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Mental health prevention in UK classrooms: the FRIENDS anxiety prevention programme

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Childhood anxiety is a common condition which, if untreated, can cause considerable distress and impairment and increase the likelihood of mental health problems in adulthood. Developing good emotional health in children is therefore an important objective which has been emphasised in recent governmental initiatives and policies. In particular, schools have been identified as having an important role in promoting positive mental health in children. This paper summarises the different approaches, outcomes and shortfalls of school-based anxiety prevention programmes. One particularly encouraging programme based upon cognitive behaviour therapy, the FRIENDS for Life programme, is described. Outcomes from UK-based studies evaluating FRIENDS are summarised and the way the programme can be integrated within schools to complement other initiatives discussed. Finally, limitations of the current research are discussed and issues about the practical implementation of FRIENDS in schools highlighted.

Keywords: anxiety; prevention; the FRIENDS programme

Introduction

Anxiety in children and young people is common, with concerns and worries being a normal part of everyday life (Muris et al. 1998). The specific nature of these worries varies during childhood and is shaped by sequential developmental challenges in cognitive, behavioural and social processes (Weems and Stickle 2005). With young infants, anxiety is typically related to sudden loud noises, unexpected events and unfamiliar people. Around the age of six, worries about the loss or separation from parents and specific fears such as those of animals and the dark are evident, whilst worries about personal injury, death, danger and natural disasters commonly emerge between the ages of 10 and 13 years. By adolescence the nature of worry is based more upon social comparisons, with anxiety about failure, criticism and physical appearance being common (Warren and Sroufe 2004).

Whilst worries during childhood are normal they become problematic when they become persistent, frequent or severe and interfere with or limit the child's everyday life and functioning. This is typically manifested through anxiety, a complex interaction involving cognitive, physiological and behavioural responses (Weems and Stickle 2005). The cognitive response involves appraising situations and events for anticipated risk; the

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physiological response prepares the body for any necessary action (e.g., flight or fight) whilst the behavioural response helps to keep the child safe by anticipating and avoiding future danger. The physiological response results in a number of symptoms which are often distressing for the child and include a racing heart, shortness of breath, butterflies in the stomach, feeling hot, sweating and dizziness.

Anxiety may become so severe that it significantly interferes with the child's ability to undertake everyday activities. This indicates the possible presence of an anxiety disorder, a mental health problem which may require treatment from specialist Child and Adolescent Mental Health Services (CAMHS). In terms of prevalence, community surveys suggest that by the age of 18, 1 in 10 children will have suffered from an anxiety disorder (Costelleo et al. 2003). In addition, many more children experience severe anxiety symptoms which fall below (i.e. sub-threshold) criteria required for a formal diagnosis but are nonetheless significant. For example, in the Great Smoky Mountains Study in the USA, Costello and others (1996) found that 20% of children suffered with severe emotional problems – a similar rate to that found by Essau and associates in Germany (2000).

The effects of anxiety are significant and can impede everyday functioning, impact on developmental trajectories and interfere with educational attainment, the development of friendships and family relationships. In terms of education, the UK mental health survey found that children with emotional disorders (e.g., anxiety and depressive disorders) were three times more likely to have a specific literacy problem than those who had no mental health disorder. Similarly, in terms of attendance, approximately half of those with an emotional disorder had missed some school days the previous term, compared with one-third of those without an emotional disorder. Prolonged absence was strongly associated with emotional disorders with 17% of this group, compared with 4% who were disorder-free being absent for 16 days or more (Green et al. 2005).

In addition to the immediate effects, anxiety disorders can persist, and if left untreated increase the likelihood of problems in adulthood. Pine and colleagues (1998) found that anxiety disorders during adolescence led to a two- to threefold increase in the risk of an anxiety disorder in young adulthood. In a longitudinal study in New Zealand, Woodward and Fergusson (2001) found that anxiety in adolescence was strongly associated with anxiety, depression, illicit drug dependence and educational underachievement in young adulthood. Similarly, Kim-Cohen and others (2003) found that 80% of young adults aged 21 with a diagnosed anxiety disorder had received a prior diagnosis before the age of 18.

In summary, anxiety disorders in children are common, can persist, interfere with educational performance and increase the likelihood of mental health problems in later life. Intervening with these children is therefore an important objective, although studies highlight that comparatively few children receive any form of intervention from specialist CAMHS. The UK mental health survey for example found that, over an 18-month period, only 18% had any contact with specialist CAMHS and half had no contact with any service at all (Ford et al. 2003).

Preventive approaches

There has been recent interest in developing more comprehensive approaches to improving the mental health of children and young people. This recognises the need to both provide specialist treatment for those with mental health disorders whilst emphasising the importance of improving and sustaining psychological wellbeing within the general population, through health prevention and promotion. This has been supported by governmental policy which has highlighted the important contributions that can be made by all those

who have contact with children in terms of emotional health prevention and early intervention (Department of Health 2004; Department for Education and Skills 2005).

This more comprehensive approach considers different levels of prevention, which have been conceptualised by Mrazek and Haggerty (1994) as primary, secondary and tertiary. Primary prevention is concerned with promoting wellbeing and in reducing the occurrence of new problems developing. Secondary prevention aims to stop mild or moderate problems from worsening by providing early interventions. Finally tertiary prevention aims to minimise the negative consequences of established disorders through the provision of effective interventions.

Prevention programmes have also been classified as universal, selective or indicated, depending upon the way the target populations are selected (Durlak and Wells 1997). In universal approaches, all members of the target population (e.g., whole schools) receive the intervention, regardless of risk status or presence of symptoms. The second approach is selective, where interventions are targeted upon children who are not yet displaying significant problems but who are at increased risk of developing disorders (e.g., children of a certain age, attending special schools). The final method is an indicated or early intervention approach, where interventions are provided for children already displaying mild to moderate problems, in order to prevent more severe disorders developing.

This framework can help to clarify the different contributions that are required for the development of comprehensive child mental health services and is summarised in Figure 1.

Tertiary prevention is usually conceptualised as treatment and is typically provided through Tier 3 and 4 specialist CAMHS. Tier 4 services are highly specialist assessment and treatment services, with many being regional or in-patient based, focused upon those with complex, severe and enduring mental illness. Tier 3 services are delivered by specialist multidisciplinary teams providing a mix of therapeutic approaches and interventions to assess and treat children with a range of mental health disorders. Secondary prevention, and the focus upon early intervention with mild and moderate problems, is currently being promoted through more community-based services. These are often referred to as Tier 2 CAMHS and include initiatives focused upon primary care staff (e.g., the development of

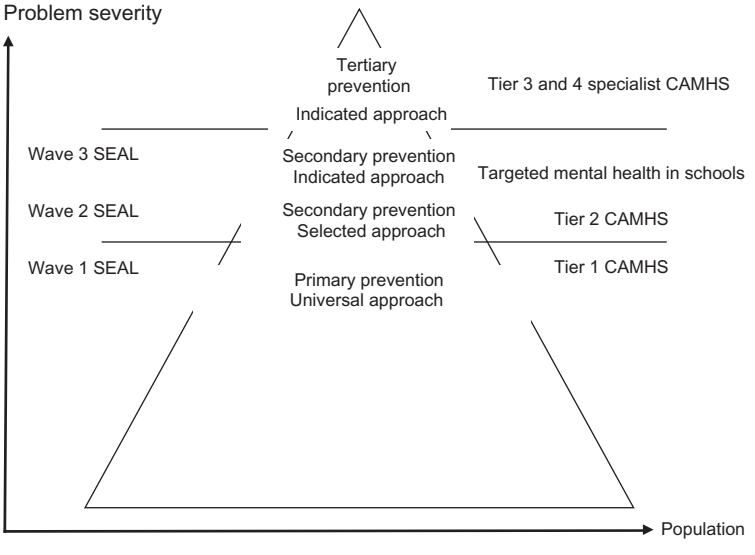

Figure 1. Prevention, SEAL and mental health provision.

primary mental health workers) (Gale and Vostanis 2003), and those working within educational settings through the Targeted Mental Health in Schools (TaMHS) initiative (Department for Children, Schools and Families 2008). These have resulted in greater availability and accessibility of mental health input and, in particular, the provision of more training, consultation and psychological advice to school-based staff. Finally, primary prevention and the focus upon emotional awareness and the promotion of wellbeing is the province of Tier 1 CAMHS and is provided through all those who have contact with children and young people. In this respect schools have an important role.

Each of the different preventive approaches offers benefits but also has limitations. Universal and selective approaches offer the potential for both immediate symptom reduction and longer term prevention, by increasing children's competencies to deal with future problems. Universal approaches have the benefits of being delivered in accessible community settings (e.g., schools) and are therefore non-stigmatising and reach large numbers of children. However, the majority of those children receiving such approaches do not, and will not, require such interventions. This raises a resource issue as to whether universal prevention is the best use of limited resources. Similarly, universal preventive programmes tend to result in more modest treatment effect sizes than indicated approaches. With indicated approaches the target group is selected on the basis of risk status. Initial levels of symptoms and subsequent reductions are therefore higher, with the resulting changes in symptoms tending to demonstrate higher levels of statistical significance. In universal interventions, initial levels of symptoms are lower and so subsequent reductions may be more modest. However in view of the greater reach of universal approaches the wider public health impact of such approaches can be significant (Rose 1992).

In terms of school-based prevention, two recent systematic reviews have explored the effectiveness of universal (Adi et al. 2007) and targeted/indicated approaches (Shucksmith et al. 2007). Both reviews found evidence to suggest that school-based universal and targeted/indicated preventive approaches can have a positive effect upon emotional wellbeing. In terms of anxiety disorders, Shuckersmith and others (2007) found evidence that preventive interventions based upon cognitive behaviour therapy (CBT) were effective. However, the reviews also noted a number of significant limitations that limit the strength of the conclusions that can be drawn. There are, for example, comparatively few well controlled studies; sample sizes in some are small; little research has been undertaken in the UK; studies use a range of outcome measures that limit comparisons between programmes; the comparative effectiveness of teacher versus mental health delivered interventions is unclear; the content and length of programmes varies; mediating variables that effect outcome and factors that affect sustainability and long-term outcomes have not been systematically evaluated. Whilst universal, selective and indicated approaches show promise, further robust research is required to determine the effectiveness of school-based prevention programmes delivered under everyday conditions in the UK.

Emotional health in schools

Increased recognition of the importance of developing positive emotional health in children has been a central tenet of recent governmental policy. The National Service Framework for children, a 10-year plan to modernise and improve health services, emphasises the need to provide comprehensive mental health services including mental health promotion and early intervention (Department of Health 2004). *Every child matters* identifies 'be healthy' as one of the five core outcomes and specifically highlights mental health

and the need for preventive approaches (HM Government 2004). Similarly, the Department of Education and Skills has heralded a major initiative, the Social and Emotional Aspects of Learning (SEAL), to promote the emotional health skills thought to underpin effective learning and positive behaviour (Department for Education and Skills 2005).

SEAL provides a comprehensive whole-school approach that is delivered through interventions at three levels. The first, a universal primary preventive approach, involves creating an emotionally aware school where the importance of social and emotional skills is recognised and supported. A range of resources are available to develop skills to promote self-awareness, manage feelings, increase motivation and to develop empathy and social skills. The materials help children develop skills such as understanding another's point of view, working in a group, sticking at things when they get difficult, resolving conflict and managing worries. They build upon work already in place in many primary schools and initiatives such as circle time and buddy schemes. Adoption of wave one SEAL has been far-reaching, with 80% of primary schools in England adopting the SEAL curriculum (Humphrey et al. 2008).

The second level SEAL, a selective secondary preventive approach, is targeted at particular classes or groups of children who are thought to require additional support to develop their social and emotional skills. A number of interventions designed to promote specific skills are available, and a recent evaluation of four of these has provided evidence of beneficial effects (Humphrey et al. 2008). The evaluation found a positive impact on at least one assessment measure for each of the interventions assessed. However the results are complex and, in terms of mental health, the post-intervention effects appear limited. Although anxiety was not specifically assessed, mental health was investigated through the use of the Strength and Difficulties Questionnaire (SDQ), a widely used child mental health screening questionnaire. Parent and teacher ratings showed little evidence of any significant post-intervention change in child mental health and none of the interventions had any effect upon the emotional sub-scale (i.e., anxiety and depression) of the SDQ (Humphrey et al. 2008). Thus whilst SEAL appears to have a small impact upon general emotional wellbeing, the specific impact upon mental health, and in particular upon anxiety, has not been demonstrated.

The third wave of SEAL, an indicated secondary preventive approach, involves one-to-one interventions with children who have not sufficiently benefited from the previous approaches. This is being delivered and evaluated through the Targeted Mental Health in Schools (TaMHS) initiative, which is predicated upon two key objectives. The first is concerned with facilitating integration where different agencies and services are encouraged to strategically and operationally work together to deliver flexible and responsive early intervention services. The second is concerned with developing evidence-based practice and in ensuring that interventions that have been rigorously evaluated and shown to be effective are implemented. In terms of anxiety, the TaMHS evidence review indicates that cognitive behavioural approaches have the strongest evidence for both prevention/early intervention and treatment (DCSF 2008). This conclusion is also reflected in the systematic review of targeted/indicated school prevention programmes undertaken by Shuckersmith and others (2007).

Cognitive behaviour therapy

CBT is a structured form of psychotherapy that focuses upon the relationship between thoughts, feelings and behaviour. The underpinning theoretical model suggests that

dysfunctional or distorted cognitions generate significant negative emotional states (e.g., anxiety), which are regulated, often unhelpfully, through behaviour (e.g., avoidance). Thus, whilst avoidance of feared or worrying situations may bring short-term relief, it prevents the child learning the necessary skills to cope with such situations. Empirical research supports the CBT model and suggests that children with anxiety disorders do exhibit dysfunctional cognitions and processes. In particular, they have more expectations that negative events will occur, make more negative evaluations about their performance, are biased towards possible threat-related cues and perceive themselves as being unable to cope with frightening events that arise (Stallard 2009).

Cognitive behaviour therapy programmes tend to involve a number of core elements. Firstly, most involve some form of psycho-education where children and their parents are educated into the CBT model and learn about the relationship between thoughts, feelings and behaviour. Secondly, most include emotional recognition and management training. This helps children become aware of their own unique anxiety response and to identify helpful ways in which their anxiety response can be managed. The third element helps children to recognise their cognitions (i.e., self-talk) in anxiety-evoking situations and some of the biased and distorted processes that have been found to be associated with anxiety disorders. Once identified, the fourth element involves children learning to challenge and replace their anxiety-increasing self-talk with positive coping and anxiety reducing self-talk. Fifthly, there is an emphasis upon practice and exposure, both imaginial and *in vivo*, during which children apply and practise their new cognitive and emotional skills. The sixth core element involves the development of self-monitoring and self-reinforcement techniques in order to acknowledge and celebrate positive attempts at facing and overcoming worries. Finally, interventions include a focus upon relapse prevention and preparing for future challenges and setbacks.

Randomised controlled trials evaluating the effectiveness of CBT for the treatment of children with anxiety disorders have consistently found positive results (Kendall 1994; Barrett et al. 1996; Kendall et al. 1997; Barrett et al. 2001; Nauta et al. 2003). This has led some to suggest that CBT is the treatment of choice for childhood anxiety disorders (Cartwright-Hatton et al. 2004; Compton et al. 2004). Whilst CBT does undoubtedly have the strongest evidence base, two recent reviews have highlighted a number of limitations (Cartwright-Hatton et al. 2004; Soler and Weatherall 2007). Few studies have, for example, compared CBT with other active interventions; little research has focused upon children under the age of seven years, and long-term follow-ups are lacking. In terms of overall effectiveness, in their Cochrane review, Soler and Weatherall (2007) found that just over half of children with anxiety disorders responded positively to CBT. Whilst this appears promising it should be noted that there was a natural recovery rate of just over one-quarter in those children on waiting lists for treatment. Similarly, important questions have been raised about the content of CBT programmes with children and whether a direct focus upon cognitions is required to bring about reductions in anxiety (Alfano et al. 2002).

CBT for anxiety prevention

Whilst CBT has shown promise in the treatment of anxiety disorders, the results of these small, carefully controlled clinic-based studies cannot necessarily be expected to be applicable to prevention programmes undertaken in schools. However, a recent systematic review evaluating the effectiveness of school-based prevention and early intervention programmes targeted upon anxiety has concluded that such interventions are effective (Neil and Christensen 2009). Twenty-seven randomised controlled treatment trials describing

20 different programmes were identified, with the majority (21) being based upon CBT. The results indicate that most universal, selective and indicated prevention programmes were effective in reducing anxiety symptoms. Although not formally tested, the authors note that the effects of CBT programmes were marginally larger than non-CBT interventions, with the median effect size for CBT programmes of 0.57, indicating a moderate effect. However, there was considerable variation in effect size between studies, suggesting the importance of variables other than the specific content of the programme. These are similar to those identified in the review by Adi and colleagues (2007), and include factors such as adherence to programme fidelity, leader rapport, relevant content, levels of participation and audience appeal (Neil and Christensen 2009).

The FRIENDS CBT anxiety prevention programme

Of the programmes identified in the review by Neil and Christensen (2009), the FRIENDS programme was one of the better evaluated. This was also noted by the World Health Organisation, who identified FRIENDS as having strong evidence of being effective as a school-based intervention for anxiety (2004).

FRIENDS, and the recent revision, FRIENDS for Life, is a 10-session programme during which the key cognitions and behaviours associated with anxiety are targeted and directly addressed. In terms of cognitions, FRIENDS for Life helps children to become aware of their anxiety-increasing cognitions and to replace these with more helpful and balanced cognitions. Through this process children are helped to become aware of the tendency for anxious children to attend to threat-related stimuli and perceive themselves as less able to cope with situations. Instead they are helped to replace these with more positive and functional cognitions. Friends for Life helps children to understand the anxiety response and their unique physiological reaction to stressful situations. They are taught a range of anxiety management techniques which provide an emotional toolbox to help them effectively manage their emotions. The final focus of the programme targets the tendency for anxious children to avoid stressful or difficult situations. Instead children are taught problem-solving skills and the use of graded exposure to systematically face and overcome their worries. This occurs within a positive group context where children learn to acknowledge and accept personal differences and to support and help each other cope with their worries.

FRIENDS is an acronym which is used to remind children of the different steps they need to take to manage their anxiety and to cope with problems and worries. The ‘F’ reminds the child to be aware of his or her anxious feelings. Once recognised, ‘R’ takes the child to the second step in which s/he manages his or her anxiety through relaxation. The child is then prompted by the letter ‘I’ to check his or her cognitions and to replace any negative or unhelpful cognitions with more positive thoughts. The ‘E’ progresses the child to the problem-solving stage, where s/he is encouraged to explore possible ways of coping, with the ‘N’ reminding them to reward their attempts to cope. Continued use and development of skills is prompted through the letter ‘D’, with the ‘S’ reminding the child that they can be successful by applying these skills to all aspects of their life.

There are versions of FRIENDS for Life for children aged 7–11 years and youth aged 12–16 years. The format of the sessions varies and involves large and small group work, completing exercises in workbooks, role plays, games, activities and quizzes.

The sessions build upon each other so that by the end of the programme the child has developed a range of emotional, cognitive and problem-solving skills. There is overlap between the different sessions but the main focus of each session and the overall structure of the programme is summarised in Figure 2.

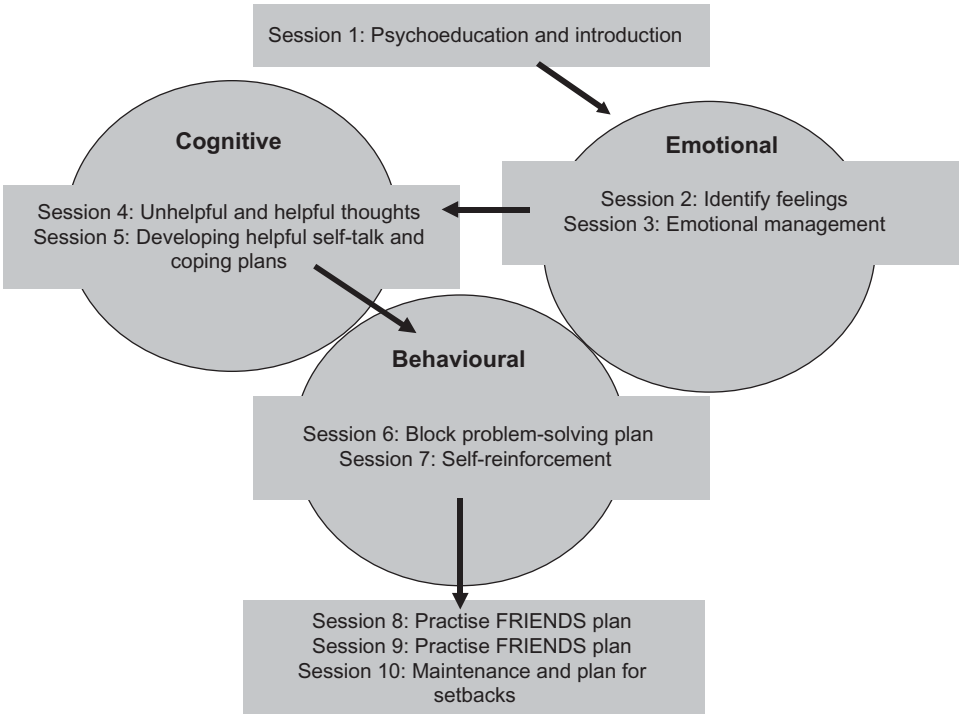

Figure 2. FRIENDS for Life: programme structure and core session themes.

There are also two to four psychoeducational sessions for parents in which they are helped to understand anxiety, to develop strategies to cope with their own anxiety and to improve their child management and problem-solving skills. In particular, parents are taught the principles of contingency management and reinforcement, in which the child's courageous and coping behaviour is rewarded, rather than their anxious talk and problem avoidance.

Is FRIENDS in schools effective in reducing anxiety?

A series of randomised controlled trials have now been reported evaluating the effectiveness of FRIENDS provided to whole classes of children. The initial study involving 489 children aged 10–12 years demonstrated significant post-intervention reductions in anxiety (Barrett and Turner 2001). These findings were replicated in a subsequent study involving 594 children aged 10–13 years, where the gains were found to be maintained at a 12-month follow-up (Lowry-Webster et al. 2001, 2003). More recently, 692 children receiving FRIENDS showed significant reductions in anxiety which were evident three years after FRIENDS (Barrett et al. 2006).

The FRIENDS programme developers have also explored important questions in terms of programme delivery. In terms of the best age range to target, a 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 demonstrated the greatest changes in anxiety symptoms (Barrett et al. 2005). Similarly, the question of whether FRIENDS is effective if delivered by trained teachers or psychologists was explored, and both were found to be equally effective (Barrett and Turner 2001).

Is FRIENDS effective in UK schools?

Much of the research evaluating FRIENDS has been undertaken by the developers in Australia. The direct application of interventions that work in Australia to children in the UK 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. Similarly, interventions are often delivered under very controlled conditions with high levels of training and supervision. This degree of support might be difficult to provide or sustain in an everyday school context and so pragmatic UK trials are required. Unfortunately no randomised controlled trials of FRIENDS have yet been undertaken in the UK, although a few small-scale evaluations have been reported.

The use of FRIENDS as a selective secondary approach provided to whole classes of children has been reported in two studies. Stallard and others (2005) reported a pre and post evaluation of 197 10-year-old children from six different classes participating in FRIENDS. The intervention was led by trained and supervised school nurses in collaboration with the class teacher. Significant post-FRIENDS reductions in levels of anxiety and improvements in self-esteem were obtained on standardised self-report measures. An analysis of 'high-risk' children – that is, those with the highest anxiety and/or lowest self-esteem at the start of the programme – showed that 60% had significantly improved by the end of FRIENDS and no longer fell within the high-risk category.

In a subsequent study, 106 children from four classes in three separate schools were assessed four times over 24 months. Scores on measures of anxiety and self-esteem assessed six months before and just before starting FRIENDS were stable. However, when assessed three months after FRIENDS, there was a statistically significant reduction in anxiety and increases in self-esteem (Stallard et al. 2007). These children were followed up and re-assessed 12 months after the end of the programme. A total of 63 children were successfully re-assessed, 59% of the original sample. The post-treatment gains in terms of reduced anxiety and improved self-esteem were maintained for both the whole group and the 'high-risk' group. There was also some evidence of a preventive effective. A total of nine children achieved pre-FRIENDS scores that resulted in them being classified as 'high risk'. This compared with three at the 12-month follow-up and, of these, all were identified as 'high risk' at baseline. None of the children initially classified as low risk at the pre-FRIENDS assessment went on to develop problems and move into the 'high-risk' group at the 12-month follow-up (Stallard et al. 2008).

Whilst these results are encouraging, both studies are small and neither involved a comparison group. As such it is not possible to determine whether the reported improvements were due to maturation, the passage of time or directly attributable to the programme. Similarly, the assessments relied upon self-report from the children and the evaluation would be enhanced by using reports from a range of assessors, particularly teachers and parents. Finally, perhaps the greatest test of emotional health preventative programmes such as these is their impact upon referrals to specialist mental health services. At present little is known regarding whether FRIENDS has reduced the incidence of emotional problems in the general population and reduced the demand upon over-stretched specialist mental health services.

The use of FRIENDS as an indicated secondary intervention in Scotland has recently been reported (Liddle and MacMillan 2008). In this study, children with possible low mood, anxiety or low self-esteem were nominated by their class teacher. A total of 39 children attending two junior schools and 19 attending two secondary schools participated in

FRIENDS delivered by educational psychologists. There were no significant changes in levels of anxiety, mood or self-esteem during a four-month waiting-list period. However there were significant post-FRIENDS improvements in anxiety, depression and self-esteem, which were maintained at four-month follow-up. Once again this is encouraging, although the sample size is very small. Similarly, programme integrity can be more easily ensured within a small group, although how this could be sustained on a large scale needs further consideration.

In terms of children's views, FRIENDS is evaluated positively. Results from 1413 children who have taken part in FRIENDS demonstrate that 81% thought it was fun; 67% had learned new skills; and 69% would recommend it to a friend (Stallard et al. forthcoming). Similar high levels of satisfaction were found by Liddle and MacMillan (2008), where 89% had learned new skills and 68% would recommend it to a friend.

Discussion

There is growing recognition of the important contribution that schools can make to the psychological wellbeing and emotional health of children. Although the available evidence for the effectiveness of school-based universal, selective and indicated preventive approaches suffers from a number of inadequacies, the results are promising. This is reflected in the recent evaluation of second-stage SEAL, where some positive, albeit limited, post-intervention changes in social and emotional skills were identified (Humphrey et al. 2008). However, in addition to promoting general emotional health, school-based prevention programmes could be more clearly focused upon common mental health problems such as anxiety. Although anxiety was not specifically assessed during the evaluation of second-stage SEAL, the results do not indicate a significant impact upon mental health. As assessed by the Strengths and Difficulties Questionnaire, changes were marginal and there was no change on the emotional sub-scale which is related to anxiety and low mood. This may reflect the insensitivity of the SDQ to detect important changes in anxiety symptoms, although it may also indicate that more focused programmes tailored specifically to address the common features of mental health disorders such as anxiety, may be required. Indeed, evaluations of school-based anxiety prevention programmes, particularly those based upon CBT, have yielded positive results and demonstrated significant post-intervention reductions in anxiety, whether delivered as universal, selective or indicated approaches (Neil and Christensen 2009). Similarly, school-based CBT anxiety programmes have also demonstrated other improvements in both specific mental health problems such as depression (Liddle and MacMillan 2008) and in general emotional wellbeing such as improved self-esteem (Stallard et al. 2007) and socially through widening friendship groupings (Stallard et al. forthcoming). However, research is very limited and comparisons of focused anxiety programmes such as FRIENDS with other SEAL interventions would help to clarify their specific effects upon mental health problems.

Mental health preventive interventions in schools can fit comfortably alongside other emotional health initiatives such as SEAL. It is important that schools develop an environment and culture where emotional health is acknowledged as important and is supported. This is the key objective of Stage 1 SEAL and provides the necessary underpinning required for children to feel safe discussing emotional problems and worries. Once this is achieved, more intensive interventions can be provided through second- and third-wave SEAL to develop general emotional and social skills or through programmes focused specifically upon mental health problems such as anxiety or depression. For example, these

could be provided as selective interventions to particular year groups coping with stress (e.g., wave 2 SEAL) or as indicated interventions for individual or small groups of children displaying moderate anxiety problems (e.g., wave 3 SEAL).

Limited research in the UK has shown that school nurses (Stallard et al. 2005) and educational psychologists (Liddle and MacMillan 2008) are effective in delivering FRIENDS. Research from Australia has shown that teachers are also effective (Barrett and Turner 2001), a conclusion endorsed in the recent systematic review (Neil and Christensen 2009). However, effective delivery will be influenced by a range of variables including leader commitment and confidence in talking about mental health issues. Our experience to date suggests that FRIENDS as a joint health and education initiative offers a number of advantages. Firstly, the health input, which is external to the school, helps to differentiate FRIENDS from other lessons and to give it a clear identity. There is therefore less emphasis upon spelling and writing, with the clear emotional health focus encouraging children to discuss worries and concerns from all aspects of their life. However, there are many issues about classroom management, discipline and student knowledge that are essential pre-requisites for delivery and this is information and expertise that teachers bring to the partnership. Similarly, teachers may not feel comfortable or skilled in discussing some of the mental health issues that might emerge. Input from a health professional with a greater awareness of mental health issues ensures that difficult issues can be raised, discussed and, if necessary, facilitate a referral for more specialist input. Finally, the joint health/education partnership ensures that FRIENDS is not overwhelmed by other competing demands within the school that might result in sessions being postponed or omitted.

A further issue is the level of knowledge required by leaders to deliver a mental health intervention based upon a clear therapeutic approach such as CBT. It is important to emphasise that at a class level, CBT programmes like FRIENDS are concerned with developing skills and in understanding the key elements of the CBT framework. This framework can then be applied to address and cope with future problems and challenges that the students may encounter. This is different to using CBT for therapy, where personal problems and worries are discussed in depth. A detailed understanding of their onset and maintenance is obtained, which is then conceptualised and treated within a CBT framework. Class leaders are not CBT therapists. They are delivering a standardised intervention with a structured set of materials that are based upon a particular model. The training and expertise to deliver standardised prevention programmes such as these is more limited and requires familiarity with the basic CBT model, understanding how each session relates to the model and an ability to adapt the specified tasks to the child's experiences and interests. CBT therapists function at a higher level of competence and require a more in-depth understanding of cognitive models for a broader range of disorders.

In summary, the emphasis upon emotional health prevention and the focus upon the important contributions that can be made by schools provides opportunities to benefit large numbers of children. However, more specific evidence-based mental health programmes might be required to have a significant effect upon common child mental health problems like anxiety. These fit within the current framework by building upon first-wave SEAL initiatives, complementing second-wave selective SEAL programmes and providing structured mental health programmes that can be provided in schools as indicated third-wave interventions. Robust research is required to determine the effectiveness of preventative mental health programmes in everyday school environments and the best way to deliver and ensure their sustainability.

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