Promoting young people’s wellbeing: A review of research on emotional health

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The views expressed are those of the authors and are not necessarily those of the SCRE Centre or of the funders.
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Executive summary

1. Introduction

Promoting young people’s mental wellbeing is a concern for many groups, ie teachers, community workers, social workers, doctors, parents and young people themselves. Many argue that it is important to mainstream mental health so that those with mental health problems are not marginalised or excluded. However, as the Public Health Institute for Scotland (2003) pointed out the challenge for service providers is to find ways of working together so that the aim of mainstreaming comes closer. This is the overarching context for this literature review, which was commissioned by the Scottish Executive Education Department and undertaken by the SCRE Centre of Glasgow University during June and July, 2003. The brief was to summarise published information, recent research and other (as yet) unpublished work on:

• Promoting emotional and mental wellbeing in young people; and
• Positive interventions for young people within the school context primarily between the ages of 12 and 18 years.

2. Methods

Four databases were searched (the British Education Index, Educational Research Abstracts, PsychInfo and the Social Sciences Citation Index) for research studies and also examples of intervention case studies from the ‘grey’ literature. Studies focusing on addictions and conduct disorders were excluded from this review.

3. Definitions

Providing an exact definition of mental wellbeing is difficult. However, generally researchers agree that a mentally healthy young person has the ability to develop:

• Psychologically
• Emotionally
• Socially
• Intellectually; and
• Spiritually.

4. What are the identified mental health issues of young people?

• Although both boys and girls are concerned about their physical appearance the evidence shows that girls worry significantly more than boys.
• Girls are currently outperforming boys academically but perversely this is putting more pressure on girls to succeed and adversely affecting their wellbeing.
• Self-harm is inappropriately used as a coping strategy for negative feelings and emotional turmoil. Self-harming behaviour can begin in early adolescence and prior to puberty for both sexes.

• In Scotland suicidal and depressed young men who are still at school are overwhelmed by the pressure of schoolwork, experience violence and bullying, and feel they have no-one to confide in.

• The mental stressors of young people in Britain may not be the same as those in other countries (Gallagher & Millar, 1996; Bagley & Mallick, 1995). This factor raises concerns about the transferability of foreign interventions to the UK setting.

5. What are the strategies young people use to maintain their own emotional and mental wellbeing?

• Most healthy young people have developed fairly sophisticated techniques for sustaining their mental and emotional wellbeing at times of stress.

• Limited life experience means that they have limited strategies for coping with events that may have perceived catastrophic impacts on their lives, such as bereavement and pregnancy.

• Young people who self-harm lack coping skills to any significant degree.

• Girls are generally more adept than boys at using social support systems.

• Young men are still beset by the masculine ‘ideal’ of being ‘strong’ and coping alone.

• Both sexes are reluctant to talk to adults about sensitive issues.

• Generally, young people have little knowledge about professionals who may be able to help, although those who have had previous contact would be prepared to seek help from mental health service staff.

6. Promoting emotional and mental wellbeing

• The EPPI-Centre review (Harden et al, 2001) of international research found that there were conflicting and disparate hypotheses and findings in the literature about how risk and protective factors operate, making it difficult to use this evidence for intervention strategies.

• Most of the studies relied on the self-reporting of young people and, like all subjective measures, the responses reflect the format and wording of the questions, the context in which they are asked, and the way the response categories are formulated.

• However, the majority of the studies presented very similar findings concerning the risk factors for young people developing mental health problems.

• The accumulation of risk factors for any individual greatly increases the likelihood of their experiencing emotional or mental health problems.
Schools may be able to bolster young peoples’ resilience with appropriate interventions, but in cooperation with the family and the wider community.

7. What programmes exist for the promotion of emotional and mental wellbeing within the school context?

- Most of the research on mental health promotion/prevention interventions has been undertaken in the USA and this must raise questions about the transferability of these interventions to Scotland.
- The effectiveness of teacher-led interventions and schools as intervention settings needs to be compared to the effectiveness of other providers and other settings (Harden et al., 2001; Edwards, 2001). Research undertaken by Sellen in 2002 indicated that some young people did not see school as the appropriate setting for counselling.
- The EPPI-Centre literature review (Harden et al., 2001) could find no evaluated interventions effective or otherwise that addressed young peoples’ concerns about workload, academic achievement or engagement in school. These are key concerns for young people in Scottish schools.
- Interventions that involve young people supporting each other need to be further explored, and strategies put in place to protect the young people who volunteer to be trained as counsellors.
- Many young people have developed their own sophisticated coping strategies (Edwards, 2001), and development work to enhance these skills needs to be undertaken, monitored and evaluated.
- However, for adolescents it would appear that adult respect for the skills they already possess is more likely to be acceptable to them than imposing programmes developed solely by adults.

8. What is the evidence for the success of programmes of intervention on the emotional and mental wellbeing of young people?

- Evidence of the success of interventions in the UK is mostly found in the ‘grey’ literature and is not based on rigorous research involving long-term follow up.
- One of the key problems with any intervention that is successful with one population is whether it is transferable or replicable in any other setting. No studies have been found describing replication that has been systematically and rigorously evaluated.
- The EPPI-Centre (Harden et al., 2001) review of the international literature on the barriers and facilitators to the promotion young peoples’ mental health concluded that mental health promotion should not rely on information alone but should involve the development of student skills using behavioural techniques that are reinforced in the wider community. They also concluded that:
The effectiveness of teachers as intervention providers and schools as intervention settings needs to be compared to the effectiveness of other providers and other settings.

(p.147)

9. **Which areas require further research?**

The main conclusions drawn from this review are that:

- There is a dearth of good research and evaluations of research on promoting emotional and mental wellbeing in young people in the UK.
- In particular, we were unable to identify research on recovery and reintegration of young people with mental health problems to schools.
1: Introduction

This literature review was commissioned by the Scottish Executive Education Department from the SCRE Centre of Glasgow University. The brief was to provide a short summary of published information, recent research and other (as yet) unpublished work on:

- Promoting emotional and mental wellbeing in young people.
- Positive interventions for young people within the school context.

Adolescents have to negotiate both developmental and educational hurdles. (Gallagher & Millar, 1996). There is now increasing evidence that positive mental health and educational attainment are linked. The school has the strongest vested interest in ensuring that every child does their best, and is the most appropriate location to ensure co-ordinated work on the promotion of emotional wellbeing (Caccamo, 2000).

Many teachers are aware that there are many young people whose spiritual and moral existence is promoted only by their school and schools are already doing a tremendous amount within the curriculum and through ethos and policies without recognizing this as mental health promotion. (Alexander, 2002)

Research has shown that one in five children and young people will suffer from clinically defined mental health problems at some point in their school career. Ten per cent of children aged between five and fifteen years of age experience clinically defined mental health problems: five per cent, conduct disorder; four per cent, emotional disorder, including low mood, eating difficulties and self harm; and one per cent are likely to be hyperactive. Therefore, in a class of 20 there are likely to be two young people with a clinically definable mental health problem and another ten per cent may experience psychological problems that warrant professional psychiatric intervention. (Alexander, 2002)

About one quarter of Scotland’s population is under age 19. At any one time about ten per cent of them, 125,000, will have mental health problems which are so substantial that they have difficulties with their thoughts, feelings, behaviour, learning, relationships on a day to day basis. (Public Health Institute of Scotland, 2003)

In Scotland there has been a thirteen per cent increase in the suicide rate since 1988 (Haydock, 2001). Between 1971/3 and 1996/8 the suicide rates among 15 to 24 year olds in Scotland more than doubled and the rates for females trebled.

In 1997 there were 1500 female admissions in the 15 to 19 year age group and 900 male admissions to the Royal Edinburgh hospital and St John’s hospital in West Lothian (Haydock, 2001). Many other unreported incidents of deliberate self-harm will also have occurred.

Research indicates that it is important to ‘mainstream mental health’ so that those with mental health problems are not marginalised or excluded. The challenge to services is to find ways of working together so that the aim of mainstreaming comes closer (Public Health Institute of Scotland, 2003).
2: Methods

Many of the mental health problems of adolescents may stem from early childhood experiences. However, the focus of this review is on research and interventions specifically targeted at young people primarily between the ages of 12 and 18 years. Studies focusing on addictions and conduct disorders are also excluded from this review of the literature. Both are large areas of concern that warrant separate reviews and both should take account of early childhood factors.

The materials reviewed fall into the following categories:

- Reviews of research
- Reports of interventions
- Research reports
- National survey reports
- Discussion documents and articles.

In the UK mental health promotion and research and evaluation of intervention programmes in schools is at an early stage, particularly in comparison to the USA. In the UK a considerable amount of work has been done in the field by non-research projects that are not published in peer reviewed journals but are nonetheless well respected by government departments who report them and by professional mental health bodies. Intervention case-studies from the ‘grey’ literature are included in this report where they have been supported and reported by organisations such as the Mental Health Foundation, the charity Youngminds, or the Audit Commission.

The databases searched for peer-reviewed research were:

- British Education Index
- Educational Research Abstracts
- PsychInfo
- Social Sciences Citation Index.
3: Definitions

3.1 Mental health

Attempting a short and simple definition of mental health runs the risk, as one author puts it, of “either coming up with something pithy but so banal as to be meaningless, or inclusive but so packed with nouns as to be impossible to follow”.

(Public Health Institute of Scotland, 2003)

Across the network of services for young people different terms are used to denote difficulties of living, learning and relating, which are mental health problems. People in education services might refer to young people who are experiencing emotional and behavioural difficulties, while those working in the health services might speak of psychiatric disorder or psychological difficulty. The terms are not simply interchangeable (Public Health Institute of Scotland, 2003).

Furthermore, mental health is not a neutral term to young people. Research with young people has shown that ‘mental health’ is often equated with mental ill health and therefore belonging to someone else. Young people do not relate to medically or professionally defined concepts such as mental illness, depression or positive mental health (Harden et al, 2001). Researchers have therefore asked young people about the things that make them feel happy and unhappy, that worry or stress them (Gordon & Grant, 1998).

Generally research has tended to agree that a mentally healthy young person is one who has the ability to develop:

- Psychologically
- Emotionally
- Socially
- Intellectually
- Spiritually.

And one who is able to:

- Initiate, develop and sustain mutually satisfying relationships
- Use and enjoy solitude
- Become aware of others and empathise with them
- Play and learn
- Develop a sense of right and wrong
- Face and resolve problems and setbacks satisfactorily and learn from them.

(Alexander, 2002)

Research studies included in this literature review have tended to use the notion of mental health to include that of emotional wellbeing rather than the mere absence of mental illness.
3.2 Mental health problems

3.2.1 Mood (Emotional) disorders

Mood disorders include major depressive, bipolar and unipolar disorders. Major depression is characterised by depressed mood, change in appetite, insomnia, or hyposomnia, fatigue, poor concentration, feelings of worthlessness and suicidal thinking.

Bipolar disorder is characterised by both depressive and manic episodes (mania can involve feeling super powerful; believing that you can change the world).

Unipolar disorder consists of either recurrent depressive or manic episodes (depressive mood can involve suicidal ideation).

(Nicholas & Broadstock, 1999)

3.2.2 Self-Harm

Self-harm is often termed deliberate self-harm. In its broadest sense it includes, cutting, burning, biting, pulling hair, scratching at and re-inflecting wounds and cuts, head banging, drinking bleach, eating glass, destructive use of alcohol and drugs, controlling eating patterns, overdosing, indulging in risky behaviours, and mental and emotional self-harm (Haydock, 2001).

3.3 Mental health promotion

Mental health promotion is the enhancement of the capacity of individuals, families, groups or communities to strengthen or support positive emotional, cognitive and related experiences.

(Hodgson & Clarkson, 1996)

Mental health promotion can be applied to a whole population, to those known to be at risk of mental health problems and to those who have a mental health problem ranging from mild to severe illness. Mental health promotion may focus on the social environment as well as the individual. It may also address life events, transitions and coping skills, providing a developmental approach to mental health development. (Hodgson & Clarkson, 1996; Harden et al, 2001).

‘Cognitive’ techniques

When young people have ‘automatic thoughts’ or cognitions (usually focussed on future failure) they can be is taught to become aware of these thoughts and to change them to realistic thoughts, so that their anxiety is lessened.

‘Behavioural’ techniques

Behavioural techniques can be used to deal with inappropriate, self-defeating thoughts, and include learning to use coping self-statements that reduce anxiety, reinforcement statements such as self-praise, and problem solving such as identifying problems and finding solutions. There are various other techniques that can be taught such as relaxation.
3.4 Prevention of mental ill health

Prevention of mental illness may be restricted to interventions that are applied before the onset of a mental illness in a target group (Institute of Medicine, 1994). The term may also be used interchangeably with mental health promotion.

3.5 Specific interventions

Specific interventions include programmes such as peer education and circle time. Peer educators are usually older pupils from years 10 and 11 upwards who are selected by panel interview and can demonstrate confidence. They tend to be individuals who are respected by the whole school community. Schools using similar student support techniques use a number of different terms: peer education; peer support; peer listening and peer counselling. Preferably, schemes involving students in peer support should be well-structured and planned, with the focus on both social and emotional development of the students.

3.5.1 Peer educators

Peer educators are used as a resource for Personal, Social and Health Education (PSHE) (Mental Health Foundation, 2002). They aim to facilitate achievement and improvements in student behaviour in the classroom.

Peer educators are trained usually by outside and often voluntary agencies in a range of skills that include:

- listening
- communication
- assertiveness
- buddying
- anti-bullying
- team building
- self-confidence
- assertiveness
- passing on what they learn to younger students.

Within these programmes, links are made with outside agencies such as GP surgeries, professional health promotion teams, youth projects and other schools.

The same outside agencies that train the students to become peer educators also train teachers to become peer support workers. The teachers meet with the peer educators on a regular basis to discuss issues that have arisen and offer appropriate support and advice.

3.5.2 Circle Time

Circle time is commonly used in primary schools in the UK. Circle time involves children sitting in a circle and working on activities together that enhance self-esteem, and develop listening skills and empathy. It is currently less commonly used in the secondary school.
4: What are the identified mental health issues of young people?

In their 2003 study the Public Health Institute of Scotland found that young people used the terms emotional and mental health interchangeably. To young people emotional/mental health means feelings at a particular time, security or insecurity, feelings about the self, how emotions are dealt with, and how people react to events. Almost all young people experience symptoms of malaise at some time and even suicidal thoughts are quite common (West & Sweeting, 2002).

Young people and parents who were interviewed by the PHIS (including some who had experience of using specialist mental health services) said that it was important to ‘mainstream’ mental health so that those with mental health problems were not marginalised or excluded.

4.1 Evidence from Scotland

In 2002, the Child and Adolescent Health Research Unit, University of Edinburgh carried out a survey of 4404 Scottish school students ranging in age from 11 to 15 years (Todd & Currie, 2003). The students were in mixed ability classes and completed an anonymous questionnaire. This survey found that the mental wellbeing of boys was better than that of girls over all measures, and that children in primary school had better mental health than those in secondary school. The survey analysed student self-reports for happiness, life satisfaction, satisfaction with appearance, and confidence. They found that happiness declines very significantly with age: 55% of 11 year olds report being very happy compared to 44% of 13 year olds and 38% of 15 year olds. At all stages boys are more likely to report being happy than girls.

No gender difference in the mean life satisfaction score of boys and girls at age 11 was found, but at ages 13 and 15 girls life satisfaction score was much lower than for boys.

Feeling satisfied with their appearance contributes to the happiness of both boys and girls. Boys (37%) are significantly more likely to report that they are good looking than girls (26%). Twenty-four per cent (24%) of girls reported that they were not good looking, compared to 13% of boys. The gender difference in self-reported perception of good looks is greatest between the ages of 13 and 15.

Confident adolescents are less likely to experience mental health problems such as depression, nervousness and irritability. The researchers found a highly significant gender difference among those who reported that they always felt confident: 28% of boys, compared to 15% of girls. When data from this survey was compared to two previous surveys carried out by the same Unit it was found that the confidence levels of young people in Scotland had improved since 1994.

West and Sweeting (2003), in a study of two cohorts of 15 year old girls, in 1987 and 1999, in the West of Scotland, found that girls in the 1999 cohort felt more pressure to perform well academically than those in the 1987 cohort. With the
exception of conduct, disorder and suicide, females consistently have more mental health problems than boys at every level (West & Sweeting, 2002).

Gordon and Grant (1997) reported research with 1634 young people (i.e., all who were in the sample schools in Glasgow and who agreed to take part) aged 13 to 14 years. Those pupils who were in school completed an anonymous questionnaire. Those excluded from the survey would have been absent from school that day, had parents who did not give permission for their child to take part, or were in schools that did not wish to take part. The research does not describe how the young people were recruited and did not mention the methods used to analyse the research. However, it gives valuable information about how young people view what contributes to or adversely affects their emotional health.

Barriers to feeling good in school were: boredom, monotony, stress of too much work, teachers’ attitudes towards them, and doing badly. Barriers to feeling good generally were: being ‘put down’, difficulties with peer relationships, being blamed unfairly, not doing well at school, not doing well at sport, not being ‘good’ (bullying, truanting, stealing), physical appearance, personal attributes (being shy, not being able to share emotions), and not being in control. Situational barriers to feeling good included bereavement, boredom, staying in, the weather and less commonly, having no money, violence, fears about going out, racism. Facilitators to feeling good were having respect from friends, boyfriends/girlfriends, families, congratulations, compliments, being good looking, doing well at school and being good at sport. The key to feeling good was to be accepted by others, feeling that they were achieving, and feeling ‘virtuous’, confident and in control. The results are similar to other research with young people in the UK (Edwards, 2001; Public Health Institute of Scotland, 2003).

An action research project was carried out in Edinburgh with 45 young people (31 females and 15 males) identifying themselves as engaging in self-harming behaviours (Haydock, 2001). The young people were between the ages of 16 and 21 years. Forty-five per cent (45%), of the sample were between 16 and 18 years of age but were not identified as being at school. There were a small number of respondents who were self-selected and so it is not clear how representative their views are. However, as all had self-harmed the information is valid. Clinical studies have suggested that deliberate self-harming behaviour begins during adolescence and is established and repeated over many years as a coping strategy (Blair et al, 2001). The Haydock project identified some of the ‘background issues’ that had led the young people to harm themselves. Self-harm was reported as a response to feelings produced as a result of a variety of issues including bullying (6 young people), sexual abuse (4), physical abuse (2), poor body image/low self-esteem (4), family break-up (4), bereavement (2), homelessness (2), drug and alcohol addiction (3), sexuality (2), and mental health problems (2).

1 Action research differs from other research in that it usually focuses on practice and involves an implementation stage as an integral part of the research project. Typically, it allows the action researcher to be both teacher/practitioner and researcher.
What are the identified mental health issues of young people?

The majority had started to harm themselves before they were 15 years old, 32% were under 12, and 32% aged between 13 and 15.

The young people gave a number of reasons for self-harm behaviour: self-punishment; a way of linking the emotions with the body; the sense of relief obtained after the action; and a temporary reprieve from emotional turmoil. Self-harm tends to be given up as a coping strategy when the young person becomes immune to its effects. Self-harm is rarely an attention seeking behaviour, it is planned, kept secret and not carried out lightly.

Blair et al (2001) point out that items in self-reporting questionnaires have relatively poor construct validity despite their high face value when used with a normal adolescent population, but might play a role in the identification of vulnerable individuals within high risk populations. This includes pupils identified as having social, emotional and behaviour disorders, young people looked after by the local authority, and those who are homeless.

A survey by Buchanan et al (1999) of 1,300 young men included a ‘schools and youth club’ subset of 288 participants. Ninety per cent (90%) of the schools and youth club group were under 16 years of age. Out of the 1300, the survey identified 152 as depressed and 40 as suicidal. The findings showed that young men who felt depressed or suicidal had very different perceptions about themselves and different experiences in their families and at school from those who did not suffer depression or suicidal feelings. Significantly, 67% of the suicidal group said that they had nowhere to go for emotional support. Fewer of the depressed group liked school or felt that school was ‘OK most of the time’, fewer liked their teachers or took their work seriously and were more likely to say that their teachers made them feel stupid when they made a mistake. The suicidal group reflected many of these findings, although significantly fewer felt that their teachers knew them as a person. 80% of the depressed and 72% of the suicidal groups felt overwhelmed often or nearly always by schoolwork. Some of the strongest feelings expressed by the suicidal group related to violence and bullying in school: 78% reported being bullied physically at school, and 38% had felt pressured to join a gang compared to 6% of the non-suicidal. However, non-depressed and non-suicidal young men were significantly more likely to be at school.

Increase in age showed an increase in the numbers who were depressed or suicidal. The pressures of continuing education post-school took their toll on emotional wellbeing for young men. Scotland has an inexplicably larger suicide rate among young people of both sexes when compared to England and Wales (West & Sweeting, 2002).

4.2 Evidence from the UK and elsewhere

Gallagher and Millar (1996) carried out a survey of adolescent worry amongst young people in Northern Ireland, using a scale they had developed largely from the expressed worries of adolescents themselves. They compared their findings with those from other cultures; notably Canada, Australia, the USA and England.
Across all the cultures a wish for academic success and fear of failure was a prevalent worry.

Problems with friends, meeting people and the opposite sex were of more concern for young people in North America and Canada than in the UK, where unemployment, school, academic achievement, family, home and factors affecting the self were more important (Gallagher & Millar, 1996).

A study comparing negative self-perception and components of stress in Canadian, British and Hong Kong adolescents (Bagley & Mallik, 1995) found that Canadian students indicated that abuse at home was the most stressful area, while both British and Hong Kong students identified academic and career problems as most stressful. The English students reported lower self-esteem than both Canadian and Hong Kong students. A limitation of the study is that the data from the three cultures was analysed on the provisional assumption that the meanings of stress are probably similar in all three cultures, based on the researchers ethnographic understanding of living and working in these cultures for several years.

King et al (1999), in a meta analysis of research on gender differences in self-esteem, reported that some studies found that adolescent boys self-esteem increases in adolescence, while that of girls’ declines at puberty. For girls puberty often coincides with the transition from primary to secondary school and thereby increases stress (Hodgson et al, 1996).

4.3 Conclusions

Although both boys and girls in Scottish-based research are concerned about their physical appearance, girls worry significantly more than boys (Todd & Currie, 2003). Girls are currently outperforming boys academically, but perversely results from a study in the West of Scotland indicate that this is putting more pressure on girls to succeed and adversely affecting their wellbeing (West & Sweeting, 2003). Self-harm is inappropriately used as a coping strategy for negative feelings and emotional turmoil. In a small-scale Scottish study, researchers found that self-harming behaviour can begin in early adolescence and prior to puberty for both sexes (Haydock, 2001). In Scotland suicidal and depressed young men who are still at school are overwhelmed by the pressure of schoolwork, experience violence and bullying, and feel they have no-one to confide in. The mental stressors of young people in Britain may not be the same as those in other countries (Gallagher & Millar, 1996; Bagley & Mallik, 1995). This factor raises concerns about the transferability of foreign interventions to the UK setting.
5: What are the strategies young people use to maintain their own emotional and mental wellbeing?

Young People are generally very adept at coping well with daily stressors and specific, difficult life events. Professionals designing mental health promotion programmes for young people would find it revealing and useful to tap into and build upon the life skills that many young people already possess.

5.1 Evidence from Scotland

A small-scale study in one New Community School in East Lothian (Edwards, 2001) focused on the self-reported views of 291 students (93 boys and 90 girls in S2, and 63 boys and 43 girls in S3) and six discussion groups (36 students). The study took place between April and May 2001. Most of the students were due to sit examinations and this had influenced their responses. Twice as many girls as boys reported that maintaining good friendships and close family relationships were important to maintaining their wellbeing. Over four times as many boys as girls said that being physically active was important in maintaining a sense of wellbeing. This may be because boys maintain friendships with physical activities like playing football, as well as being able to ‘let off steam’.

The young people were asked who they would talk to about their worries. They reported that they would talk to family members and friends but only on a limited range of issues. They reported feeling doubt, fear and embarrassment in talking about emotional issues even in a close relationship, and were reluctant to talk to their guidance teachers because of peer pressure, embarrassment and a belief that their guidance teachers did not really understand them.

Haydock (2001) reports that young people between 16 and 21 years who deliberately self-harmed also felt that they could not talk to their teachers. However, young people in the Edwards study identified by the school as having special educational needs and social and behavioural problems said that they would talk to their guidance teacher (Edwards, 2001). This may be because the individual in post was trusted or because students with special needs have more contact and support from guidance staff than their peers. Young people reported having little knowledge about professionals who work outside the school setting and who may be able to help.

In 2000, Scott Porter Research and Marketing Ltd carried out research for the Health Education Board for Scotland (HEBS) into the mental wellbeing of young people. Focus groups made up of friendship pairs were used to collect data. Single sex focus groups of six or seven young people each were conducted with nine groups of young people, four with young people aged 14 and 15 years, three of 12 and 13 years of age and two of 16. The young people came from mixed socio-economic backgrounds in the south and west of Scotland.
The young people were asked to talk about coping strategies for three levels of problems. For minor problems they reported listening to music, writing things down, having a long bath, physical activity, eating chocolate, and sleeping. These strategies were also reported in the Edwards (2001) study. For more difficult problems such as bereavement or pregnancy the young people said that they would consult an adult or person in authority but on the whole they had difficulties expressing strategies for these more serious concerns. Scott Porter Research found a gender difference in the coping strategies the young people said they would employ. Young women were more likely to talk to friends, be positive and optimistic and indulge themselves than young men. Young men were more likely to prefer to cope alone or ignore, the problem until it became impossible to ignore, and were more likely to lash out. These findings echo those of Buchanan et al (1999), where young men said that seeking help put them in a vulnerable or weak position. Sixty-seven per cent of the suicidal group in the Buchanan et al study said that they had ‘nowhere’ to go for emotional support.

In 2002 the Public Health Institute of Scotland (PHIS, 2003) carried out a needs assessment on child and adolescent mental health that involved consulting children, young people and parents. In different parts of Scotland a range of young people were consulted, including:

- Children and young people who were not in difficulty.
- Young people at risk of exclusion from mental health services, eg children looked after and accommodated by the local authority and those with personal disabilities.
- Young people with mental health problems, including those who had used specialist mental health services and those who had looked for other forms of help.
- Parents of children and young people.

In all, a total of 77 young people (38 girls and 39 boys) aged between 12 and 18 years were consulted.

The young people reported coping with angry feelings by taking them out on inanimate objects, siblings or, less commonly, on other young people. When feeling sad or depressed it was more common for young people to internalise these emotions as a way of coming to terms with a problem before attempting its resolution. This often involved seeking solitude, or being physical in a positive way such as playing games. Gordon and Grant (1997) report similar findings.

For many in this group, who had experience of mental health problems and specialist support, coping with negative feelings involved talking as an important way to feel better. Younger people said that they would talk to a parent or friend, while older adolescents said that they would approach a doctor, family member, friend, or school staff. They would prefer to talk to someone who had had a similar experience. The young people valued talking to someone who would listen and help, getting a cuddle from a boy- or girlfriend, and simply knowing that people cared. Young people would prefer to approach someone who was not
merely ‘nice’ but who could give straightforward advice that would help them come to a decision or who would know who to refer the young person to for appropriate treatment or advice.

5.2 Evidence from the UK and elsewhere

The EPPI-Centre (Harden et al., 2001) reported 345 studies from the USA, Canada, England and Scotland and found only four Scottish studies, meeting their criteria, reporting young peoples’ views on what does or could help them to feel good. Two of these were the Gordon and Grant (1997) and the Scott Porter Research (2000) studies discussed above. A third study (Armstrong et al., 1998) reviewed by the EPPI-Centre was of young people with identified mental health problems. This group differed from the ‘normal’ students in the other two studies in that they used self-harm techniques and stealing when they felt angry, both of which gave a ‘buzz’, and presumably took their mind of their problems temporarily. Counsellors were mentioned in two of the studies and in a negative light in one of these. However, two out of three young people who had experience of social workers said they would choose to talk to them about emotional problems.

A study using a self-report questionnaire that took place between 2000 and 2001 (Hawton et al., 2002) asked students to describe acts of self-harm rather than merely report whether or not they had self-harmed. A total of 6020 students in 41 schools in three areas of England were surveyed. Ninety per cent (90%) of these young people were aged 15 or 16 years, 82% were white, 11% Asian, 3% black and 3% mainly mixed race. Ten per cent (10%) reported having deliberately self-harmed, 7% in the previous year. The researchers found that 41% of the self-harmers turned to friends for help before self-harming, few turned to family, teachers, doctors or social workers. Just over 20% felt that they could talk to a teacher despite many more reporting having problems with schoolwork that could precipitate self-harm. After self-harming 22% sought support from either friends (49%) or family (21%). Generally the young people who self-harmed had poor coping strategies and tended to get angry, drink alcohol or shut themselves away rather than seek help. They felt that a stigma was attached to approaching voluntary agencies for support.

Sellen (2002) researched a target population of young people aged over 12 years from the black and minority ethnic communities in a London borough. Young people under the supervision of a youth work team carried out the research. The researchers organised a music event that was attended by 750 young people between 11 and 19 years of age. One hundred and forty-one (141) young people volunteered to complete a questionnaire designed by a team of supervised young action researchers. Although this was a random sample there were 70 boys and 71 girls, and 86 respondents described themselves as black. Overall, the girls were in a younger age group than the boys. There were significant differences between the sexes in their replies as to what they did to make themselves feel good and the age difference between the sexes may also have made a difference to their responses. The most popular way of feeling good for the girls was to spend
money (34%); and for boys, sexual activity (26%), followed closely by spending (21%). The least favoured activities for girls were drink/drugs and sex (4%); and for boys, eating (9%). When asked what these activities did for them most young people replied that it made them feel good and calmed them down. The young people were asked to say where they would go for counselling: 38% of the boys said their GP, and 28% of the girls said their youth club; few of either sex (6% of boys, and 5% of girls) favoured counselling in school.

5.3 Conclusions

Evidence from Scotland and the rest of the UK indicates that most healthy young people have developed fairly sophisticated techniques for sustaining their mental and emotional wellbeing at times of stress. Limited life experience means that they have limited strategies for coping with events that may have perceived catastrophic impacts on their lives such as bereavement and pregnancy. Young people who self-harm lack coping skills to any significant degree. Girls are generally more adept than boys at using social support systems. Young men are still beset by the masculine ‘ideal’ of being ‘strong’ and coping alone. Both sexes are reluctant to talk to adults about sensitive issues. Generally, they have little knowledge about professionals who may be able to help, although young people who have had previous contact would be prepared to seek further help from mental health service staff.
6: Promoting emotional and mental wellbeing

6.1 Risk and resilience

Risk and resilience/protective factors are two key elements in the promotion of mental health and emotional wellbeing. A young person living in a supportive environment in the family and at school, and in possession of good coping skills will be better able to weather the trials and tribulations of life. A young person in a poor environment with little outside support and lacking coping skills is at greater risk of developing mental health problems when faced with life’s problems. The research shows that risk accumulates and that a young person experiencing three risk factors is at greater risk of developing mental health problems than a young person experiencing one factor (Public Health Institute of Scotland, 2003).

What are the risks that impact on mental health and emotional wellbeing?

Risk-taking behaviour increases in adolescence (Harden et al., 2001), and mental health problems increase with a significant proportion of young people reporting persistent negative mood states (Hodgson et al., 1996).

Young peoples’ likelihood of developing mental health problems is greatly increased when they experience adverse external circumstances, for example poverty, poor environment and problematical family relationships (Hodgson et al., 1996; Harden et al., 2001) combined with particular personal characteristics, such as temperament (Alexander, 2002). However, a study of young people in the 11–15 years age group found that young people from the poorest households reported the least worries (Bergman & Scott, 2001).

The Audit Commission, in their 1999 report, deemed young people to be at greater risk of developing mental health problems than their peers when they were:

• Living with only one natural parent, either in a step-family or with a lone parent
• Living in families where the main breadwinner was unemployed
• Experiencing some form of learning disability
• Looked after by the local authority.

(Audit Commission, 1999)

Similarly, Meltzer et al. (2001) found that the prevalence for self-harm among 11–15 year olds is greater in children in:

• Lone parent- compared with two parent families (3.1% and 1.8%)
• Families with step-children compared to those without (3.7% and 1.9%)
• Families with five or more children compared to those with less (6.2% and 2%)
• Families who were social sector tenants (3.7%) private renters or (3.2%) compared with owner-occupiers (1.5%)
• Wales (2.8%), England (2.2%) rather than Scotland (1%)

(Meltzer et al., 2001)
And young people who have:
- Learning difficulties of any kind
- Enduring physical ill health
- Experienced physical or sexual abuse
- Witnessed domestic violence
- A parent with mental health problems.

(Public Health Institute of Scotland, 2003)

6.2 Specific risk: Being an asylum seeker

Asylum seekers are a vulnerable group. Since the Immigration and Asylum Act 1999 around 9,000 asylum seekers have come to Glasgow. West Dumbartonshire, Fife and Edinburgh may also receive dispersed asylum seekers. Most of those in Scotland come from Iraq, Iran, Afghanistan and Somalia. There is as yet no systematic information on the mental health of the young people within this population. However, the literature shows that there are increased levels of psychological morbidity especially post traumatic stress disorder, depression and anxiety disorders within this group (Public Health Institute of Scotland, 2003).

6.3 Having a propensity to depressive symptoms

A North American study found that difficulties related to depressive symptoms were conduct problems, low academic achievement, low social competence and poor peer relations (Jaycox et al, 1994). The report of the research did not make clear how depressive symptoms and educational and social performance are related. Are the depressive symptoms caused by poor education and social performance or does poor academic achievement and poor peer relationships precede the onset of depressive symptoms?

6.4 Using self-harm as a coping mechanism

Young people who self-harm reported (Haydock, 2001) that they came from a variety of backgrounds and levels of education, and these factors were not considered to influence their behaviour. A common element for self-harming and suicidal behaviour, however, was found to be a multiplicity of simultaneous emotional upheavals that included: bullying, sexual abuse, physical abuse, poor body image, low self-esteem, family break up, bereavement, homelessness, drug and alcohol addiction, sexuality, mental health problems that encompassed borderline personality disorder, obsessive compulsive disorder and clinical depression (Haydock, 2001; Buchanan et al, 1999). However, a longitudinal study (Chase-Lansdale et al, 1995) found that only a minority of young adults who experienced parental divorce in childhood developed serious mental health problems as a result.
6.5 Does gender have an influence on risk?
Adolescent girls who move schools at the onset of puberty are more at risk of experiencing depressed mood than boys, and report more family, peer and intimacy stressors than boys (Hodgson et al, 1996). On the other hand, girls are reported to have wider support systems than boys and are less likely than boys to internalise negative feelings (Edwards, 2001). Generally, research shows that being female is a protective factor.

6.6 What are the protective factors that make young people resilient?
Resilience to developing mental health problems is strengthened where there is someone who is constantly available to the young person with whom he/she has a trusting relationship. Positive personal attributes that protect the individual from developing mental health problems include an adaptable nature and positive self-esteem. A range of good family and peer relationships, education and employment opportunities, good housing, fairness and stability in relationships also increase resilience (Scottish Public Mental Health Alliance, 2002; Public Health Institute of Scotland, 2003).

6.7 Conclusion
The EPPI-Centre (Harden et al, 2001) review of international literature found that there were conflicting and disparate hypotheses and findings in different research studies about how risk and protective factors operate, making it difficult to use this evidence to develop intervention strategies.

Most of the studies relied on the self-reporting of young people and, like all subjective measures, the responses reflect the format and wording of the questions, the context in which they are asked, and the way the response categories are formulated. However, the majority of the studies presented very similar findings about the risk factors for young people developing mental health problems. The accumulation of risk factors for any individual greatly increases the likelihood of their experiencing emotional or mental health problems. Schools may be able to bolster young peoples’ resilience with appropriate interventions, but in cooperation with the family and the wider community.
7: What programmes exist for the promotion of emotional and mental wellbeing within the school context?

In this chapter research is reviewed that looked at both prevention of mental health problems and promotion of emotional and mental wellbeing. It is unclear whether there is any real difference in the terms but it may be that promoting good mental health is more positive and optimistic terminology than preventing ill health and is therefore more acceptable to schools and young people.

Based on their review of the literature the authors of the EPPI-Centre (Harden et al., 2001) report gave the following definitions of mental health interventions:

- **Primary prevention of mental ill health or promotion of emotional wellbeing** is defined as any initiative that is directed at young people who do not have an established diagnosis of a mental health problem.

Primary prevention can be further divided into:

- ‘Universal’ interventions that target all individuals
- ‘Selective’ interventions that target those individuals at increased risk of developing mental health problems
- ‘Indicated’ interventions targeted at those showing early signs of mental ill health.

This range of need led the EPPI-Centre (Harden et al., 2001) to conclude that the promotion of young peoples’ emotional wellbeing should be the concern of a range of organisations that can offer a variety of expertise in a variety of settings. This conclusion seems to point the way to integrated or joint working between schools, and statutory and voluntary agencies dedicated to the care of young peoples’ mental health. The Public Health Institute of Scotland (2003) state that it is important to ‘mainstream’ mental health so that those with mental health problems are not marginalised or excluded. Their report states: ‘The challenge to services is to find ways of working together so that the aim of mainstreaming comes closer’.

However, it is important to remember that young people do not relate to medically- or professionally-defined concepts such as mental illness, depression or positive mental health. Interventions need to make sure that their context and presentation is relevant to the context of young peoples’ everyday lives (Harden et al., 2001; Sellen, 2002).

The EPPI-Centre (Harden et al., 2001) review of the literature on the barriers and facilitators to young peoples’ mental health concluded that three key factors might promote emotional wellbeing and mental health and thus shore up the young person against developing mental health problems. These factors are:

- Coping skills
- Self-esteem
- Social support.
Weare (2001; 2002) reviewed previous research into mental health and argued for a new paradigm for the health-promoting school which would recognise that the fundamental causes of mental ill-health, including risk and resilience factors are social not individual. She concluded that ‘four features have been shown from copious research to lead to a wide range of positive mental health and academic outcomes, which include higher self-esteem, increased feelings of attachment to others, higher morale, more enjoyment of school, higher motivation, more effective academic performance and less absenteeism among students and teachers, and less disturbed and anti-social behaviour of students’ (2001, p.39). These features are:

- Supportive relationships
- A high degree of participation by staff and students
- Clarity of structures, boundaries and relationships
- Encouragement of autonomy.

Below we evaluate the evidence base to support various interventions.

7.1 Internal interventions: evidence from Scotland

7.1.1 Promotion/prevention

The Public Health Institute of Scotland report (2003), based on consultation with health professionals, teachers, young people and parents, summarised that interventions have the potential to be effective when:

- The introduction of an intervention is early in the problem cycle and preferably when the child is young.
- The intervention involves familiar people or people who are able to empower parents and work in partnership with professionals such as health visitors and trained volunteers.
- The intervention is intensive and sustainable.
- The intervention is multifaceted and involves parents and young people and focuses on health, education and parent training.
- The interventions are of proven effectiveness.
- The interventions involve joint working with a range of health professionals such as GPs, health visitors, social workers, trained volunteers and Child and Adolescent Mental Health Services (CAMHS) professionals.

7.1.2 Support

Support encompasses a wide range of strategies that help the whole school population including families and carers. The PHIS (2003) final report argued that carefully designed and implemented preventative programmes can reduce the rate of subsequent mental health problems in high risk groups. Almost all of the 230 teachers and 83 school nurses surveyed said that they had formal prevention strategies, but no details were given. School nurses reported spending at least two hours a week supporting young people with mental health problems. However,
the survey noted that only nine per cent of class teachers reported receiving any training in child and adolescent mental health. It is not clear from the report how many ‘class teachers’ were working in secondary schools.

A Scottish Executive project (Scottish Development Centre for Mental Health, 2003) aimed to obtain examples of practice in the field of suicide and self harm prevention within the wider goal of improving emotional and mental wellbeing. Their report cited the example of Burnfoot Community School in Hawick where the school nurse runs a drop in centre, offers information, and provides links to other organisations that can support young people. After-school activities provide a backdrop for discussion about a wide range of health and social issues that include mental health but do not single it out.

7.1.3 Reintegration
A young person who has been excluded and who has mental health problems will not successfully reintegrate into school unless and until the mental health problems are addressed (Public Health Institute of Scotland, 2003).

I need ongoing contact with the school with someone who knows about my son’s behaviour problems. At present they are only in touch if there’s a problem. He has been told that he has been labelled as a trouble maker by some of his subject teachers and this is contributing to his problems.

(Parent, PHIS, 2003 consultation)

The 77 young people and their parents consulted by PHIS said that problems had to become serious before they could access help. When referrals for assessment and treatment are made there is no service available for months.

7.1.4 Recovery
Research on recovery in Scotland could not be found in the ‘grey’ literature or peer reviewed journal articles. Internal school initiatives tend to be focused on traumatic events such as bereavement. The Calouste Gulbenkian Foundation funded a booklet that informed teachers about young peoples’ responses to disasters and gave them the tools with which to prepare school policy (Yule & Gold, 1993). This booklet was sent free of charge to every school in the UK. Edwards et al (2003) researched young people and bereavement, and produced a support pack of materials for guidance teachers and other professionals working in secondary schools in Scotland and Northern England. An evaluation of the use of the materials in schools coupled with the provision of training to guidance and pastoral care teachers helped schools to work on the development of the materials to suit the needs of their particular students. The evaluation showed that whole school commitment and ownership of a bereavement support programme was important in its success as a tool for both individual and class support. When bereavement becomes a long-term problem affecting the day-to-day function of the young person, schools usually refer the student to an appropriate service such as that offered by clinical psychologists at the Notre Dame Centre in Glasgow.
7.2 External interventions: evidence from Scotland

For the purposes of this review, jointly operated or integrated programmes, where outside professionals support or work with teachers in the school setting, are classed as external interventions.

The PHIS (2003) reported that National Health Service (NHS) Child and Adolescent Mental Health Services (CAMHS) are under-resourced throughout Scotland, and that staff work under enormous pressure. The amount of resources that any CAMHS is prepared to put into joint or integrated working in schools is therefore limited. Generally, CAMHS focus primarily on assessment and early intervention rather than mental health promotion. They offer consultancy, training and supervision to teachers, and some have developed specialist projects targeted at particular groups, including school-based assessment for adolescents with depression (Blair et al, 2001). Work with schools is currently in an embryonic stage, and long-term studies will be needed to assess the impact of interventions and their transferability to a range of school settings.

Action research took place in Edinburgh over a six-month period with young people aged between 16 and 21 years who self-harm (Haydock, 2001). The group of 45 young people made suggestions for an effective service that would help them to deal with their self-harming behaviour. The young people said a good service would include a multi-skilled team of trained staff such as youth workers, nurses, teachers and counsellors. The service suggested by the young people contained the following components:

- One-to-one counselling (86% of young people suggested this component)
- Outreach(detached youth work (77%)
- Drop-in facilities (68%)
- Group work sessions (68%)
- Creative groups, drama, art (64%)
- Facilitated self-help groups (56%)
- Information desk/library (59%)
- Internet access (59%).

The Young Peoples’ Unit of the Royal Edinburgh Hospital (Blair et al, 2001) carried out research to examine teachers’ recognition of depression in young people. Their aim was to find out whether teachers’ awareness of depression in their students could be improved by an intervention designed by mental health professionals and including training.

The researchers gained the cooperation of eight Lothian secondary schools and conducted a survey using a two stage screening process to identify young people suffering from depressive illness. Of the 1902 students screened, about 10% reported some previous deliberate self injury, and 69 cases of affective disorder were identified, of whom only five had been previously diagnosed by their GP as suffering from a mental health problem.
152 teachers involved with the 1902 students were then given a two-hour interactive teaching seminar. The pre- and immediate post-session knowledge and recognition skills of the teachers were assessed, and shifts in attitudes and knowledge measured. The researchers found the outcomes disappointing. Although there was significant improvement in the teachers’ attitude and knowledge, they were unable to identify students who were clinically depressed. However, fewer students were wrongly identified by teachers as depressed. After six months most of the 69 young people who had been identified by the researchers as having depression had not contacted their GP to discuss mental health problems.

7.3 Internal interventions: evidence from the UK, USA and elsewhere

Research in the UK, as a whole has been very limited and most of the studies reported come from the USA. Nicholas and Broadstock (1999) in their review of the literature on early intervention in youth mental health found that there has been little good quality research done on programme effectiveness and that studies tended to focus on children in middle childhood rather than adolescence.

7.3.1 Promotion/prevention

In the UK, circle time\(^1\) has been used successfully to promote emotional wellbeing in the primary school for some years. Ofsted reports have recognised and commented on the contribution of circle time in the primary school in the promotion of positive behaviour and relationships, and the early identification of disaffected children. Its use has been very limited in the secondary school. Alexander (2002) reported a recent research project that was carried out by the Calouste Gulbenkian Foundation. Their work indicates the potential of the use of circle time for mental health promotion in the secondary school. The research reported that:

- Most students (83%) enjoyed circle time
- Shyness was reduced, and there was an increased willingness among students to ask teachers questions in class and thereby facilitate learning
- There was increased confidence in sharing feelings with peers
- The sense of social cohesion increased.

A circle time group was specifically focused on preventing future offending behaviour of a target group of boys in years 8 and 9 (Alexander, 2002). The boys had a history of being ‘in trouble’ and circle time sessions were set up that looked at their behaviour. The young people visited local residents and did a survey of their problems. Younger students were recruited to do some gardening and litter collection for the residents. The aim was to change behaviour by having positive expectations and involving others. Although there were lapses in the boys’ behaviour the headteacher intended to continue with the project.

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\(^{1}\) Circle time is a form of group work which includes structured opportunities for pupils to discuss issues affecting them in school. Most commonly they are used in primary schools.
7.4 Mood affective disorders

Nicholas and Broadstock (1999), in their review of the literature, cite Clarke et al (1995) as the only good study of mood disorder prevention. This involved a randomised controlled trial carried out in the USA. High school students were screened for high risk of depression through a clinical interview and the intervention participants were offered 15 sessions of after-school training in coping techniques. There was some evidence of reduced depression shortly after the intervention, which disappeared by the one-year follow up assessment. However, using survival analysis, the study demonstrated that there was lower incidence of depressive disorder in the intervention group after one year.

Jaycox et al (1994) described the development and preliminary efficacy of a programme designed to prevent depressive symptoms in at risk 10–13 year olds. The young people were identified as at risk based on depressive symptoms and their reports of parental conflict. Sixty-nine (69) young people participated in the treatment groups and were compared to 73 young people in control groups. Depressive symptoms and related difficulties such as behaviour problems, low academic achievement, low social competence and poor peer relations were treated by teaching the young people cognitive techniques. The researchers found that depressive symptoms were significantly reduced and classroom behaviour was significantly improved in the treatment group compared to the control group at post-test. Follow-up at six months showed continued reduction in depressive symptoms and significantly fewer externalising behaviour problems as compared to young people in the control groups. The reduction in symptoms was most pronounced in the young people who were most at risk.

7.5 Social and Emotional Learning programmes

General school-based Social and Emotional Learning (SEL) programmes as a framework for promoting mental health and reducing risk behaviour are reported as successful when:

- They have good curriculum design
- They co-ordinate with larger systems
- The teacher/professional is prepared
- The programme is well supported and evaluated.

These programmes primarily address health, substance abuse, violence prevention, sexuality, character and social skills. The key SEL competencies are: awareness of self and others, positive attitudes and values, responsible decision making, and social interaction skills (Payton et al, 2000; Elias et al, 2000). These North American programmes may equate to the Personal, Social and Health Education courses offered in Scottish schools.

7.6 Literature reviews

A Scottish Needs Assessment Programme (SNAP) literature review of effective mental health promotion interventions among young people (2000) evaluated
studies which appeared in peer-reviewed journals and were specifically targeted towards young people aged 12–18 years. The studies reviewed were based within both health and non-health settings such as schools.

- A North American meta-analysis of 177 child and adolescent promotion/prevention mental health interventions (Durlak & Wells, 1997) was reported by SNAP. The meta-analysis focused on interventions targeted at normal populations. Their results indicated that the majority of interventions achieved positive effects with average effect sizes ranging from 0.24 to 0.93, depending on the particular intervention reported. These intervention effects were reported to be superior to those achieved for preventative medical interventions that have effect sizes typically estimated as 0.07.

- Another North American study (Clarke et al., 1993) involved the random selection of experimental and control groups of mixed sex 14 and 15 year olds in two schools. Two interventions were set-up. These were a brief educational intervention and a behavioural skills-training intervention. Neither intervention ‘had any effect on depression knowledge, attitudes towards treatment or actual treatment seeking’ (p.183).

- The School Transitions Environment Project (Felner et al., 1993), also in North America, aimed to reduce stress levels and increase support for high-risk students on their transfer to a new school. The project involved making changes in the school system so that new students were assigned to ‘homerooms.’ The homerooms provided stability in that the same 20 to 30 students who shared the homeroom also stayed together for at least four subjects during the day. The homeroom teachers were given extra responsibility for offering advice and counselling to their homeroom students. An evaluation of the intervention found that STEP ‘prevented deterioration in grades, attendance and levels of self-concept’ (Durlak, 1997). Teachers reported that classroom behaviour and adjustment were better for the STEP participants. A four year follow-up study (Felner et al., 1993) found that drop out rates for STEP participants were 56% lower than for a control group.

- A number of North American studies have demonstrated the negative impact of divorce on children, but individual resilience factors such as emotional predisposition and environmental factors may also come into play. Most of the research on divorce reported by SNAP was carried out with 7 to 13 year olds rather than with adolescents and was prior to 1993 (and therefore outwith the confines of this review). SNAP report that there are limitations in the children-of-divorce literature, but that evidence does appear to suggest some observable short-term improvement through interventions on measures of social competence, school adjustment and child/parent relationships.

The systematic review of research on the barriers and facilitators to young peoples’ mental health carried out by the EPPI-Centre (Harden et al., 2001) identified a few North American studies and one New Zealand study on school-based mental health promotion/prevention that met their inclusion criteria.

- One school-based intervention (Klingman & Hochdorf, 1993) which focused on coping with distress and self-harm was found to be effective at reducing
suicide potential. The 12-week programme based on a three phase intervention model of education and training, was also effective for increasing knowledge of suicide and available sources of help. Reviewing the evidence, Nicholas and Broadstock (1999) concluded that the self-concept and self-esteem needs of young people should be met through the whole curriculum as well as through specialist activities in personal, social and health education.

- A review in 1998 (Haney & Durlak) considered 102 studies which sought to promote self-esteem and self-concept. Interventions aiming to treat poor self-esteem were also included. The impact of these interventions, as measured by average effect size, was described as ‘modest’. Harden et al note that those interventions with a primary focus in promoting self-esteem and self-concept were more effective than broader, more general interventions.

- Youth suicide prevention interventions by primary healthcare professionals were reviewed in 1998 for the New Zealand Health Technology Assessment Programme (Hider, 1998). The review found few controlled evaluations of school-based suicide prevention.

- A review of the literature on school-based suicide prevention programmes was also carried out as part of the Ontario Effective Public Health Practice Project (Ploeg et al, 1999). The interventions were broadly classified as education and general coping skills training and were carried out by teachers, counsellors and social workers. Nine studies were included, seven of which were carried out in the USA. Beneficial effects were detected for suicide potential, depression, perceived stress and anger. Limited effects were found for knowledge and attitudes and some harmful effects were even identified, mostly for young men. Ploeg et al concluded that there is insufficient evidence to support school-based curriculum prevention programmes for young people, but that comprehensive multi-strategy programmes may be more effective than narrowly focused interventions. They also point out that their findings may not be generalisable to countries other than Canada.

Hodgson et al (1996) carried out a literature review of effective mental health promotion focusing on evidence from randomised controlled trials and ‘good quasi-experimental designs’. They also relied on publications (1988–1994) commissioned by the American Psychological Association, MIND, the International Union for Health Promotion and Education-Europe, and the US Institute of Medicine. They only included research that could be replicated within a different culture and which provided convincing evidence of change that was statistically and practically meaningful. Like a number of the North American studies the primary school age group is the focus of most research, and the only study that is just applicable to the present review is one carried out with 10–12 year olds: a programme of assertiveness training delivered to predominantly working-class children in one school. In comparison with a control group, the training improved social competence and academic achievement at a one-year follow up.

A review of the effectiveness of mental health promotion carried out in England (Tilford et al, 1997) found that most studies (1980–1995) were North American,
and that this limited their direct applicability to the British context. Evaluation studies of mental health promotion were identified that included contributory ‘outcomes’ such as self-esteem, in addition to the prevention of mental illness and related symptoms or precursors. The authors tentatively conclude that school-based programmes which focus on social and cognitive competence are worthy of funding.

7.7 Support

7.7.1 Peer support (UK and elsewhere)

Alexander (2002) reports case studies in five English schools that developed various types of interventions to promote the mental health of young people. Some of the peer support programmes were part of multifaceted strategies that were adopted by particular schools. Interviews were conducted with the staff of each of the case study schools – a small semi-rural town school of 750 students, two large mixed London comprehensive schools with 1300 students and 2000 respectively, a school in a deprived area in the North East (numbers of students not provided), and a large mixed comprehensive school of 1500 students in a city suburb.

- The small semi-rural school had a team of 24 peer counsellors who had been chosen through application and interview, and trained by Childline staff in London. Teachers reported in interview that those selected to be peer counsellors were encouraged to develop a mature attitude. They had the opportunity to gain insights regarding their peers, and to develop confidence and interpersonal skills. The peer counsellors’ support for new students was particularly appreciated.

- In the London comprehensive school with over 1300 students, 70 different languages are spoken in the young peoples’ homes. As part of a wide range of strategies to promote the mental wellbeing of young people a peer listening scheme supported the anti-bullying strategy, and peer education operated to develop strategies for anti-discrimination in attitudes and behaviour for students from years 8 to 10. Two outside voluntary agencies provided peer education.

- In the other large London comprehensive with over 2000 students, 71% of students had English as a second language. The peer listening programme was set up with the main aim of combating bullying. The peer listeners were trained by Relate Central Middlesex. The peer listeners told the interviewer that they made themselves available in the playground at breaks to all students, and in particular to befriend younger pupils. Their presence often helped to diffuse situations and create a better atmosphere. Teachers who volunteered to become peer support workers for the peer listeners received the same training from Relate.

- In the school in North East England students received general peer support training that included listening skills, communication skills, buddying skills and anti-bullying strategies. The impetus for peer support came from the students themselves who were concerned about the level of bullying in the school. Since the support system was set up it had developed a wider remit
that included anti-bullying, peer pressure, smoking, health education, team building, self-confidence, and listening skills. The peer supporters met with staff once every half-term for guidance and support. In the wider community good links had been established with the local medical centre and the youth project.

- In the city suburb school of 1500 students the focus was on the school counsellor who trained peer mediators.

The Mental Health Foundation (MHF 2002) funded seven projects in London to develop systems of peer support with young people of secondary school age as a way of promoting positive mental health. Five of the projects were school-based. The projects were evaluated at the beginning and end of the programme and all projects carried out their own internal monitoring and evaluation. The MHF found that the success of the projects in schools depended on the continued support of the senior management team, and peer supporters who adequately reflected the demographics of the school.

The external evaluation of the MHF projects was limited because 66% of peer supporter responses came from only three of the five schools involved and 57% of the staff responses came from only two schools. Girls tended to dominate the peer support programmes, and of the 50 peer support respondents only six were male. The reason why boys were reluctant to volunteer was not investigated. Despite these limitations the Mental Health Foundation concluded that peer support benefits participants and the whole school, and promotes mental health by:

- Giving access to sources of help
- Building confidence and self-esteem in supporters and supported
- Teaches strategies to deal with difficult situations such as bullying or peer pressure
- Promotes confidence and the acquisition of skills in peer supporters
- Helps to promote educational achievement by promoting good mental health
- Teaches students how to inter-relate.

Lessons that may be generaliseable from the projects are:

- Peer support has to be part of a whole school approach to guidance/pastoral care
- The support of senior staff, guidance staff, and a group of staff ready to commit to the project is essential
- A needs analysis that provides clear aims and objectives for the programme
- Adequate time needs to be put aside to set up and maintain the programme
- There should be clear rules on confidentiality and the limits to confidentiality
- Regular and consistent supervision for the peer supporters needs to be in place and consistently monitored
• There should be ongoing monitoring and evaluation of the programme to inform further developments.

The findings of this study are compatible with those of Rider (2000) in her report of a buddy system in a secondary school that focused on the support of a child with special educational needs.

7.8 External interventions: evidence from the UK, USA and elsewhere

7.8.1 Prevention

In the USA there is a national movement to bring comprehensive mental health services to young people in their schools. The programme began in the mid-1980s and accelerated in the 1990s. The Expanded School Mental Health Programs (ESMH) augment traditional mental health services provided by school counsellors, educational psychologists and school social workers, by linking schools to community mental health centres, health departments and other social services. In doing so the ESMH can provide a range of mental health services to young people in mainstream and special schools that include assessment, case management, treatment, and also prevention. ESMH programmes focus on whole-school mental health promotion activities. Evaluations to date and early research findings demonstrate that these programs are leading to outcomes valued by the whole school community. For example, there have been improvements in school attendance, academic achievement, and behaviour, and decreased referrals to special education. Even so, programme funding is still patchy and tenuous (Weist et al, 2003).

7.8.2 Support: joint/integrated working

In Britain Child and Adolescent Mental Health Services (CAMHS) rely most heavily for their effectiveness on high levels of collaboration across health, education and social care. Some authorities are bringing services closer together through locally designed partnerships. For example, Surrey County Council has created integrated children’s services with a unified management structure across social care and education. The expertise and judgements of teachers are important to the outcomes for young people who are vulnerable or at risk but there are problems with the integration of services in that education operates within a different statutory framework to mental health services (Booker, 2003; Pettitt, 2003).

The Audit Commission (1999) found little integrated work in England and Wales, and that little time was spent on supporting education. It found that only two per cent of specialist CAMHS staff time was spent on providing consultation to others, and that only one per cent of their time was spent giving support to ‘Tier 1’ services such as health workers, teachers, and social workers. Referrals to CAMHS were often restricted, with only 14% coming from social services or education. In the area of identifying mental health service needs for young people, over 80% of the Health Authorities involved education and the social services. About 50% consulted other agencies, such as GPs and voluntary organisations, and 40% consulted youth justice services; but only one third of the Health
Authorities consulted young people and their parents. The Health Authorities mainly used a measure of socio-economic deprivation to evaluate needs. Fewer looked at risk factors for mental health such as the numbers of children and young people excluded from school or in temporary accommodation.

There is evidence of good integrated working. For example, in Huddersfield school nurses with the support of the CAMHS have developed an effective method of screening Year 9 students’ health needs that include emotional and psychological wellbeing. Filling in the confidential questionnaire is a voluntary activity and where there are indications that the young person may be having difficulties they are interviewed by the school nurse, and if necessary, referred to CAMHS. The CAMHS provides the school nurses with support on a monthly basis. The school uses the questionnaires to inform the development of the Personal, Social, Health and Education curriculum (DfEE, 2001).

The Mental Health Foundation (MHF) explored joint working between CAMHS and schools (Pettitt, 2003). One of the aims of the research was to identify the factors that contribute and those that create barriers to joint working. All CAMHS in England were sent a semi-structured questionnaire, 171 (55%) of which were returned. Four case studies were selected from the questionnaire responses. The case studies comprised interviews with a range of staff from CAMHS, education and social services. The majority of the CAMHS responding to the survey said that they worked with schools, 81% with secondary and 76% with primary schools. CAMHS work with the mainstream secondary sector involves consultation, support, training, and advice to school nurses, special educational needs co-ordinators and counsellors. Direct work with young people includes individual and group treatment, social skills groups, anti-bullying projects, work with young people at risk of exclusion, anger management classes, work with peer trainers, mental health promotion work, and input into the PSHE curriculum. Three CAMHS reported specific work with minority ethnic groups. However, as indicated by the earlier Audit Commission (1999) survey the work in schools represented a relatively small proportion of CAMHS work.

Evaluation of the work of CAMHS in schools is problematic as it entails measuring outcomes for young people as well as the impact of joint working. Only 30% of CAMHS in the MHF survey (Pettitt, 2003) were currently evaluating their services, and these to varying degrees. However, Pettitt stresses the importance of evidence-based practice, given that no particular model of work or theoretical basis could be found for CAMHS from the literature or from the survey.

The SNAP (2000) review of the literature on effective mental health promotion interventions to young people reported a project run by a clinical psychologist in one North American school (Gilham et al., 1995). The intervention was selective and reported a reduction in symptoms of depression among 11–12 year olds over a two-year follow up period. One hundred and eighteen participants who demonstrated significant scores on a tested measure of depression and a tested measure of perception were randomly allocated to an intervention group (n=69) or a control group (n=49). The intervention group met in smaller groups of 10–12
young people for 1.5-hour sessions over a 12-week period. The clinical
psychologist used two main components in the small group work: a cognitive
component and a social problem-solving component. Evaluation was conducted
pre- and post-intervention and at six month intervals for a period of two years.
After two years (at age 13 and 14 years) those in the intervention group reported
crere depressive symptoms on average than the control group. Young people in
the intervention group were found to be only half as likely as those in the control
group to report symptoms in the moderate to severe range.

The national Norwegian anti-bullying strategy designed by Dan Olweus (1992)
was based on his study of the characteristics of both bullies and victims. 2,400
students were involved in the intervention, which focused on the larger social
environment, involving the whole school, the families and individuals. Schools
and families were provided with information and with bullying prevention
strategies. The intervention demonstrated significant reductions in bullying at a 20
month follow-up (Olweus, 1991).

A 1998 UK self-report survey of 904 school students aged between 12 and 17
years found that the male to female ratio of bullies was 3:1 – a decrease on the 4:1
ratio reported by Olweus in 1994. The difference in ratios may mean that anti-
bullying strategies are more effective on the direct bullying behaviour of boys and
less so on the indirect behaviour of girls (for example, excluding peers from
activities and friendship groups). However, the Olweus and UK studies also
involved different cultures.

7.8.3 Recovery
Little research has been found that focuses on the recovery of young people who
have had emotional or mental health problems and then returned to school with
further support. In the USA school-based post-suicide crisis interventions have
been developed to support the peer group who may experience cognitive, social,
emotional and psychological problems. These are referred to as postventions and
are aimed at recovery and readjustment. This literature review has not located any
evaluations of the outcomes of postvention.

7.9 Conclusions
Most of the research on mental health promotion/prevention interventions has
been undertaken in the USA and this must raise questions about the
transferability of these interventions to Scotland.

The effectiveness of teacher-led interventions and schools as intervention settings
needs to be compared to the effectiveness of other providers and other settings,
London borough indicated that some young people did not see school as the
appropriate setting for counselling.

The EPPI-Centre review of international literature (Harden et al, 2001) could find
no evaluated interventions effective or otherwise that addressed young peoples’
concerns about workload, academic achievement or engagement in school. These
are key concerns for young people in Scottish schools (Edwards, 2001). Interventions that involve young people supporting each other need to be further explored; peer counselling schemes in particular need to be rigorously evaluated, and strategies put in place to protect the young people who volunteer to be trained as counsellors.

Many young people in Scotland have developed their own sophisticated coping strategies (Edwards, 2001), but development work to enhance these skills needs to be undertaken, monitored and evaluated. For adolescents it would appear that adult respect for the skills they already possess is more important to them than imposing programmes developed solely by adults, however professional and well-meaning.
8: What is the evidence for the success of programmes of intervention on the emotional and mental wellbeing of young people?

Evidence of success should be demonstrated by rigorous evaluations of interventions that show successful outcomes for young people at whom the interventions were targeted. However, there is a current shortage of agreed indicators of mental health and methods of measurement. As a result there are few fully evaluated initiatives in the literature (PHIS, 2003). Also certain categories of intervention exacerbate the problems of evaluation; for example mental health interventions targeted at large populations from various socio-economic backgrounds with individual multiple risk and resilience factors.

The ‘grey’ literature describes case studies that purport to have successful outcomes for the student population and that may point the way forward for other schools. This literature, although valuable in providing recent evidence, does not provide rigorous evaluation, relying only on the self-reported views of teachers and students.

8.1 Evidence from the UK

8.1.1 Circle time (universal\(^1\) and selective)

A research project by the Calouste Gulbenkian Foundation showed some of the potential of circle time in the secondary school according to Alexander (2002). Ofsted reports have also recognised the value of circle time in the primary school in promoting positive behaviour and relationships and early identification of disaffected students.

8.1.2 Peer education (universal and selected)

Peer-led interventions are given various names: supporters, listeners, counsellors buddies. Peer support has been reported in the UK within a case study framework (Mental Health Foundation, 2002). Evaluations have taken the form of anonymised self-report questionnaires to, and interviews with staff, and students. These evaluations provide the following information:

Benefits to peer supporters:
- Encouraged to have a mature attitude
- Gain insights to their peers
- Gain opportunities to develop confidence and skill.

(Alexander, 2002)

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\(^1\) Primary prevention of mental ill health or promotion of emotional wellbeing can be defined as any initiative that is aimed at young people who do not have an established diagnosis of a mental health problem. Mrazek and Haggerty (1994) suggest that primary prevention can be further divided into: ‘Universal’ interventions that target all individuals; ‘Selective’ interventions that target those individuals at increased risk of developing mental health problems; and ‘Indicated’ interventions targeted at those individuals showing early signs of mental ill health.
Benefits to users:

- Someone to talk to who will listen
- Help with resolving problems
- Being able to talk and open up
- Support from older students
- Knowledge that there is help available.

(The Mental Health Foundation, 2002)

Teachers report that relationships are improved throughout the school community and as a result everyone’s confidence and feeling of wellbeing is boosted. Links are also built up and maintained with outside support agencies such as Childline who train peer counsellors.

Peer support appears to work well in schools where the whole of the senior management team is committed to it and is willing to provide time, effort and space. Even so, there are difficulties in attracting some young people to become supporters (boys are very reluctant), and to be supported.

Although the signs seem to indicate that peer support promotes emotional wellbeing the evidence for success is very limited. Sixty-six per cent (66%) of peer supporter responses in the Mental Health Foundation research were from only three schools, and 57% of staff responses came from only two schools.

Independent assessments of the effectiveness of peer support systems have not been available. Measurements of mental health and wellbeing among students have not been made prior to and post-intervention (Rider, 2000).

8.1.3 Mood affective disorders (indicated)

Blair et al, 2001 conducted a systematic evaluation of the effectiveness of a specially developed educational intervention to help secondary school teachers to recognise symptoms of clinical depression in their students. The researchers stated that their evaluation paralleled others ‘in the broad field of health education, where knowledge and attitudes appear to be more readily changed than measurable behaviour of skills’. The researchers think that effective models exist in other countries but that the cost of controlled long-term evaluations is prohibitive.

8.2 Evidence from the USA and elsewhere

8.2.1 Literature reviews

Broadstock and Nicholas (1999) found that most of the studies they reviewed on the effectiveness of early interventions for preventing mental illness were school-based with some parental and community involvement. They concluded that there was insufficient evidence to assess the impact of parent and community involvement as an added feature and few studies demonstrated effects on behavioural measures.
The EPPI-Centre (Harden et al., 2001) found that the international evidence from systematic reviews of the effectiveness of interventions was mixed and sometimes contradictory. For example, a school-based study that focused on coping with distress and self-harm was found to be effective at reducing suicide potential and was also effective for increasing knowledge of suicide and the sources of help. Yet overall, the researchers stated that there is currently insufficient evidence to recommend school-based suicide prevention interventions. In some cases suicide prevention interventions have even been found to be harmful.

Interventions that focus on the promotion of self-esteem and self-concept were found to be more effective than broader-based interventions. The EPPI-Centre reported three clear findings:

- A six-week programme that taught girls how to recognise and restructure self-defeating thoughts was effective in improving knowledge about the technique itself.
- Short knowledge-based sessions about depression were ineffective in improving long-term depressive symptoms, risk factors, knowledge, attitudes or intentions.
- A suicide curriculum was ineffective in knowledge gain and combating stress, anxiety, and feelings of hopelessness.

Durlak and Wells (1997) drew some positive conclusions from their North American meta-analysis of primary prevention mental health programmes for children and adolescents. They reviewed 177 primary prevention programmes designed to prevent behavioural and social problems. They found that programmes modifying the school environment, individually focused mental health promotion, and interventions to help children negotiate stressful transitions produced significant effects.

### 8.2.2 Joint/integrated work

Informal evaluations of the Expanded School Mental Health Programs (ESMH) have shown positive outcomes for young people and their families and schools (Weist & Christodulu, 2000). The integration of several services into one program means that young people with multiple problems can be helped in one setting. There were no research reports found, however, comparing ESMH schools with compatible non-ESMH schools.

### 8.3 Conclusion

Evidence of the success of interventions in the UK is mostly found in the ‘grey’ literature and is not based on rigorous research involving long-term follow up. One of the key problems with any intervention that is successful with one population is whether it is transferable or replicable in any other setting. No studies were found describing replication that has been systematically and rigorously evaluated.
The EPPI-Centre (2001) review of the international literature on the barriers and facilitators to the promotion of young peoples’ mental health concluded that mental health promotion should not rely on information alone, but should involve the development of students’ skills, using behavioural techniques that are reinforced in the wider community. They also concluded that:

*The effectiveness of teachers as intervention providers and schools as intervention settings needs to be compared to the effectiveness of other providers and other settings.*
9: Which areas require further research?

There is a dearth of good research and evaluations of programmes for promoting emotional and mental wellbeing in young people in the UK. Although a lot of studies have been undertaken in the USA of interventions that claim to have effective outcomes we have to consider the problem of the transferability of the interventions to the UK population. Ideally research should be of rigorous design, involve large groups, long-term monitoring and evaluation, and generalisable outcomes. There is a great need for appropriate UK evidence-based interventions. Interventions in the UK, including multi-agency inputs will have to take account of the level of resources local CAMHS can provide to schools. Increased research on the promotion of emotional wellbeing and mental health of young people will also be likely to lead to recommendations for extra resources in schools and funding to improve the CAMHS.

The following fields for research have been identified in the literature and are appropriate to one or more of the three types of intervention: universal, selective and indicated:

- The link between substance abuse in early adolescence and the onset on mental ill health and suicide.  
  (Anderson, 1999)

- The early prevention of mood and eating disorders

- The effectiveness of interventions with adolescents

- Research into resilience and protective factors.  
  (Nicholas & Broadstock, 1999)

- Research into effective interventions that address the stress young people experience in:
  - School workload
  - Academic achievement and engagement in school
  - Future employment/unemployment
  - Access to resources and support
  - Leisure facilities
  - Family problems and physical appearance

- Research into effective interventions building on the favoured coping strategies of young people, such as talking to friends

- Research into the effectiveness of peer support

- Research that starts from the viewpoint of young people especially that of socially excluded young people

- Research into the extent to which caring for an adult or younger siblings impacts on the mental health of the young carer

- Research on the listening and communication skills of teachers working with adolescents.  
  (EPPI-Centre, 2001)
Which areas require further research?

- Research into the effectiveness of circle time in the promotion of emotional wellbeing
- Research into the effectiveness of the prevention of self-harm in the Scottish context
- Outcome evaluations for school mental health programmes.
  \((\text{Nabors et al, 2000})\)
- Research on the views of young people who have used mental health services, to integrate their views into the development of mental health service provision.
  \((\text{Leon & Smith, 2001})\)
- Research into the impact of family dysfunction on the aftercare of adolescents who self-harm.
  \((\text{Kerfoot et al, 1996})\)
- Research on effective coping strategies for adolescents suffering chronic stress.
  \((\text{Townsend & Walker, 1998})\)
- Research into the joint working between schools, GPs, and mental health and social services in the delivery of mental health promotion to young people.
  \((\text{PHIS, 2003; Townsend & Walker, 1998})\)

9.1 Conclusion

The existence of effective interventions does not guarantee that services will be effective. It is, therefore, important to evaluate services (PHIS, 2003). The search of the databases of peer reviewed research, the search of the ‘grey’ literature, and personal communication with a range of agencies such as Youngminds and the Young People’s Unit in Edinburgh, did not identify research on recovery and reintegration of young people with mental health problems to schools. There is, therefore, much that service providers need to know in order to promote effectively the mental wellbeing of young people in Scotland.
References


