NICE National Institute for Health and Care Excellence

NICE guideline

Social and emotional wellbeing in primary education

Public health guideline

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This guideline should be read in conjunction with CG28.

Introduction

The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE or the Institute) to produce public health guidance on promoting the social and emotional wellbeing of children in primary education.

The guidance is for teachers, school governors and professionals with public health as part of their remit working in education, local authorities, the NHS and the wider public, independent, voluntary and community sectors.

The Public Health Interventions Advisory Committee (PHIAC) has considered the reviews of the evidence, an economic appraisal, stakeholder comments and the results of fieldwork in developing these recommendations.

Details of PHIAC membership are given in appendix A. The methods used to develop the guidance are summarised in appendix B. Supporting documents used in the preparation of this document are listed in appendix E. Full details of the evidence collated, including fieldwork data and activities and stakeholder comments, are available on the NICE website, along with a list of the stakeholders involved and the Institute's supporting process and methods manuals.

The guidance complements and supports, but does not replace, NICE guidance on: depression in children and young people; and parent training and education in the management of children with conduct disorders (for further details, see section 7).

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1 Recommendations

This document constitutes the Institute's formal guidance on promoting the social and emotional wellbeing of children in primary education. Primary education refers to all educational settings serving children aged 4–11 years.

Children's social and emotional wellbeing is important in its own right but also because it affects their physical health (both as a child and as an adult) and can determine how well they do at school. Good social, emotional and psychological health helps protect children against emotional and behavioural problems, violence and crime, teenage pregnancy and the misuse of drugs and alcohol ('Systematic review of the effectiveness of interventions to promote mental wellbeing in children in primary education' Adi et al. 2007).

This guidance complements existing national initiatives to promote social and emotional wellbeing. It should be considered in the context of the Social and Emotional Aspects of Learning (SEAL) programme (Department for Education and Skills 2005a; 2005b), the Healthy Schools programme (Department for Education and Skills 2005c) and related community-based initiatives. These all stress the importance of enabling children to participate fully in the development of such programmes to ensure their views are heard.

Depending on local service configuration and capacity, all those cited under 'Who should take action' could be involved in implementing the recommendations.

The evidence statements underpinning the recommendations are listed in appendix C. The evidence reviews, supporting evidence statements and economic appraisal are available on the Institute's website.

Comprehensive programmes

Recommendation 1

Who is the target population?

Professionals working with children in primary education.

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Who should take action?

Commissioners and providers of services to children in primary education including those working in: children's trusts, local authority education and children's services, schools, primary care trusts (PCTs), child and adolescent mental health services and voluntary agencies.

What action should they take?

- Develop and agree arrangements as part of the 'Children and young people's plan' (and joint commissioning activities) to ensure all primary schools adopt a comprehensive, 'whole school' approach to children's social and emotional wellbeing. All primary schools should:
  - create an ethos and conditions that support positive behaviours for learning and for successful relationships
  - provide an emotionally secure and safe environment that prevents any form of bullying or violence
  - support all pupils and, where appropriate, their parents or carers (including adults with responsibility for looked after children)
  - provide specific help for those children most at risk (or already showing signs) of social, emotional and behavioural problems
  - include social and emotional wellbeing in policies for attaining National Healthy Schools status and reaching the outcome framework targets[1]
  - offer teachers and practitioners in schools training and support in how to develop children's social, emotional and psychological wellbeing. The trainers should be appropriately qualified and may be working in the public, voluntary or private sectors. In the public sector, they may be working in: children's services, healthy schools teams, educational psychology or behaviour support, community nursing, family support or child and adolescent mental health services (at tiers one and two – for example, primary mental health workers).
- Put in place and evaluate coordinating mechanisms to ensure primary schools have access to the skills, advice and support they need to deliver a comprehensive and effective programme that develops children's social and emotional skills and wellbeing (see recommendations 2–3).
- Schools and local authority children's services should work closely with child and adolescent mental health and other services to develop and agree local protocols. These should support a

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'stepped care' approach to preventing and managing mental health problems (as defined in NICE clinical guideline 28 on depression in children and young people). The protocols should cover assessment, referral and a definition of the role of schools and other agencies in delivering different interventions, taking into account local capacity and service configuration.

Universal approaches

Recommendation 2

Who is the target population?

Children in primary education (aged 4–11 years), their parents or carers and teachers.

Who should take action?

- Head teachers, teachers and practitioners working with children in primary education.
- Those working in (and with) local authority education and children's services (including healthy schools teams), primary care (including school nurses), child and adolescent mental health services (tiers one and two) and voluntary agencies.

What action should they take?

Provide a comprehensive programme to help develop children's social and emotional skills and wellbeing. This should include:

- A curriculum that integrates the development of social and emotional skills within all subject areas. (These skills include problem-solving, coping, conflict management/resolution and understanding and managing feelings.) This should be provided throughout primary education by appropriately trained teachers and practitioners.
- Training and development to ensure teachers and practitioners have the knowledge, understanding and skills to deliver this curriculum effectively. The training should include how to manage behaviours and how to build successful relationships.
- Support to help parents or carers develop their parenting skills. This may involve providing information or offering small, group-based programmes run by community nurses (such as school nurses and health visitors) or other appropriately trained health or education practitioners. In addition, all parents should be given details of the school's policies on promoting social and emotional wellbeing and preventing mental health problems.

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- Integrated activities to support the development of social and emotional skills and wellbeing and to prevent bullying and violence in all areas of school life. For example, classroom-based teaching should be reinforced in assemblies, homework and play periods (in class as well as in the playground).

Targeted approaches

Recommendation 3

Who is the target population?

- Children in primary education (aged 4–11 years) who are showing early signs of emotional and social difficulties, in particular, those who are:
  - showing early signs of anxiety or emotional distress (for example, children who have poor peer relations, low self-esteem, are withdrawn or have behavioural problems)
  - at risk of developing (or who already display) disruptive behavioural problems.
- Parents or carers of children aged 4–11 years who are showing early signs of emotional and social difficulties.

Who should take action?

- Teachers and practitioners working with children in primary education.
- Those working in (and with) local authority education and children's services (including healthy schools teams), primary care (including school nurses), child and adolescent mental health services (tiers one and two) and voluntary agencies.

What action should they take?

- Ensure teachers and practitioners are trained to identify and assess the early signs of anxiety, emotional distress and behavioural problems among primary schoolchildren. They should also be able to assess whether a specialist should be involved and make an appropriate request. Children who are exposed to difficult situations such as bullying or racism, or who are coping with socially disadvantaged circumstances are at higher risk. They may include: looked after children (including those who have subsequently been adopted), those living in families where there is conflict or instability, those who persistently refuse to go to school, those who have experienced adverse life events (such as bereavement or parental separation), and those who have been exposed to abuse or violence.

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- Identify and assess children who are showing early signs of anxiety, emotional distress or behavioural problems. Normally, specialists should only be involved if the child has a combination of risk factors and/or the difficulties are recurrent or persistent. The assessment should be carried out in line with the Common Assessment Framework (to ensure effective communications with the relevant services) and using other appropriate tools.
- Discuss the options for tackling these problems with the child and their parents or carers. Agree an action plan, as the first stage of a 'stepped care' approach (as defined in NICE clinical guideline 28 on depression in children and young people).
- Provide a range of interventions that have been proven to be effective, according to the child's needs. These should be part of a multi-agency approach to support the child and their family and may be offered in schools and other settings. Where appropriate, they may include:
  - problem-focused group sessions delivered by appropriately trained specialists in receipt of clinical supervision. These specialists may include educational psychologists or those working in child and adolescent mental health services (at tiers one and two)
  - group parenting sessions for the parents or carers of these children, run in parallel with the children's sessions.
- Ensure parents or carers living in disadvantaged circumstances are given the support they need to participate fully in any parenting sessions that are offered. For example, they may need help with childcare or transport.

(See also: NICE technology appraisal 102 on parent training and education in the management of children with conduct disorders, and the NICE clinical guideline 72 on attention deficit hyperactivity disorder).

[1] HM Government (2004) Every child matters: change for children. London: Department for Education and Skills.

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2 Public health need and practice

Young children's social and emotional wellbeing is important in its own right but also because it affects their physical health (both now and in the future). It can determine whether or not they develop healthy lifestyles. It can also determine how well they do at school.

In 2004, 10% of children and young people aged 5–16 had a clinically diagnosed mental disorder (Office for National Statistics 2004). Older children (aged 11–16 years) were more likely than younger children (aged 5–10) to be affected (12% compared with 8%). Mental disorders among young people increased between 1974 and 1999 (Collishaw et al. 2004). However, this upward trend was halted during 1999–2004, according to the most recent national survey of young people aged 5–16 years (Office for National Statistics 2004).

In 2004, boys were generally more likely to have a mental disorder than girls, and the prevalence of mental illness was greater among children living:

- within disrupted families (lone parent, reconstituted)
- with parents who have no educational qualifications
- within poorer families and in disadvantaged areas (Office for National Statistics 2004).

There is variation by ethnicity. Children aged 5–10 who are white, Pakistani or Bangladeshi appear more likely to have a mental disorder than black children. Indian children are least likely to have such problems. Looked after children aged 5–10 were at least five times more likely than average to have a mental disorder (42% versus 8%) (Office for National Statistics 2004).

Policy background

The guidance will support the following national service frameworks (NSFs) and other government policies:

- 'National service framework for children, young people and maternity services' (DH 2004a)
- 'National service framework for mental health' (DH 1999)
- 'Every child matters' green paper (HM Government 2003), and 'Every child matters: change for children' programme (HM Government 2004)
- 'Higher standards, better schools for all' (Department for Education and Skills 2005a)

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- 'Promoting children's mental health within early years and school settings' (Department for Education and Employment 2001)
- 'Excellence and enjoyment: social and emotional aspects of learning' (Department for Education and Skills 2005b)
- 'Healthy minds: promoting emotional health and wellbeing in schools' (Ofsted 2005)
- 'Bullying – a charter for action' (Department for Education and Skills 2003a)
- 'Bullying: effective action in secondary schools' (Ofsted 2003)
- 'Guidance for schools on developing emotional health and wellbeing' (Department for Children, Schools and Families 2007)
- 'The respect action plan' (Home Office 2006)
- 'Healthy living blueprint for schools' (Department for Education and Skills 2004)
- Education and Inspection Act (HM Government 2006)
- 'Choosing health: making healthier choices easier' (DH 2004b)
- National healthy school status – a guide for schools' (Department for Education and Skills 2005c)
- 'Our health, our care, our say' (DH 2006)
- 'Making it possible: improving mental health and well-being in England' (National Institute for Mental Health in England 2005)
- 'Aiming high: raising the achievement of minority ethnic pupils' (Department for Education and Skills 2003b)
- 'Promoting the health of looked after children' (DH 2001)
- 'A better education for children in care' (Social Exclusion Unit 2003)
- 'Managing pupil mobility' (Department for Education and Skills 2003c)
- 'Special education needs: third report of session 2005–06' (House of Commons Education and Skills Committee 2006).

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3 Considerations

PHIAC took account of a number of factors and issues in making the recommendations.

3.1 PHIAC adopted an holistic approach to social and emotional wellbeing within primary schools. This emphasises the importance of a supportive and secure environment and an ethos that avoids stigma and discrimination in relation to mental health and social and emotional difficulties. It includes support for pupils with special needs.

3.2 The guidance should be used within the context of a range of services and processes that promote children's social and emotional wellbeing in primary education. These may range from school-based, universal approaches to the referral and treatment of children with a mental illness.

3.3 At some point, all children may demonstrate emotional, social and behavioural difficulties during the normal experience of childhood. But they are not always indicative of a significant psychological or medical problem.

3.4 While prevention of child abuse is not the primary focus of this guidance, neglect and abuse can lead to mental health problems. This guidance must therefore be used in conjunction with local child protection and other procedures to safeguard them.

3.5 Effective programmes to promote social and emotional wellbeing in primary education are based on partnership working with children. Ensuring children can express their views and opinions is a vital aspect of this.

3.6 PHIAC considered that universal approaches to promote social and emotional wellbeing should be the main focus. This includes early identification of children at risk of having their learning disrupted by social and emotional difficulties. A strong focus on prevention could also avoid inappropriate referrals to clinical services.

3.7 PHIAC recognised that the national SEAL and Healthy Schools programmes (and related local policies on, for example, anti-bullying) provide important vehicles for implementing these recommendations. The recommendations

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should also help support Ofsted in its inspection of progress in schools towards achieving the goals set out in 'Every child matters' (HM Government 2004).

3.8 Children's social and emotional wellbeing is influenced by a range of factors, from their individual make-up and family background to the community within which they live and society at large. As a result, school-based activities to develop and protect their social and emotional wellbeing can only form one element of a broader, multi-agency strategy. Other elements will include, for example, the development of policies to improve the social and economic circumstances of children living in disadvantaged circumstances.

3.9 It is important to recognise and respond to issues relating to equality. That involves taking account of the needs of children from different socioeconomic, cultural and ethnic backgrounds. It also involves ensuring programmes are culturally sensitive. The latter is particularly important to ensure social and emotional difficulties are not misinterpreted. The distinct needs of disabled children also need to be considered.

3.10 Practitioners involved in delivering interventions may face confidentiality issues, for example in relation to child abuse. Similarly, children must be made aware of their rights on confidentiality. This guidance should be used in the context of local policies and protocols regarding confidentiality.

3.11 Lack of investment in mental health promotion in primary schools is likely to lead to significant costs for society. Research shows that a child's emotional, social and psychological wellbeing influences their future health, education and social prospects. Children who experience emotional and social problems are more likely, at some point, to: misuse drugs and alcohol, have lower educational attainment, be untrained, unemployed or involved in crime.

3.12 Taking a longer term view, the interventions were considered to be cost effective. An integrated approach, using universal and targeted interventions, could prevent the negative behaviours which can lead to costly consequences for the NHS, social services and the criminal justice system.

3.13 Programmes to promote social and emotional wellbeing will help children cope with particularly stressful times such as the transition from primary to secondary school.

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3.14 When using group-based approaches, care is needed with groups that include both aggressive and non-aggressive children, as this approach may have adverse consequences on the latter. It is also important to respond to individual needs.

3.15 Programmes designed to promote the emotional and social wellbeing of children need to be rigorously evaluated. Evaluation could be funded by research agencies and the Department for Children, Schools and Families.

3.16 Teachers and practitioners in primary education need basic and ongoing training to promote young children's social and emotional wellbeing, provided by relevant training and education organisations.

3.17 This guidance does not consider:

- the effectiveness of interventions in relation to educational attainment as well as social and emotional wellbeing
- interventions that address the relationship between social and emotional wellbeing and factors such as physical activity levels and nutrition
- assessment of children with special needs
- clinical interventions for established mental illness.

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4 Implementation

NICE guidance can help:

- NHS organisations meet DH standards for public health as set out in the seventh domain of 'Standards for better health' (updated in 2006). Performance against these standards is assessed by the Healthcare Commission, and forms part of the annual health check score awarded to local healthcare organisations.
- Local authorities (including social care and children's services) and NHS organisations meet the requirements of the government's 'National standards, local action, health and social care standards and planning framework 2005–2008'.
- Provide a focus for children's trusts, health and wellbeing partnerships and other multi-sector partnerships working on health within a local strategic partnership.
- Support schools aiming for healthy school status.
- National and local organisations within the public sector meet government indicators and targets to improve health and reduce health inequalities.
- Local authorities fulfill their remit to promote the economic, social and environmental wellbeing of communities.
- Local NHS organisations, local authorities and other local public sector partners benefit from any identified cost savings, disinvestment opportunities or opportunities for re-directing resources.

NICE has developed tools to help organisations implement this guidance.

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5 Recommendations for research

PHIAC recommends the following research questions should be addressed in order to improve the evidence relating to promoting the emotional and social wellbeing of children in primary education.

1. What indicators should be used to measure the emotional and social wellbeing of primary schoolchildren and to monitor any changes over time? How can such measures be used in evaluation, including economic appraisals?
2. What is the most effective and cost effective way to improve the emotional and social wellbeing of primary schoolchildren? How do interventions to improve emotional and social wellbeing (including multi-component programmes) affect social, health and education outcomes (and costs) in the longer term.
3. What are the most effective and cost-effective ways of improving the emotional and social wellbeing of vulnerable primary schoolchildren? This includes those from certain black and minority groups and looked after children (including those who have subsequently been adopted).
4. What are the most effective ways to involve parents or carers, particularly those from disadvantaged backgrounds, in primary school programmes to improve their children's emotional and social wellbeing?
5. What are the most effective ways of involving children in the development, implementation and evaluation of programmes to promote emotional and social wellbeing in primary schools?

More detail on the evidence gaps identified during the development of this guidance is provided in appendix D.

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6 Updating the recommendations

NICE public health guidance is updated as needed so that recommendations take into account important new information. We check for new evidence 2 and 4 years after publication, to decide whether all or part of the guidance should be updated. If important new evidence is published at other times, we may decide to update some recommendations at that time.

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7 Related NICE guidance

Published

Behaviour change at population, community and individual levels. NICE public health guidance 6 (2007).

Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. NICE public health guidance 4 (2007).

Interventions in schools to prevent and reduce alcohol use among children and young people. NICE public health guidance 7 (2007).

Computerised cognitive behaviour therapy for depression and anxiety. NICE technology appraisal 97 (2006).

Methylphenidate, atomoxetine and dexamfetamine for attention deficit hyperactivity disorder (ADHD) in children and adolescents. NICE technology appraisal 98 (2006).

Parent-training/education programmes in the management of children with conduct disorders. NICE technology appraisal 102 (2006).

The management of bipolar disorder in adults, children and adolescents in primary and secondary care. NICE clinical guideline 38 (2006).

Depression in children and young people: identification and management in primary, community and secondary care. NICE clinical guideline 28 (2005).

Obsessive compulsive disorder: core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005).

Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE clinical guideline 9 (2004).

Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE clinical guideline 16 (2004).

Attention deficit hyperactivity disorder. NICE clinical guideline 72 (2008).

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Under development

Personal, social and health education focusing on sex and relationships and alcohol education. NICE public health guidance [Suspended].

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Appendix A: Membership of the Public Health Interventions Advisory Committee (PHIAC), the NICE Project Team and external contractors

Public Health Interventions Advisory Committee (PHIAC)

NICE has set up a standing committee, the Public Health Interventions Advisory Committee (PHIAC), which reviews the evidence and develops recommendations on public health interventions. Membership of PHIAC is multidisciplinary, comprising public health practitioners, clinicians (both specialists and generalists), local authority employees, representatives of the public, patients and/or carers, academics and technical experts as follows.

Professor Sue Atkinson CBE Independent Consultant and Visiting Professor, Department of Epidemiology and Public Health, University College London

Mr John F Barker Associate Foundation Stage Regional Adviser for the Parents as Partners in Early Learning Project, DfES National Strategies

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Professor Simon Capewell Chair of Clinical Epidemiology, University of Liverpool

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Ms Sharon McAteer Public Health Development Manager, Halton and St Helens PCT

Mr David McDaid Research Fellow, Department of Health and Social Care, London School of Economics and Political Science

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Ms Jane Putsey Lay Representative. Chair of Trustees of the Breastfeeding Network

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Dr Mike Rayner Director, British Heart Foundation Health Promotion Research Group, Department of Public Health, University of Oxford

Mr Dale Robinson Chief Environmental Health Officer, South Cambridgeshire District Council

Ms Joyce Rothschild School Improvement Adviser, Solihull Local Authority

Dr Tracey Sach Senior Lecturer in Health Economics, University of East Anglia

Professor Mark Sculpher Professor of Health Economics, Centre for Economics (CHE), University of York

Dr David Sloan Retired Director of Public Health

Dr Dagmar Zeuner Joint Director of Public Health, Hammersmith and Fulham PCT

Expert cooptees:

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Mrs Anne Devrell Head Teacher, Langley Primary School, Solihull

Ms Sue Mackay Health Promotion Specialist, Kent Health Promotion Service

Ms Marilyn Phipps Head Teacher, Damson Wood Infant School, Solihull

Mr Peter Scott Blackmann Chief Executive Officer, The Afiya Trust

Expert testimony:

Ms Deborah Michel Programme Lead for Social and Emotional Aspects of Learning, Primary and Secondary National Strategies, Department for Children, Schools and Families

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External contractors

External reviewers: effectiveness reviews

Review 1: 'Systematic review of the effectiveness of interventions to promote mental wellbeing in children in primary education. Report 1: universal approaches (non-violence related outcomes)' was carried out by the Health Sciences Research Institute (HSRI), Warwick Medical School, University of Warwick. The principal authors were: Yaser Adi, Amanda Killoran, Kulsum Janmohamed, Sarah Stewart-Brown.

Review 2: 'Mental wellbeing of children in primary education (targeted/indicated activities)' was carried out by the University of Teesside (a NICE national collaborating centre). The principal authors were: Susan Jones, Janet Shucksmith, Carolyn Summerbell, Vicki Whittaker.

Review 3: 'Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools: universal approaches with a focus on prevention of violence and bullying' was carried out by the Health Sciences Research Institute (HSRI), Warwick Medical School, University

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of Warwick. The principal authors were: Yaser Adi, Amanda Killoran, Anita Schrader McMillan, Sarah Stewart-Brown.

External reviewers: economic appraisal

The economic review 'A systematic review of cost-effectiveness analyses of whole school and focused primary school-based interventions to promote children's mental health' was carried out by the Academic Unit of Health Economics (AUHE), Leeds Institute of Health Sciences, University of Leeds. The principal author was Christopher McCabe.

The economic analyses 'Estimating the short-term cost effectiveness of a mental health promotion intervention in primary schools' and 'Cost effectiveness of mental health promotion in schools – focused interventions supplementary analysis' were carried out by the AUHE, Leeds Institute of Health Sciences, University of Leeds. The principal author was Christopher McCabe.

Fieldwork

The fieldwork report comprises two documents: 'Mental wellbeing of children public health guidance' produced by Dr Foster Intelligence; and 'Children and young people's voices on emotional well-being report for NICE 2007' by YoungMinds.

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Appendix B: Summary of the methods used to develop this guidance

Introduction

The reports of the reviews and economic appraisal include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the PHIAC meetings provide further detail about the Committee's interpretation of the evidence and development of the recommendations.

All supporting documents are listed in appendix E and are available from the NICE website.

The guidance development process

The stages of the guidance development process are outlined in the box below.

1. Draft scope
2. Stakeholder meeting
3. Stakeholder comments
4. Final scope and responses published on website
5. Reviews and cost-effectiveness modelling
6. Synopsis report of the evidence (executive summaries and evidence tables) circulated to stakeholders for comment
7. Comments and additional material submitted by stakeholders
8. Review of additional material submitted by stakeholders (screened against inclusion criteria used in reviews)
9. Synopsis, full reviews, supplementary reviews and economic modelling submitted to PHIAC
10. PHIAC produces draft recommendations
11. Draft recommendations published on website for comment by stakeholders and for field testing
12. PHIAC amends recommendations
13. Responses to comments published on website
14. Final guidance published on website

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Key questions

The key questions were established as part of the scope. They formed the starting point for the reviews of evidence and facilitated the development of recommendations by PHIAC. The overarching question was:

Which universal, 'whole school', indicated and targeted interventions effectively promote the mental wellbeing of children aged 4–11 in primary education?

The subsidiary questions included the following.

1. What elements of 'whole school' approaches are effective (and cost effective) in promoting the mental wellbeing of children aged 4–11 years?

2. What elements of targeted approaches are effective (and cost effective) in promoting the mental wellbeing of children aged 4-11 years?

3. What type of activities are most effective?

4. What is the frequency, length and duration of an effective intervention?

5. Is it better if teachers, school support staff or a specialist (such as a psychologist or school nurse) delivers the intervention?

6. What is the role of governors?

7. What is the role of parents?

8. What are the barriers to – and facilitators of – effective implementation?

9. Does the intervention lead to any adverse or unintended effects?

Reviewing the evidence of effectiveness

Three reviews of effectiveness were conducted.

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Identifying the evidence

The following databases were searched for whole school, universal and targeted interventions (from January 1990 to June 2007):

- ASSIA (Applied Social Science Index and Abstracts)
- CENTRAL (BioMed Central)
- CINAHL (Cumulative Index of Nursing and Allied Health Literature)
- Cochrane Database of Systematic Reviews
- DARE (Database of Abstracts of Reviews of Effectiveness)
- EMBASE (Excerpta Medica)
- ERIC (Education Resources Information Centre)
- Medline
- PsycINFO (Psychological Information)
- SIGLE (System for Index of Grey Literature in Europe)
- Sociological Abstracts.

Searches were also conducted of the following websites:

- CASEL
- Community Guide
- Joseph Rowntree Foundation
- Joseph Rowntree Trust
- Search Institute

In addition, bibliographies of reviews and studies known to the research teams were searched to identify further studies that might be suitable for inclusion. Further details, including details of the databases, search terms and strategies used, are included in the review reports.

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Selection criteria

Studies were included if they:

- promoted the mental wellbeing of children aged 4–11 in primary education (maintained, independent and special schools)
- (whole schools review) spanned primary and secondary schools but the mean age was below 12
- (whole school review) adopted a whole school or universal approach
- (targeted/indicated review) adopted a targeted/indicated approach
- (targeted/indicated review) described interventions lasting more than 1 month.

Studies were excluded if they:

- included children aged above 12 years
- included children who did not attend school
- (targeted/indicated review) were aimed at secondary school pupils
- (targeted/indicated review) had no connection with school other than being delivered to school-aged children
- (targeted/indicated review) were not based in school
- (whole school/universal review) did not include a control group
- (whole school/universal review) were not published in English
- (whole school/universal review) were carried out in developing countries (according to World Bank/IMF classifications)
- (whole school/universal review) were published before 1990.

For further details of the inclusion and exclusion criteria for each effectiveness review, see the NICE website.

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Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the NICE technical manual 'Methods for development of NICE public health guidance' (see appendix E).

Each study was described by study type and graded (++, +, -) to reflect the risk of potential bias arising from its design and execution.

Study type

- Meta-analyses, systematic reviews of randomised controlled trials (RCTs) or RCTs (including cluster RCTs).
- Systematic reviews of, or individual, non-randomised controlled trials, case-control studies, cohort studies, controlled before-and-after (CBA) studies, interrupted time series (ITS) studies, correlation studies.
- Non-analytical studies (for example, case reports, case series).
- Expert opinion, formal consensus.

Study quality

++ All or most criteria have been fulfilled. Where they have not been fulfilled the conclusions are thought very unlikely to alter.

+ Some criteria fulfilled. Those criteria that have not been fulfilled or not adequately described are thought unlikely to alter the conclusions.

- Few or no criteria fulfilled. The conclusions of the study are thought likely or very likely to alter.

The interventions were also assessed for their applicability to the UK.

Summarising the evidence and making evidence statements

The review data was summarised in evidence tables (see full reviews and the synopsis of the evidence).

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The findings from the reviews were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements reflect the strength (quantity, type and quality) of evidence and its applicability to the populations and settings in the scope.

Economic appraisal

The economic appraisal consisted of an economic review (covering universal approaches and targeted initiatives) and two cost-effectiveness analyses.

Review of economic evaluations

In addition to scanning the effectiveness evidence the following databases were searched:

- Econlit
- Health Economics Evaluation Database (HEED)
- NHS EED (NHS Economics Evaluation Database).

The search strategies for these reviews were developed by NICE in collaboration with the Centre for Reviews and Dissemination at the University of York. Further detail can be found in the full reviews.

Studies were reviewed if they provided economic evidence directly linked to whole school, universal, targeted and indicated approaches. Published studies that met the inclusion criteria were rated to determine the strength of the evidence using the Drummond checklist. ('Guidelines for authors and peer reviewers of economic submissions to the BMJ' Drummond MF, Jefferson TO [1996] British Medical Journal 313: 2075–283.)

Cost-effectiveness analysis

An economic model was constructed to incorporate data from the whole school and targeted effectiveness reviews (reviews 1 and 2).

The 'Health utilities index mark 2' (HUI2) was used to estimate the cost effectiveness of a combined parent/classroom-based intervention in the short term. Modelling was used to predict how targeted interventions could lead to longer term cost savings for the health, social, voluntary and legal sectors (by improving children and young people's mental health and consequently, their behaviour).

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The results are reported in 'Estimating the short-term cost effectiveness of a mental health promotion intervention in primary schools', and 'Cost effectiveness of mental health promotion in schools – focused interventions supplementary analysis'. They are available on the NICE website.

Fieldwork

Fieldwork was carried out in three stages. The aim was to evaluate the relevance and usefulness of NICE guidance for practitioners and the feasibility of implementation.

The first fieldwork stage comprised:

- Qualitative interviews carried out by Dr Foster Intelligence with 91 professionals and parents, either in small groups or individually across 35 sites in London, Newcastle and Liverpool. Participants included: primary school head teachers; primary school teachers with responsibility for pastoral care, PSHE, SEAL, or Healthy Schools; PCT and LEA staff (including local authority directors of children's services and policy staff from local authorities, PCTs and CAMHS); school governors; and parents of children with emotional and behavioural issues.

The second fieldwork stage comprised:

- An online discussion group, similar methodologically to a face-to-face group interview, on the revised draft recommendations. This was run by Dr Foster Intelligence. It involved four primary school teachers and a child counsellor from England and a primary school teacher from Scotland. All had responsibility for pastoral care in primary schools.

The third fieldwork stage comprised:

- Qualitative research conducted by YoungMinds with 60 primary school-aged children and young people from central London. Participants were invited to a conference to express their views on what kind of emotional support they felt they need to improve their emotional wellbeing.

The main issues arising from the fieldwork are set out in appendix C under 'Fieldwork findings' and 'Qualitative report findings'. The full fieldwork report is available on the NICE website.

How PHIAC formulated the recommendations

At its meeting in July 2007 PHIAC considered the evidence of effectiveness and cost effectiveness to determine:

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- whether there was sufficient evidence (in terms of quantity, quality and applicability) to form a judgement
- whether, on balance, the evidence demonstrates that the intervention is effective or ineffective, or whether it is equivocal
- where there is an effect, the typical size of effect.

PHIAC developed draft recommendations through informal consensus, based on the following criteria.

- Strength (quality and quantity) of evidence of effectiveness and its applicability to the populations/settings referred to in the scope.
- Effect size and potential impact on population health and/or reducing inequalities in health.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of risks and benefits.
- Ease of implementation and the anticipated extent of change in practice that would be required.

Where possible, recommendations were linked to an evidence statement(s) (see appendix C for details). Where a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

The draft guidance, including the recommendations, was released for consultation in November 2007. At its meeting in January 2008 PHIAC considered comments from stakeholders and the results from fieldwork and amended the guidance. The guidance was signed off by the NICE Guidance Executive in January 2008.

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Appendix C: The evidence

This appendix lists evidence statements provided by three reviews and links them to the relevant recommendations (see appendix B for the key to study types and quality assessments). The evidence statements are presented here without references – these can be found in the full review (see appendix E for details).It also sets out a brief summary of findings from the economic appraisal and fieldwork report.

The three reviews of effectiveness are:

- Review 1: 'Systematic review of the effectiveness of interventions to promote mental wellbeing in children in primary education. Report 1: universal approaches (non-violence related outcomes)'.
- Review 2: 'Mental wellbeing of children in primary education (targeted/indicated activities)'.
- Review 3: 'Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools: universal approaches with a focus on prevention of violence and bullying'.

Evidence statement number **UES1** indicates that the linked statement is numbered 1 in review 1; evidence statement **TES1** indicates that the linked statement is numbered 1 in review 2; and evidence statement **VPES1** indicates that the linked statement is numbered 1 in review 3.

The reviews and economic appraisal are available on the NICE website. Where a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by IDE (inference derived from the evidence) below.

Recommendation 1: Evidence statement VPES2, IDE

Recommendation 2: Evidence statements UES1, VPES1

Recommendation 3: Evidence statements TES1, TES2, TES5

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Evidence statements

Evidence statement VPES1

There is evidence from three out of four 'moderate' quality RCTs and two out of two good quality controlled trials (CTs) that multi-component programmes comprising teacher training in management of behaviour, parenting education and a social skills development curriculum are effective in improving outcomes relevant to bullying, violence and mental health.

Two of these studies have reported positive long-term outcomes (RCT [+]) reporting on arrests at 3 years post intervention and reporting violent delinquent acts and school misbehaviour at 18 years.

Examples of this type of multi-component programme include: the Linking Interests of Families and Teachers (LIFT) programme, the Seattle Social Development Project and the Resolving Conflict Creatively programme.

Evidence statement VPES2

There is evidence from a 'good quality' RCT and a 'moderate' quality RCT indicating that the Peace Builders programme is effective in improving outcomes related to violence and mental health (as measured by teacher report on social competence and aggressive behaviour and visits to the school nurse for injury). The main focus of the Peace Builders programme is on change to the school ethos and environment. This aims to incorporate positive social values and ways of behaving among children and staff into every aspect of school life. The programme also includes peer mentoring, parent engagement behaviour management and a small classroom component. While no long-term studies are available, effects have been demonstrated at 2 years post-implementation of the intervention (as measured by teacher report on social competence and aggression).

Evidence statement UES1

There is good evidence (five randomised controlled trials of high quality [++]) to support the implementation of multi-component programmes, which include significant teacher training and development and support for parenting. Most of these programmes have been researched and developed in the US and may need adapting for the UK. Interventions with similar characteristics are available in the UK but have not been the subject of robust trials. While the majority of these programmes were implemented over a year or more, further research is needed to establish the optimum content and length as well as the appropriate level of teacher training and support and support for parenting.

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Evidence statement TES1

Cognitive behavioural therapy (CBT) based programmes targeted at reducing anxiety disorders have been transferred successfully between countries, indicating a high degree of generalisability or applicability.

Two studies (both quality rated 1 [++]) show that brief (10 weeks and 9 weeks) targeted interventions aimed at reducing anxiety or preventing the development of symptoms into full blown disorders appear to be successful in groups of children showing the precursor symptoms associated with anxiety disorders. One study (quality rated 1 [++]) was able to demonstrate that when parent training is combined with child group CBT there are additional benefits for children.

Two studies (quality rated 1 [++]) of indicated interventions aimed at children of divorce and children who are anxious school refusers show sustained benefit for children from CBT-based skills training.

Evidence statement TES2

All studies examined use CBT-based approaches. One study (quality score 1 [+]), the Penn Prevention Programme, showed that it may be possible to relieve and prevent depressive symptoms using a targeted school-based approach where a traditional cognitive behaviour component was allied with a social problem-solving component.

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

One study (quality rating 1 [+]) assessed the effectiveness of an 8 week programme comprising small group-based cognitive-behavioural sessions (entailing role play, games, video and homework activities) in producing improvements in depression scores in children scoring high on the 'Children's depression inventory'. Children receiving the intervention were significantly more likely to have reduced levels of depressive symptoms immediately post-intervention and at 9 months follow-up, compared with children receiving the no-treatment control.

One study (1 [+]) found that social competence training (1 hour sessions for 8 weeks) for children (aged 7–11 years) who were within the 'clinical depression range' of the 'Children's depression inventory', did not significantly improve depression scores at 2 months follow-up, compared with either an attention placebo or no treatment control. Interventions directed at indicated subgroups show some degree of success (two 1 [+]). One study (quality rating 1 [+]) of young people exposed

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to violence and showing clinical symptoms of post-traumatic stress disorder (PTSD) showed reasonable effect sizes. The programme involved a high proportion of black and minority ethnic children and also used trained school personnel to deliver part of the programme.

Evidence Statement TES5

Multi-component interventions designed for targeted groups of children suffering from conduct disorders show that improved social problem-solving and the development of positive peer relations are among the outcomes with the strongest programme effects. Two studies (both rated 1 [++]) showed improved academic achievement as significant outcomes of intervention.

Timing may be critical. Complex longitudinal multi-component studies like that undertaken by the Metropolitan Area Child Study Research Group (quality rating 1 [++]) support the case for early intervention with aggressive disruptive children, but also attest to the improved benefits of giving a booster intervention towards the end of primary education. Significant 'school effects' were found in the study. Better understanding of school effects, including impediments and resources, is called for.

Recruitment and retention into parent programmes is clearly a major challenge, even when incentives (for example, childcare and transport costs) are offered. Given a choice, evidence from one study (quality rating 1 [++]) indicates that parents may prefer targeted children to receive the intervention at school rather than at home.

Some adverse effects are reported by Metropolitan Area Child Study Research Group (quality rating 1 [++]) as a consequence of bringing aggressive hostile children together in small groups only in later elementary stages, with such groups setting up negative norms of aggressive behaviour.

Cost-effectiveness evidence

Overall, the economic modelling demonstrated that universal interventions to promote mental health in primary schools do lead to short-term health benefits and are cost effective. In the longer term, these interventions could lead to further benefits for society as a whole, making them even more cost effective.

The modeling found that targeted interventions are not cost effective in the short term, as they incur similar costs to universal interventions but only a small proportion of the school population benefits. However, they may be cost effective in the longer term (after 4 years) when both the health and broader societal benefits are taken into account.

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The systematic review of published literature did not find any published analyses of the cost effectiveness of universal interventions and only one for focused (targeted) initiatives.

Fieldwork findings

Fieldwork aimed to test the relevance, usefulness and the feasibility of implementing the recommendations and the findings were considered by PHIAC in developing the final recommendations. For details, go to the fieldwork section in appendix B and full fieldwork reports: 'Mental wellbeing of children public health guidance', and 'Children and young people's voices on emotional well-being report for NICE 2007'.

Overall, first stage fieldwork participants felt the recommendations were appropriately targeted and easy to understand and could help promote social and emotional wellbeing and prevent mental illness among primary school-age children.

In addition, the following implementation issues were raised:

- Whether the recommendations could be implemented as part of the Healthy Schools and SEAL (Social and Emotional Aspects of Learning) Programmes.
- Whether the resources needed for training would be made available.
- Whether the recommendations might be used as part of the Ofsted inspection process to assess a school's progress in meeting the outcomes set out in 'Every child matters'.
- Whether it is possible to increase access to a range of specialists, particularly child and adolescent mental health services, given the constraints on resources.

Second stage fieldwork participants considered the recommendations useful and relevant, although again, there were concerns about implementation, particularly in terms of the resources needed.

Third stage fieldwork (the research on childrens' views) highlighted the importance of children being involved in helping to develop and implement methods of promoting emotional and social wellbeing in schools. Children stated that bullying and racism were key issues, although school itself made some participants very sad.

Pupil participation in the recruitment of emotional support staff would ensure they could turn to staff they valued. However, participants also felt it might mean they could no longer turn to other staff they have talked to in the past.

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The report also highlighted a need to remove the stigma surrounding mental health issues and a need to share information about mental heath services with children – and to increase their access to such information.

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Appendix D: Gaps in the evidence

PHIAC identified a number of gaps in the evidence relating to the interventions under examination, based on an assessment of the evidence. These gaps are set out below.

1. There is a lack of valid methods for measuring the emotional and social wellbeing of primary schoolchildren and monitoring changes over time.
2. There is a lack of evidence on the cost effectiveness of interventions to promote the emotional and social wellbeing of primary schoolchildren, particularly multi-component programmes. There is also a lack of evidence on the effect of these interventions on social, health and education outcomes (and costs) in the longer term.
3. There is a lack of evidence on the relationship between standard measures of emotional and social wellbeing and those used to measure quality adjusted life years (QALY).
4. There is a lack of UK evidence on the effectiveness and cost effectiveness of interventions to prevent and manage stress, including the use of relaxation and cognitive behavioural techniques.
5. There is a lack of evidence on effective and cost effective ways of promoting the emotional and social wellbeing of vulnerable primary schoolchildren. Vulnerable children include those from certain black and minority groups, those who are looked after and others at risk of experiencing emotional problems.
6. There is a lack of evidence on effective ways to involve the parents or carers of primary schoolchildren in school-based programmes to improve their children's emotional and social wellbeing. Evidence is particularly needed on how to engage parents or carers from disadvantaged backgrounds.

The Committee made 5 recommendations for research. These are listed in section 5.

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Appendix E: Supporting documents

Supporting documents are available from the NICE website. These include the following.

- Reviews of effectiveness:
  - Review 1: 'Systematic review of the effectiveness of interventions to promote mental wellbeing in children in primary education. Report 1: universal approaches (non-violence related outcomes)'
  - Review 2: 'Mental wellbeing of children in primary education (targeted/indicated activities)'
  - Review 3: 'Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools: universal approaches with a focus on prevention of violence and bullying'.
- Economic appraisal:
  - Economic review: 'A systematic review of cost-effectiveness analyses of whole school and focused primary school-based interventions to promote children's mental health'
  - Economic analyses: 'Estimating the short-term cost effectiveness of a mental health promotion intervention in primary schools' and 'Cost effectiveness of mental health promotion in schools – focused interventions supplementary analysis'.
- Fieldwork reports:
  - A quick reference guide for professionals whose remit includes public health and for interested members of the public.

  For information on how NICE public health guidance is developed, see:

  - 'Methods for development of NICE public health guidance (second edition, 2009)'
  - 'The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)'.

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About this guidance

NICE public health guidance makes recommendations on the promotion of good health and the prevention of ill health.

This guidance was developed using the NICE public health intervention guidance process.

The recommendations from this guidance have been incorporated into a NICE Pathway. Tools to help you put the guidance into practice and information about the evidence it is based on are also available.

Your responsibility

This guidance represents the views of the Institute and was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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