving skills, stress and anger management skills, and provides substance abuse education. The Children's Skills Training component teaches children to increase their communication, social, and peer resistance techniques, covering topics such as understanding feelings, coping with anger and criticism, stress management, social skills, effective problem-solving, resisting peer pressure, the consequences of substance use, communication skills, and compliance to parental rules and boundaries. The parent and child sessions typically end with Family Life Skills Training, which aims to increase co-operation between family members, and consists of practicing newly acquired skills.

SFP has been extensively evaluated and has been shown to reduce and prevent substance abuse, child externalising behaviours (e.g. aggressiveness, hyperactivity) and internalising behaviours (e.g. uncommunicativeness, obsessive/compulsive tendencies), conduct disorders, parental depression, and increases child social competence (e.g. Kumpfer et al, 2002). There is also evidence that SFP improves parenting skills and aspects of family environments, particularly family cohesion (Kumpfer et al, 2002).

US: Systematic Training for Effective Parenting (STEP)

STEP is a highly structured parent training programme aimed at developing three basic skills in participating parents – developmentally appropriate and realistic expectations of children, effective communication and discipline of children, and decreasing parental isolation (Adams, 2001). It is aimed at families with parent-child relationship problems, including those at risk of child maltreatment, and was originally devised for parents of children aged 6 to 12 years, but has also been used with parents of teenagers.

The programme consists of eight weekly child management training sessions led by a trained professional, and covers the following topic areas:

understanding children's behaviour and misbehaviour (including attention, power, revenge, display of inadequacy); understanding more about children and being a parent (including emotions, family atmosphere and values, sex roles, methods of training); encouragement (including building self-esteem); communication (including how to listen to children and express feelings and ideas to children); understanding natural and logical consequences (the concept of problem ownership), applying natural and logical consequences (including discipline strategies that develop responsibility, daily chores and hygiene); family meetings; and developing confidence and using potential.

STEP is effective in improving child behaviour, self-concept and parental attitudes and behaviour. Adams (2001) reports that significantly improved problem-solving, communication, affective responsiveness and behaviour control in families participating in the STEP programme.

Parenting Interventions: For parents of children from birth to adolescence

US: Triple P - Positive Parenting Programme

Triple P is a programme for parents and children from birth to 12 years. The programme aims to prevent severe emotional, behavioural and developmental problems in children by increasing parenting knowledge, skills, confidence, self-sufficiency and resourcefulness; enhancing family environments by helping parents provide nurturing, non-violent, low-conflict and engaging home contexts; and fostering emotional, social, intellectual and behavioural competence in children (Sanders & Markie-Dadds, 1996; Sanders, 1999). It is a multi-level, multi-disciplinary preventative family intervention designed to reach families with varying levels and types of support needs. The 'strength' or dosage of the intervention is determined by the (assessed) severity of child behavioural problems, and includes the following:

Level 1: A universal population-level media information campaign directed at all families, including a self-help written materials (readings and homework tasks) with no practitioner contact.

Level 2: written materials and brief telephone consultations targeting challenging child behaviours.

Level 3: written material and active skills training (including instructions, modelling, role-playing and feedback).

Level 4: written material, active skills training and support provision (including all Level 3 components and home visits to assist in generalising acquired skills).

Level 5: 'enhanced' family intervention, including intensive behavioural parent training and therapeutic work around particular areas of family distress.

Specific outcomes that the programme aims for vary as a function of the level of the Triple P intervention delivered, i.e. Level 1: non-problem child behaviours (e.g. toilet training, dressing self); Level 2: specific problem behaviours (e.g. thumb-sucking, temper tantrums etc.); Level 3: less specific,

more severe problem behaviours (e.g. bedtime disruptions, mealtime behaviour problems); Level 4: behavioural disorders, including conduct disorder, oppositional defiant disorder, aggressive behaviour; Level 5: severe, long-term and concurrent child and parent problems, severe conduct disorder.

There have been few independent evaluations of Triple P, and studies have varied in their methodological rigorousness. However, existing evidence suggests that the programme is effective in enhancing parental efficacy and competence, and reducing disruptive behaviour and attentional/hyperactive difficulties (in non-clinical and clinical populations).

US: Webster-Stratton

Webster-Stratton 'Incredible Years' parent training has been used extensively, typically with parents (and teachers) and children in the 2 to 12 years age range, both with and without behavioural problems. It aims to prevent, reduce and treat aggression and conduct problems in young children, and enhancing child social competence. Additional objectives include promoting parent competencies, strengthening family relationships, promoting teacher competencies and enhancing home-school connections (Webster-Stratton, 2001).

The Webster-Stratton programmes are a comprehensive set of interventions using videotape modelling, group discussion, role-playing and rehearsal techniques, homework activities and supportive telephone calls to prevent, reduce and treat conduct problems, and increase social competence in children. The programmes have been revised to facilitate the development of social support networks for parents, and promote stronger home-school bonds (Webster-Stratton, 2001).

The programme has been evaluated in a great number of studies show an impact on many child and parenting outcomes: child behavioural/conduct problems, parent-child interactions, punitive discipline, parental attitudes, child social competence, parent and child problem-solving abilities, conflict management, parental involvement in schools, school readiness, parental stress, and parental self-esteem.

UK: Parent Network - Parent-Link

Parent-Link aims to increase parenting knowledge, enhance parental confidence in parenting skills and improve family relationships. It was developed in the 1980s by the founders of Parent Network (Sokolov & Pearson), and is a parent education and support programme based on client-centred therapy, theories of interpersonal communication, and family relationships. Parent-Link consists of thirteen parent-led group sessions that focus on assertiveness, communication and listening skills, and can be used across children's age range.

Evaluation of the programme shows that children of participating parents showed a statistically significant reduction in behavioural (aggression) and social problems, internalising symptoms (anxiety and depression), and

delinquent behaviour (Davis & Hester, 1996). These changes were significant for children who scored in the normal range and the clinical range for behavioural problems. Parent-Link also produced a significant improvements in parents' self-esteem, family relationships (parent-partner and parent-child relationships), attitudes towards discipline (less authoritarian), and facilitated reductions in parental stress (Davis & Hester, 1996).

UK: Sure Start

Sure Start is a government initiative launched in July 1998 aimed at preventing the social exclusion of disadvantaged children, from conception to age fourteen years (and older for those with special education needs). Sure Start aims to promote physical, emotional, intellectual and social development in pre-school children by increasing childcare availability, supporting parents in employment and in developing their careers, providing parent skills training and education on child development, health and family support services.

Rather than providing one specific service, Sure Start attempts to change and add to existing services by reshaping and enhancing these services, providing new services, and increasing and improving co-ordination between agencies. Sure Start services include childcare, children's centres, children's information services (information on nursery education and childcare availability), early excellence centres (a range of educational and care services for parents and children), extended schools (co-ordinating childcare services), health and family support (parental education on child development, promoting awareness of healthy living, early identification of difficulties), neighbourhood nurseries, out-of-school childcare, local programmes (including family support, advice on nurturing, health services, and early learning opportunities). A large-scale, six-year evaluation of all Sure Start programmes in England, led by the Institute for the Study of Children, Families and Social Issues, University of London, is currently underway to determine the impact of the programme. Early findings regarding its effectiveness show a mixed picture. Less disadvantaged families benefit more than the most disadvantaged, with variations across different areas (National Evaluation of Sure Start, 2005). Further investigation is underway to clarify reasons for mixed results. (It has been included in this report on the basis of scale and policy significance rather than on the basis of evidence of effectiveness.)

School-based intervention programmes

The descriptions of school-based programmes that are shown below are extracted from Weare and Gray (2003) and are US-based programmes, with the exception of The Bullying Prevention Programme which originated in Norway.

The Child Development Project (Battistich et al, 1989)

This was an elementary school intervention designed to improve cognitive, affective, and behavioural aspects of children's development, and promote concern for and understanding of others. A key element was the

establishment of a 'caring classroom environment' through participation in co-operative and helping activities, positive discipline techniques and positive role modelling, and the use of role-play, games and stories to enhance students' understanding of others. The approach extended to the whole school and also included community activities. Teachers were trained in programme implementation, and parents and teachers were involved in curriculum development. Cohorts of children were followed up and assessed annually over five years following the commencement of the programme. Outcomes included improved behaviour in difficult social situations and a greater ability to resolve conflict. This was assessed in interviews using hypothetical situations.

School Transition Environmental Project (STEP) (Felner et al, 1982).

This programme was designed to help children cope better with the transition to high school by reorganising the environment in the new school to increase social stability. Students remained in the same peer groups for most lessons, and the pastoral, administrative and family link roles of their homeroom teachers were strengthened. Students were randomly allocated to these classes. The results showed that self-concept, which was measured using an adapted self appraisal inventory consisting of yes/no items, decreased less in intervention group students than it did in the control group. Five year follow-up results showed a significant difference between the intervention and control group for dropout from school, absenteeism, and improved grades in Years 1 and 2. A replication evaluation showed positive effects on measures of school, family and general self-esteem, depression, anxiety, delinquent behaviour; and high levels of academic expectations.

School Development Project (Haynes and Comer, 1990)

This was initiated in the late 1960s in schools serving largely African-American children from socio-economically disadvantaged backgrounds. The three main elements of the programme were: the establishment of a school management team involving staff and parents; a mental health team that addressed issues to do with school ethos and the mental health concerns of individual staff and students; and a programme to encourage parents to participate as equal partners in planning and decision-making in the school. The intervention also included community-based projects for school children and social activities. The aim was to create a 'well-functioning social system' with a positive, sensitive and caring school climate to facilitate the students' development of a healthy self-concept, and improvements in their behaviour and achievement. The evaluation of this programme showed positive change favouring intervention group children in a range of different dimensions.

Resolving Conflict Creatively (Aber et al, 1998)

This project aimed to transform the culture of schools by teaching elementary school children non-violent ways of dealing with conflict, and increasing their understanding of their own and other cultures. It consisted of a classroom curriculum in creative conflict resolution in which teachers were trained with the assistance of project consultants. Selected students were trained to act as peer mediators, and some school administrators and parents also received

training to support the programme. Teachers could choose how much training in the delivery of the curriculum they received: this ranged from 0 to 25 hours. The amount of classroom time devoted to the programme varied, with a maximum of 55 classroom sessions in a year. Children who had been most exposed to the programme showed more positive responses in relation to the possession of competent and aggressive interpersonal negotiating strategies. There were, however, no differences in behaviour problems measured using the Seattle Personality Inventory. Due to the fact that the programme had been implemented progressively, the length of follow-up from the start of the programme ranged from six months to two and a half years. The authors acknowledge that the possible effects of teacher self selection were not excluded, given that teachers themselves determined how much training they received and how many RCCP lessons they delivered.

PATHS Curriculum (Greenberg et al, 1995)

PATHS is underpinned by the premise that a child's behaviour and internal regulation is a function of their emotional awareness, affective-cognitive control, and social-cognitive understanding. The intervention was delivered 3 times per week for a period of 20 –30 minutes over three terms, using didactic instruction, role-play, class discussion, modelling by teachers and peers, social and self-reinforcement, worksheets and generalisation techniques. Teachers received a three-day training workshop in conjunction with weekly consultation and observation from project staff. After one year, children's emotional understanding was measured using seven different approaches. Eight out of the 18 measures showed positive change favouring the PATHS children including: number of positive and negative feelings words, ability to identify three emotional states in others, better level of reasoning as regards general questions about feelings, and a significantly improved ability to provide appropriate personal examples of their own emotional experiences.

Coping with Junior High Curriculum (Snow et al, 1986)

This programme aimed to help students cope with school transition and stress. It comprised an eight week class-based curriculum, which was delivered by educators from outside the school before students were due to move to junior high school. It included information about the new school and taught problem-solving and coping with difficult situations. Four schools (278 students in twelve classes) were randomly allocated to an intervention or control arm. Problem solving and social skills strategies, anxiety, depression, and self-esteem were assessed. Positive changes favouring the intervention group were found for problem-solving skills, namely giving direct refusals and generating solutions to social problem situations. Students in the intervention group perceived themselves to be better prepared for junior high school, but also reported significantly more anxiety about the transition.

Bullying Prevention Program (Olweus, 1993)

(This description is extracted from Office of Juvenile Justice and Delinquency Prevention, (2001)).

The Bullying Prevention Program was developed, refined, and systematically evaluated in Bergen, Norway, after three young Norwegian boys committed suicide as a consequence of severe bullying by peers. The original project, which took place from 1983 to 1985, involved 2,500 youth in 42 schools throughout the city. According to more than 150,000 Norwegian and Swedish students ages 7–16 who completed a bully/victim questionnaire, 15 percent had been involved in bully/victim problems. Of these, 5 percent had been frequent targets of bullies or had bullied frequently (once a week or more). In a recent U.S. study, 23 percent of more than 6,000 middle school students in rural South Carolina reported that they had been bullied several times or more during the past 3 months; 20 percent claimed they had bullied others with the same frequency. Because bullying is such a prevalent problem, the Program has been replicated throughout Norway and in other countries, including the United States.

The Program's major goal is to reduce bullying among elementary, middle, and junior high school children by reducing opportunities and rewards for bullying behaviour. School staff are largely responsible for introducing and carrying out the Program, and their efforts are directed toward improving peer relations and making the school a safe and pleasant environment. Bullying Prevention increases awareness of and knowledge about the problem, actively involves teachers and parents, develops clear rules against bullying behaviour, and provides support and protection for bullying victims. Core components of the Program are at three levels:

- **School.** School personnel disseminate an anonymous student questionnaire to assess the nature and prevalence of bullying, discuss the problem, plan for program implementation, form a school committee to coordinate program delivery, and develop a system of supervising students during breaks.
- **Classroom.** Teachers and/or other school personnel introduce and enforce classroom rules against bullying, hold regular classroom meetings with students, and meet with parents to encourage their participation.
- **Individual.** Staff hold interventions with bullies, victims, and their parents to ensure that the bullying stops.

The use of school, classroom, and individual interventions ensures that students are exposed to a consistent, strong message from different people in different contexts regarding the school's views of and attitudes toward bullying.

In Bergen, Norway, the frequency of bullying problems decreased by 50 percent or more in the 2 years following the original project. These results applied to both boys and girls and to students across all grades studied. In addition, school climate improved and the rate of antisocial behaviour in general such as theft, vandalism, and truancy dropped during the 2-year period. In the South Carolina replication site, the Program slowed the rate of increase in youth's engagement in antisocial behaviour. In addition, students

reported that they bullied other students less after 7 months in the Program (a 25-percent reduction in the rate of bullying).

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