

# The FRIENDS Emotional Health Programme: Initial Findings from a School-Based Project

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Emotional disorders in children are common and although effective interventions are available comparatively few receive specialist help. School nurses were trained to deliver an evidence-based emotional health cognitive behaviour therapy programme, FRIENDS, to 106 non-referred children aged 9–10 attending three schools. Levels of anxiety and self-esteem were stable in the 6-month period before FRIENDS. Three months after completing FRIENDS, anxiety had significantly decreased and self-esteem increased. Children with the most severe emotional problems benefited from the programme. The value of delivering standardised evidence based programmes in schools by school nurses is discussed and the need for further research highlighted.

**Keywords:** Cognitive-behaviour therapy; emotional problems; school-based; universal intervention

## Introduction

Emotional disorders in children are common, with community surveys indicating that 4–8% of children fulfill DSM diagnostic criteria for a severe disorder with accompanying impairment (Costello et al., 2003; Ford, Goodman & Meltzer 2003a). Rates are significantly higher if the impairment criteria are omitted, with Costello et al., (1996) reporting 20.3% in the Great Smoky Mountains study. Similarly, studies in Germany have found lifetime rates for emotional and anxiety disorders of approximately 20% (Essau, Conradt, & Petermann, 2000). If left untreated, emotional disorders persist and have been found to increase the risk of subsequent anxiety, depression, illicit drug dependence and educational underachievement in young adulthood (Kim-Cohen et al., 2003; Woodward & Ferguson, 2001).

Effective interventions, using cognitive behaviour therapy, are available for the treatment of childhood anxiety and depressive disorders (Clarke et al., 1999; Kendall, 1994; Kendall et al., 1997; Lewinsohn et al., 1990). However, whilst effective interventions are available, comparatively few children with significant emotional disorders receive interventions from specialist child mental health services. A recent study found 53.1% of children with significant emotional disorders had no contact with any front line or specialist mental health services over an eighteen-month period (Ford, Goodman, & Meltzer, 2003b). Consideration therefore needs to be made as to how effective interventions can be made accessible for those with significant emotional disorders.

An alternative approach to improving the emotional health of children, highlighted in the recent National Service Framework for Children, Young People and

Maternity Services (Department of Health, 2004), is to provide interventions designed to prevent emotional disorders developing. Durlak and Wells (1997) note that primary prevention programmes can be characterized in terms of the target of the intervention (person versus environment centred) and the way populations are selected. In universal approaches all members of the population (e.g. whole classes of children), receive the intervention. The second is a selective approach in which interventions are targeted upon children who are not yet displaying significant problems but who are at risk of developing disorders (e.g. children in single parent families where the parent has a mental health problem). The final method is an indicated or early intervention approach where interventions are provided for children with mild to moderate problems in order to prevent more severe disorders developing.

Reviews have highlighted that primary prevention programmes can have a positive impact upon the emotional health of children (Durlak & Wells, 1997; Wells, Barlow, & Stewart-Brown, 2003). In particular, universally delivered interventions can have the dual benefits of significantly reducing current problems whilst increasing children's competencies to deal with future problems. Of the many programmes available, Durlak and Wells (1997) noted that behavioural and cognitive-behavioural interventions appeared particularly promising yielding effects sizes twice those achieved by other preventive programmes. An additional feature of universal mental health preventative programmes for children is that they are typically delivered through schools. Providing interventions in schools increases accessibility, improves attendance at sessions and reduces potential stigma associated with

mental health issues. However, Hoagwood and Erwin (1997) note that whilst there are many school-based mental health programmes, few have been rigorously evaluated.

There are a limited number of well-evaluated universal school-based preventative programmes specifically designed to address depression or anxiety. In terms of depression, preventative programmes have shown inconsistent results (Clarke et al., 1993; Possel et al., 2004; Possel et al., 2005). The largest study to date involved 1500 children aged 12–14 and was delivered by trained classroom teachers. Participation in the 8-session Problem Solving for Life programme resulted in significant post-treatment reductions in symptoms of depression compared to a non-intervention comparison group (Spence, Sheffield, & Donovan, 2003). However this difference was not significant when assessed 12 months later. More sustained results were found in the Resourceful Adolescent Programme (RAP) and the New Zealand adaptation (RAP-KIWI). In the initial study, RAP, delivered by trained psychologists, was found to result in lower levels of depressive symptomatology and hopelessness at post intervention than a comparison group (Shochet et al., 2001). These gains were maintained when re-assessed at 10 months follow-up. In RAP-KIWI the 11-session intervention was delivered by trained teachers and resulted in significant post treatment gains on measures of depression that were maintained up to 18 months after the programme (Merry et al., 2004). However, whilst depressive symptoms reduced, feedback from teachers was less positive. Concerns were raised about the prescriptive nature of the programme and the way the concepts were taught (Merry et al., 2004). Negative perceptions such as these will undoubtedly have implications for the longer term sustainability and integrity of the programme.

Universal preventative programmes for anxiety are more limited, with most tending to adopt an indicated approach (Dadds et al., 1997, Dadds et al., 1999). A notable exception is FRIENDS, a 10-session cognitive behavioural intervention based upon the well evaluated Coping Cat programme that was developed for children with established anxiety disorders (Kendall, 1994; Kendall et al., 1997). The initial study involving 489 children aged 10–12 demonstrated significant post intervention reductions in anxiety following FRIENDS (Barrett & Turner, 2001). These results were replicated in a subsequent study involving 594 children aged 10–13 and were maintained at 12 months (Lowry-Webster, Barrett, & Dadds, 2001; Lowry-Webster, Barrett, & Lock, 2003). In addition, FRIENDS was found to have a positive effect upon levels of depression in children who also had high levels of anxiety. In the most recent study, 692 children were either allocated to FRIENDS or a monitoring group and were followed up for three years (Barrett, Lock, & Farrell, 2005; Barrett et al., 2006). The FRIENDS group demonstrated significantly greater reductions in anxiety and depression. There was also evidence of a preventative effect with significantly fewer children in the FRIENDS group being classified as high risk of an emotional disorder at the 3-year follow-up than in the monitoring condition. In addition, comparison between children aged 9–10 years and those aged 14–16 years showed that, although both age groups benefited from FRIENDS, the younger group demon-

strated the greatest changes in anxiety symptoms. The authors concluded that earlier preventive interventions may potentially be more advantageous than those provided in adolescence (Barrett et al., 2005).

The results from these studies have led the World Health Organisation to cite FRIENDS as the only evidence-based programme effective at all levels of intervention for anxiety in children (WHO, 2004). However, although FRIENDS is effective as a universal preventative emotional health programme, it is not widely used in the UK. The direct application of interventions that work in Australia to British children in the English school system needs to be made with caution. Australian studies have typically involved children in independent rather than state education and it is therefore unclear whether similar benefits would be found within the UK educational setting.

A final issue to consider in providing school-based emotional health prevention programmes is who delivers the intervention. Lowry-Webster et al. (2001) found that trained teachers were as effective as psychologists in delivering FRIENDS. Whilst this is encouraging, Merry et al. (2004) identified difficulties in using teachers to deliver mental health preventative programmes. In particular these focused upon the teachers' level of awareness and understanding of general mental health issues and their knowledge of specific psychological therapeutic models. Limited knowledge may result in potential mental health problems going unrecognised or severe problems not being referred for more specialist treatment. Similarly a failure to understand underpinning therapeutic models may compromise the way materials and information are presented and processed. An alternative model of delivery involves training and supporting professionals who already have a basic understanding of mental health issues and psychological models. In this context, school nurses have considerable awareness and experience of emotional problems and have established links with schools and specialist child mental health services. They have a key role in terms of health promotion and as such are both experienced and ideally placed to deliver standardised evidence based emotional health preventative programmes in schools. School nurses are not, however, routinely involved in delivering structured mental health programmes, and their ability to effectively deliver such programmes has not been determined. This paper addresses this issue by reporting the initial evaluation of FRIENDS provided as a universal programme in UK schools to whole classes of children by trained school nurses.

## Method

### *FRIENDS*

FRIENDS is a manualised 10-session cognitive-behaviour therapy (CBT) programme. FRIENDS utilises behavioural, physiological and cognitive strategies to teach children practical skills to identify their anxious feelings and to learn to relax; to identify unhelpful anxiety increasing thoughts and to replace these with more helpful thoughts; and how to face and overcome their problems and challenges. Each child has an attractive workbook that they complete throughout the 10-session programme (Barrett, Lowry-Webster, &

**Box 1.** Content of the FRIENDS programme

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Session 1: Introduction to FRIENDS
Session 2: Introduction to feelings
Session 3: The relationship between thoughts and feelings
Session 4: Learning to cope with worries – emotional recognition, relaxation and how to feel good
Session 5: Learning to cope with worries – developing positive self-talk
Session 6: Learning to cope with worries – challenging negative/unhelpful thoughts
Session 7: Learning to cope with worries – developing problem solving skills
Session 8: Learning to cope with worries – step plans and praising self for success
Session 9: Learning to cope with worries – role play and practice using the FRIENDS skills
Session 10: Review and party – recap on what learned and identify any potential problems

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Turner, 1999). The format of the programme involves large and small group work, completing exercises in workbooks, role plays, games, activities and quizzes. The content of each session is detailed in Box 1.

At the start of each programme, parents are invited to a psycho-educational session. This provides them with information about the cognitive model underpinning FRIENDS, the programme content and the skills their children will be learning.

The programme was delivered as part of the school day over 10 weekly sessions through the spring school term.

*FRIENDS programme leaders*

School nurses in Bath and North East Somerset were trained to deliver FRIENDS. A two-day training session was provided to familiarise them with the FRIENDS programme and the underlying theoretical model of cognitive-behaviour therapy. The UK FRIENDS trainer provided the first training day and a clinical psychologist with expertise in CBT (PS) provided the second. The training involved a mixture of presentations, role-plays and exercises in which the school nurses worked through each of the FRIENDS sessions. Each nurse received a leader's manual providing a detailed structure for each of the 10 sessions. They attended a monthly supervision group of approximately 1.5 hours. In addition, the school nurses participated in end of FRIENDS programme reviews, where the content of each session and problems encountered in the delivery and understanding of exercises and concepts were discussed.

FRIENDS is provided to whole classes of children, with each programme being led by two trained members of the school nursing team in partnership with members of the teaching staff. The class teacher and any classroom assistants participate in the programme and facilitate small group work.

*Participants*

Children aged 9–10 years from three schools in Bath and North East Somerset participated in the study. One Bath school was selected because of the high rate of emotional and behavioural problems in the year 5 class resulting in the school nurse already providing a considerable input. The second had similar identified

problems but in addition had a catchment area that included the third most deprived ward in Bath and North East Somerset. The final school was from a rural area and was selected in order to represent the mixed city and rural population that constitute Bath and North East Somerset. The children were from four separate classes. Of the 107 eligible children, parental permission was refused for one child resulting in data being obtained for 106 children (60 boys, 46 girls).

*Assessments*

Children were assessed on three separate occasions: six months before (T1), upon starting (T2) and 3 months after (T3) completing FRIENDS. On each occasion the children completed two standardised measures:

1. *Spence Children's Anxiety Scale*. This self-completed 44 item questionnaire assesses anxiety in the different areas of social phobia, separation anxiety, panic attacks and agoraphobia, physical injury fears, obsessive-compulsive disorder and generalised anxiety disorder. The scale has high internal reliability and good concurrent validity (Spence, 1997).
2. *Culture-Free Self-Esteem Questionnaire Form B*. This 30 item self-completed scale provides an overall score of self-esteem, as well as sub-scales assessing general, social, academic, and parental self-esteem. The scale has been extensively used, has good psychometric properties with a total score of 10 or less identifying children with very low self-esteem (Battle, 1992).

All children participated in FRIENDS and none were referred to specialist CAMHS as a result of the initial assessments. Any concerns about individual children and particular problems were discussed and monitored via the monthly supervision group. Finally, no child was excluded from the programme for disruptive or challenging behaviour, and no child was subsequently withdrawn by their carers.

**Results**

Table 1 summarises total and sub-scale scores for children at each point of time

Out of the total cohort ( $n = 106$ ), 89 children were present and completed the assessments at Time 1 and Time 2, with 87 completing the final assessment. In total, 69 children, 65% of the total cohort completed all three assessments. In order to address the issue of missing data, an intention to treat analysis was undertaken. Scores from the last assessment were substituted if the data were not available.

Initial ANOVAs revealed a significant change for total anxiety ( $F = 5.84$ ,  $df = 2,315$ ,  $p = 0.003$ ) and self-esteem ( $F = 2.98$ ,  $df = 2,315$ ,  $p = 0.052$ ) across time. Post-hoc comparisons using Tukey's test revealed no significant change in anxiety or self-esteem over the two pre-intervention assessments (T1 – T2) but a significant change from T1 to post-intervention (T3) for both anxiety ( $p = 0.002$ ) and self-esteem ( $p = 0.040$ ).

In terms of sub-scales, there was no significant difference on any sub-scale across the two pre-FRIENDS assessments (T1 – T2). There were significant differ-

**Table 1.** Comparison of anxiety and self-esteem scores six months before, upon starting, and three months after completing FRIENDS

Measure	Time 1 6 months pre-FRIENDS <i>n</i> = 89 mean ( <i>SD</i> )	Time 2 immediately pre-FRIENDS <i>n</i> = 89 mean ( <i>SD</i> )	Time 3 3 months post-FRIENDS <i>n</i> = 87 mean ( <i>SD</i> )	One way ANOVA significance	Post Hoc Tukey time 1 – 3 significance	Post Hoc Tukey time 2–3 significance
Total self-esteem	17.84 (4.51)	18.99 (4.47)	20.09 (4.48)	<i>p</i> = 0.052	<i>p</i> = 0.040	
General self-esteem	7.02 (2.23)	7.60 (2.17)	7.97 (2.20)			
Social self-esteem	3.02 (1.13)	3.24 (1.68)	3.55 (0.99)	<i>p</i> = 0.050	<i>p</i> = 0.038	
Academic self-esteem	3.48 (1.40)	3.74 (1.29)	4.03 (1.19)			
Parental self-esteem	4.26 (1.20)	4.42 (0.96)	4.52 (0.93)			
Total anxiety	34.06 (16.49)	31.64 (15.95)	25.47 (13.05)	<i>p</i> = 0.003	<i>p</i> = 0.002	
Panic attacks	5.19 (4.29)	4.45 (4.42)	3.66 (3.42)			
Separation anxiety	5.63 (3.76)	5.02 (3.24)	3.86 (2.75)	<i>p</i> = 0.003	<i>p</i> = 0.002	
Injury fears	3.60 (2.94)	3.84 (3.30)	2.84 (2.35)			
Social phobia	6.01 (3.25)	6.01 (3.12)	5.09 (2.81)			
Obsessive compulsive	6.61 (3.43)	6.14 (3.82)	4.18 (3.04)	<i>p</i> = 0.0001	<i>p</i> = 0.0001	<i>p</i> = 0.003
Generalised anxiety	6.94 (3.25)	6.43 (3.05)	5.66 (2.62)	<i>p</i> = 0.029	<i>p</i> = 0.022	

ences in anxiety between T1 and the post-FRIENDS assessment (T3) on separation anxiety, obsessive compulsive behaviour, and that assessing generalised anxiety disorder. Similarly, there was a significant difference on the social self-esteem subscale between T1 and T3.

**High risk group**

The impact of FRIENDS on children with more substantial problems was assessed by examining those children with the highest anxiety or lowest pre-assessment self-esteem scores. The highest scoring 10% of children (*n* = 11) on the anxiety scale had scores in excess of 54 on both pre-FRIENDS assessments. These scores are consistent with children who are clinically anxious (Spence, 1997). Similarly, inspection of the data revealed 8 children who had very low or low self-esteem (12 or less) on both pre-FRIENDS assessments. Three children fell in both groups resulting in the high risk group comprising of 16 separate children. The average scores of the high risk children at each assessment are presented in Table 2.

An intention to treat analysis of variance for the high anxiety group (*n* = 11) found the reduction in anxiety over time was significant (*F* = 5.30, *df* = 2,30, *p* =

0.011). This was particularly noticeable on the subscales assessing separation anxiety (*F* = 6.91, *df* = 2,30, *p* = 0.003) and obsessive compulsions (*F* = 4.17, *df* = 2,30, *p* = 0.025). The reduction in total anxiety scores was significant between T1 – T3 and T2 – T3 but not between the two pre-FRIENDS assessments (T1 – T2).

Similarly, an intention to treat analysis for the low self-esteem group (*n* = 8) found the increase in total self-esteem over time to be significant (*F* = 5.78, *df* = 2,21, *p* = 0.010) and this was evident on the general self-esteem sub-scale (*F* = 3.67, *df* = 2,21, *p* = 0.043). The increase in total self-esteem scores was significant between T1 – T3 and between T2 – T3, and in general self esteem between T1 and T3. As above, there were no significant differences between the two pre-FRIENDS assessments (T1 to T2).

**Discussion**

These preliminary results suggest that a universal school-based mental health programme delivered by non-mental health specialists can have a positive impact upon the emotional health of children. Anxiety and self-esteem were stable in the six months before the

**Table 2.** Comparison of anxiety and self-esteem scores across assessments for the high risk group

Measure	Time 1 6 months pre-FRIENDS mean ( <i>SD</i> )	Time 2 immediately pre-FRIENDS mean ( <i>SD</i> )	Time 3 3 months post-FRIENDS mean ( <i>SD</i> )	One way ANOVA significance	Post Hoc Tukey time 1–3 significance	Post Hoc Tukey time 2–3 significance
Culture free self-esteem	<i>n</i> = 8	<i>n</i> = 8	<i>n</i> = 8			
Total self-esteem	7.88 (3.04)	8.88 (2.95)	14.00 (5.18)	<i>p</i> = 0.010	<i>p</i> = 0.012	<i>p</i> = 0.038
General self-esteem	2.63 (1.06)	3.25 (2.05)	5.38 (2.20)	<i>p</i> = 0.043	<i>p</i> = 0.044	
Social self-esteem	1.50 (1.20)	2.13 (0.99)	2.50 (1.20)			
Academic self-esteem	0.88 (0.84)	0.88 (0.99)	2.13 (1.73)			
Parental self-esteem	2.88 (1.73)	2.63 (1.60)	4.00 (1.41)			
Spence Children’s Anxiety Scale	<i>n</i> = 11	<i>n</i> = 11	<i>n</i> = 11			
Total anxiety	63.55 (10.91)	66.45 (10.04)	47.91 (19.20)	<i>p</i> = 0.011	<i>p</i> = 0.041	<i>p</i> = 0.014
Panic attacks	12.27 (3.98)	13.18 (4.83)	8.18 (5.98)			
Separation anxiety	11.55 (1.86)	10.27 (2.65)	7.36 (3.38)	<i>p</i> = 0.003	<i>p</i> = 0.003	<i>p</i> = 0.044
Injury fears	6.73 (3.66)	8.82 (4.96)	5.27 (3.44)			
Social phobia	9.55 (4.03)	10.09 (4.04)	8.91 (3.27)			
Obsessive compulsive	11.91 (2.43)	12.00 (2.72)	8.73 (3.77)	<i>p</i> = 0.025	<i>p</i> = 0.050	<i>p</i> = 0.043
Generalised anxiety	11.82 (2.79)	11.36 (2.66)	9.45 (3.42)			

intervention but improved when assessed three months after FRIENDS. Anxiety demonstrated the greatest change, and in view of the nature of the programme this was not surprising. FRIENDS is specifically designed to focus upon the key aspects of anxiety such as identifying and modifying unhelpful anxiety-increasing cognitions and learning to control anxious feelings. Given this specific focus, it is encouraging to note the wider benefits upon children's general self-esteem. These results suggest that the process of identifying and challenging unhelpful cognitions may have generalised to other aspects of the children's life resulting in positive improvements in the way they perceive themselves, their academic attainment and relationships with others. Longer-term evaluations are required to determine whether these benefits are maintained and whether they represent genuine changes in general cognitive processes.

This improvement in anxiety and self-esteem was not confined to children with lesser problems. The analysis of those children with the lowest pre-FRIENDS self-esteem or highest anxiety showed significant improvements following FRIENDS. These results are encouraging and suggest that children with significant emotional problems can be helped through universal interventions. The clinical significance of this change and the effects upon the children's everyday functioning are however not known. Further studies with larger cohorts using diagnostic interviews are required to substantiate these findings.

Providing FRIENDS as part of the school curriculum resulted in all but one of the eligible children participating in the programme. Working in schools increases accessibility, whilst delivering FRIENDS to all children, irrespective of risk status, reduces possible stigmatisation about mental health issues. Informal comments from teachers highlighted the development of a supportive culture within the classroom in which worries and feelings were openly and positively discussed. Further studies evaluating the wider social and academic benefits of mental health promotion programmes are required.

Our experience suggests that trained and supervised school nurses are able to effectively deliver standardised emotional health interventions. This is consistent with research in Australia where trained teachers were found to be as effective as psychologists in delivering FRIENDS (Barrett & Turner, 2001). Within the UK context, school nurses are particularly well suited to delivering FRIENDS. They have established links with education, experience of group work and have an understanding of mental health problems. In addition, the school nurse lead signals to the children that FRIENDS is different from other lessons and that there are no right or wrong answers. Significant emotional health concerns can be identified, assessed and referred to appropriate agencies. In addition, the joint health/education partnership ensures that FRIENDS is not overwhelmed by other educational demands and that emotional health remains a central issue within the school.

Training and supporting school nurses to deliver standardised CBT programmes increases the availability of effective emotional health interventions. In addition, such developments are consistent with the stepped care approach suggested in recent guidelines

from the National Institute of Clinical Excellence (NICE) and the National Service Framework (NSF) care pathways policy direction. However, the limitations of the nurses' expertise and skills in CBT are clear. They are delivering a standardised CBT-based group intervention rather than functioning as specialist CBT therapists, and as such their role requires a more limited level of CBT expertise and training. To deliver FRIENDS, they need to be familiar with the basic CBT model, understand how each session relates to the model and be able to adapt the specified tasks to the child's experiences and interests. CBT therapists function at a higher level and require a more in depth understanding of cognitive models for a broader range of disorders. These models provide the framework that is used for assembling the child's experiences and cognitions within a cognitive formulation. The formulation subsequently informs the content of the intervention, with the therapist using a wide range of therapeutic techniques and processes that are individually selected and adapted to the child's age and developmental level.

This was a pragmatic evaluation and as such the conclusions of this study are limited by the small sample, limited follow-up period and the single cohort design. In addition, complete data for all three assessments were obtained for only 65% of the sample. Although an attempt was made to control for possible respondent bias through the intention to treat analysis the actual psychological functioning of the remaining third is unknown. Similarly, whilst the results highlight improvements in the emotional health of the children, it is not possible to determine whether FRIENDS has prevented emotional health problems from developing. The positive change could simply be due to the passage of time and would occur irrespective of the intervention. In order to be able to attribute this positive change to FRIENDS, a more robust design is required involving random allocation and a non-intervention control group. Nonetheless, these results are encouraging and are consistent with those obtained in the Australian trials. Larger scale randomised trials are required to determine the longer-term durability of FRIENDS as a universal school-based emotional health programme, and the effects upon usage of specialist mental health services.

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