**RCN Foundation Project Grant**

# Nursing-led Interventions to support the psychological and emotional wellbeing of children and young people: A scoping review

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# Part 1: Introduction

This scoping review was requested and funded by the RCN Foundation Charity. Following a competitive tendering process, a team from Sheffield Hallam University was appointed to undertake the review.

## 1.1 Review context

The National Wellbeing Survey in 2018 reported higher levels of mental ill health and loneliness in 16 to 24 year olds than any other age group (ONS, 2018). However, little detail is provided and under 16-year olds were not included. The most recent British surveys carried out by the Office for National Statistics of children and young people aged 5–15 years in 1999 and 2004 (the British Child and Adolescent Mental Health Surveys or B-CAMHS) found that 10% had a clinically diagnosable mental disorder (ONS, 1999 and Green et al,2005). In these two surveys the prevalence of anxiety disorders was 2–3%, depression 0.9%, conduct disorder 4.5–5%, hyperkinetic disorder (severe ADHD) 1.5%, and autism spectrum disorders 0.9%. Rarer disorders including selective mutism, eating disorders and tics disorders occurred in 0.4% of children.

Self-harm in young people was also found to be highly prevalent. In the 2004 B-CAMHS survey, the rate of self-harm in 5–10 year olds without a psychiatric diagnosis was 0.8%, rising to 6.2% in those with an anxiety disorder and 7.5% among the group of children with hyperkinetic disorder, conduct disorder or one of the less common disorders. Suicide is the leading cause of death in young people.

The suicide rate among 10–19 year olds is 2.2 per 100,000. This rate is higher in males (3.14 compared with 1.30 for females) and in older adolescents (4.04 among 15–19 year olds compared with 0.34 among 10–14 year olds) (Windfuhr et al, 2013).

There were 392,502 referrals to mental health services across the UK during September 2018 for people aged under 19 years, of which 48,043 were new referrals. There were however, 39,453 discharges during the same month and, of the 1,209,715 people in contact with mental health services at the end of September, 286,221 (23.7%) were aged under 19 years. Overall, the number seeking help for conditions such as anxiety, depression and eating disorders is rising sharply.

Almost 50,000 children and young people a month are being referred in the UK, mainly by their GP, for mental health treatment (NHS Digital, 2018). Between 1 July and 30 September 2018, there were 2,545 new referrals for young people aged under 19 years with eating disorder issues alone.

NHS England reports that only 25% of people under 18 with a diagnosable mental health problem receive treatment, with the others deemed to fall below the service's referral criteria after undergoing triage (Department of Health & Social Care, NHS England and Health Education England, 2018). It plans to increase that to 35% of all those needing help by 2020-21. Psychiatrists specialising in children's and young people's mental health welcomed the

growing number of referrals as a sign that more were being treated, but cautioned that the NHS mental health workforce was too small to treat all those seeking help.

In light of this burgeoning problem, the RCN Foundation developed a call for a scoping review project to identify the available evidence on nurse-led interventions that support the mental health and emotional wellbeing of children and young people. They particularly wanted to focus on 'pre-crisis' and 'early' interventions. The results of the scoping review would be used to guide their grant-giving programme for the subsequent three years.

## 1.2 The RCN Foundation's tender criteria

The scoping research should look at all areas of nursing that play a key role in promoting mental health and emotional wellbeing in children and young people. This includes, but is not limited to, health visitors, practice nurses, school nurses, looked after children's nurses and children and young people's mental health nurses. Interventions should cover all ages from 0 to18. The scoping research will identify initiatives and possible gaps in service provision and will address the following:

1) With regards to nursing-led pre-crisis and early interventions that address the mental health and emotional wellbeing needs of children and young people: Where in the UK is this taking place? In which settings? What is the focus? What are the outcomes and impact?
2) What experience, skills and knowledge are required to deliver these interventions?
3) How can nurses from all settings and fields deliver these services? Including but not restricted to children's nurse specialists in areas such as diabetes, epilepsy and asthma, practice nurses and school nurses.

## 1.3 Agreed aims and objectives

This review's agreed aim is therefore to combine the current literature with expert opinion on the nurse-led psychological interventions for children and young people's wellbeing across the UK that are (or are perceived as) effective to inform the funding of future RCN research projects. The objectives are to:

- Undertake a scoping review of the literature to identify the current evidence-base surrounding nurse-led interventions, examples of excellence in practice and gaps in provision.
- Use the results of the literature review to inform a two-round, online/email modified Delphi survey of practitioners in CYPMH to elicit views on effective psychological interventions and any additional nursing-led mental health interventions that they feel have merit.
- Analyse and synthesise the findings from the literature review and the primary investigation to affirm, refute and prioritise the evidence-base.
- Produce a report which describes and illustrates current best practice from interventional and workforce perspectives and makes recommendations for practice.

## 1.4 Legal and scientific justification for the project

The University undertakes research as part of its function for the community under its legal status. This scoping review sets out to deliberately explore, qualify and evaluate the use of psychological therapies in children and young person's mental health (CYPMH) by nurses. The Health Research Authority's (HRA) on-line assessment tool indicated this project was an evaluation research study. On this basis, full ethical approval was gained from: Sheffield Hallam University's ethics committee, the HRA and its partner NHS organisations in Scotland and Wales. It was subsequently reviewed and included on the National Institute for Health research's (NIHR) portfolio.

## 1.5 Overarching project design

Quantitative evaluations by definition, deal with numbers (Cormack 2000). There is an emphasis on systematic and controlled procedures for acquiring dependable, empirical information (Polit and Hungler 1995). Qualitative methods are primarily associated with the thoughts, behaviour, experiences and feelings of people within their natural environment (Holloway and Wheeler 2002). The participants' views and interpretations are the focus, normally utilising interviews and observations as a basis for the measurement tool (Burns and Grove, 2001).

The methodological approach for this review is, however, one of a mixed methodology. Whilst in its infancy, Parahoo (1997, p65) viewed mixed methodologies as a modern approach where ‘different aspects of the same phenomena can be either studied by one or the other approach’. Mixed methods have subsequently become 'mainstream', with the triangulation of statistical and qualitative data being routinely managed effectively (Bowling 2009) to mitigate the weakness of both qualitative and quantitative techniques (Dawson 2009).

- Part 1 reviewed the available literature.
- Part 2 a modified Delphi study whereby in Round 1we canvassed nurses across the UK as to their initial opinions on a set of questions into early intervention and nurse led interventions for young people's psychological wellbeing. In Round 2 of the Delphi extrapolated a number of questions for rating from the data asking responders to agree or disagree with the statement.
- Part 3 synthesised the findings of the literature review and Delphi study.
- Part 4 summarised and made recommendations.

# Part 2: Scoping Literature review

## 2.1 Overview

This scoping review of the literature has been designed to identify the nature and extent of the literature and to provide a characterisation of the overall quantity and quality of the literature (Grant and Booth, 2009).

The literature search strategy used both a pre-determined set of search terms applied across a range of databases, and 'pearl growing'; for example, starting with a handful of key, already known, papers. The following databases were used: MEDLINE (EBSCO); CINAHL (EBSCO), and PsycInfo and the range of databases extended if necessary. Grey literature, such as reports from charitable organisations, were sought. All papers yielded from the literature searches were screened for relevancy; first using a title and abstract screening, and second, a full-text screening.

In line with the scoping literature review method, a formal quality appraisal exercise was not undertaken. Instead the overall quality characteristics for the body of evidence were considered. The data extraction process was supported through use of selected information fields from a standardised template. Data outcomes extracted include information about the setting, including the country; details of the type of nurse and their experience, skills, knowledge; descriptions of the intervention; and information on the population and their health conditions. Data has also been extracted on the effectiveness and efficacy of the intervention and the lived experience for those delivering and receiving the intervention.

Data synthesis draws on a process of mapping, followed by categorisation, sub-categorisation and comparisons within and across groups. Data is presented in both graphical and narrative format.

## 2.2 Screening and selection

A search of Medline (EBSCO), CINAHL (EBSCO) and PsycINFO (ProQuest) from 2009-present yielded 7999 results. Upon de-duplication, this number was reduced to 5401 unique records. 5401 records were screened using the title and abstract, with 5207 records excluded at this stage. 194 records were screened using the full text to determine inclusion in the synthesis. The main reason for exclusion at the stage (n=72) was that the study was not reporting on an identifiable intervention, for example, review papers, protocols, case studies, opinion pieces, editorials or commentaries.

The second reason for exclusion was that a study was not conducted in the UK or other relevant country (n=44). The reviewers initially aimed to identify solely studies conducted in the UK. However, after application of the eligibility criteria, it was determined that there was a lack of literature outlining mental health interventions for young people with significant nurse involvement. Indeed, only seven studies in the UK were identified. The decision was taken to update the criteria to include studies from those countries with a similar health infrastructure to the UK; that is, free at the point of access. For this reason, studies from the United States were not included. The reviewers felt that because of the markedly different healthcare climate, any results would be of limited use and relevance to this review.

The third reason for exclusion was that the paper did not report significant nurse involvement in the design, development, or delivery of the intervention (n=31). Many papers were returned by the search because of the mention of nurses, usually a recommendation that nurses implement something into practice. However, upon retrieving the full text of such papers, nurse involvement was found to be limited or non-existent.

Finally, a number of papers (n=26) were excluded because the outcomes did not pertain to young persons' mental health or well-being, the study population was not children or young people, or, in cases where adults and young people were included, the data for only young people could not be separated. There were also several papers (n=3) that were not written in the English language. Eighteen studies were subsequently selected for synthesis. The PRISMA flow diagram can be seen in Figure 1.

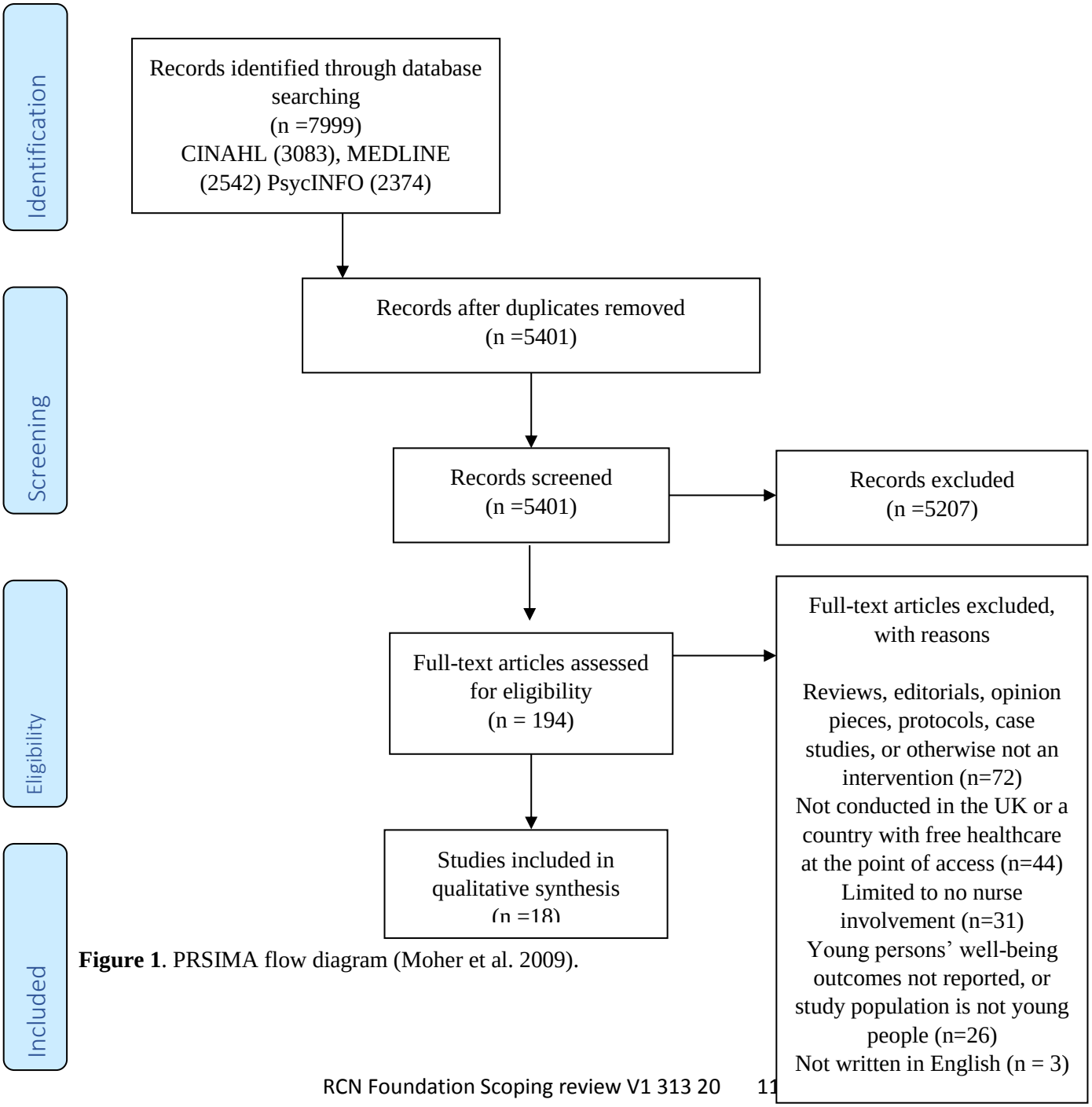



**Figure 1**. PRSIMA flow diagram (Moher et al. 2009).

## 2.3 Study Characteristics

Table 1. provides an overview of each selected study and its key characteristics.

### 2.3.1 Setting

Of the 18 papers included for synthesis, only seven studies were from the United Kingdom, with four conducted in Scotland. Two studies took place in the Netherlands, two in Denmark, and two in Australia. One study took place in each of the following: Italy, Spain, Turkey, South Korea and Nigeria. Eight studies were conducted in a hospital setting, five within schools, and five within the community. Within the community studies, one was in Child, Adolescent Mental Health Services (CAMHS), two were youth centres, and two were conducted in people's homes.

### 2.3.2 Nurses

The most frequently occurring type of nurse involved in interventions was school nurses, involved in the delivery of four interventions. Other nurses included paediatric nurses, midwives, mental health nurses, emergency department nurses, community health and community psychiatric nurses, epilepsy nurses and one study involving student nurses.

### 2.3.3 Intervention Type

Thirteen of the interventions were preventative in nature, conducted amongst either well populations, or those with mild/sub-clinical symptoms of emotional problems and low mood. From the five reactive interventions, two were conducted among populations diagnosed with restrictive eating disorders, two amongst those with developmental disorders, and one amongst those with psychosis.

Figure 2 shows a graphical representation of the settings of each study as well as its nature. It shows that preventative interventions tended to be carried out across a multitude of settings, most frequently within schools (targeting adolescents and pre-adolescent age-groups), while both hospitals and the community were also used for implementation. In contrast, reactive interventions tended to take place within hospitals and inpatient units, with only one taking place in the community. Several of the studies used a pre-post-test interventional design, for example, an urban forest health promotion program in South Korea (Bang et al., 2018), an online CBT programme delivered through school in the UK (Attwood et al., 2012), and resilience training delivered to students by school nurses in Nigeria (Olowokere & Okanlawon, 2014).

The reviewers left the definition of 'intervention' purposefully broad, and indeed a variety of study types were identified. Several studies tested the effectiveness of screening tools aimed at identifying the incidence, or risk, of psychiatric disorders. For example, midwives in two studies in Denmark (Ammitzboll et al., 2018; Ammitzboll et al., 2019) administered an infant mental health questionnaire at the 9-10 month home visit to determine the risk factors and associations between the outcomes and ICD-10 disorders at the 18 month home visit. Similarly, in another study in Australia, midwives once again administered a psychiatric screening tool to adolescent women seeking maternity care in order to reduce late or non-recognition of mental health problems in this high-risk demographic (Laios et al., 2010).

*Table 1. Characteristics of Selected Studies*

| Author | Year | Country | Setting | Nurse | Preventative/Reactive |
|---|---|---|---|---|---|
| Alparslan & Yildiz | 2014 | Turkey | Hospital | Nurse | Preventative |
| Ammitzbøll, Skovgaard, Holstein, Andersen, Kreiner & Nielsen | 2019 | Denmark | Community | Community Health Nurses (CHN) | Preventative |
| Ammitzbøll, Thygesen, Holstein, Andersen & Skovgaard | 2018 | Denmark | Community | Community Health Nurses (CHN) | Preventative |
| Attwood, Meadows, Stallard & Richardson | 2012 | UK | School | School Nurse | Preventative |
| Bang, Kim, Song, Kang & Jeong | 2018 | South Korea | Community centres used by children from low-income families | Student Nurse | Preventative |
| Bannink, Broeren & Raat | 2014 | The Netherlands | School | Nurse | Preventative |
| Bannink, Broeren, Joosten-van, van As, van de Looij-Jansen & Raat | 2014 | The Netherlands | School | School Nurses | Preventative |
| Bastida-Pozuelo, Sanchez-Ortuno & Meltzer | 2018 | Spain | Community - Youth mental health centre | Paediatric Nurse | Reactive |
| Coghill & Seth | 2015 | Scotland, UK | Hospital | Specialist Nurse | Reactive |
| Doi, Wason, Malden & Jepson | 2018 | Scotland, UK | School | School Nurses, Nurse managers | Preventative |
| Dorris, Broome, Wilson, Grant, Young, Baker et al. | 2017 | Scotland, UK | Hospital | Epilepsy Nurse | Preventative |
| Felluga, Rabach, Minute, Montico, Giorgi, Lonciari, Taddio & Barbi | 2016 | Italy | Hospital | ED Nurse | Preventative |
| Laios, Steele & Judd | 2010 | Australia | Hospital | Midwives, Psychiatric Consultation Liaison Nurse (PCLN) | Preventative |
| Olowokere & Okanlawon | 2014 | Nigeria | School | School Nurses | Preventative |
| O'Reilly, Kiyimba & Karim | 2016 | UK | CAMHS | Community Psychiatric Nurses (CPN) | Preventative |
| Street, Costelloe, Wootton, Upton & Brough | 2013 | UK | Hospital | Paediatric Nurse | Reactive |
| Walker & Kelly | 2011 | UK | Hospital | Mental Health Nurse | Reactive |
| Zugai, Stein-Parbury & Roche | 2014 | Australia | Hospital | Registered Nurses | Reactive |

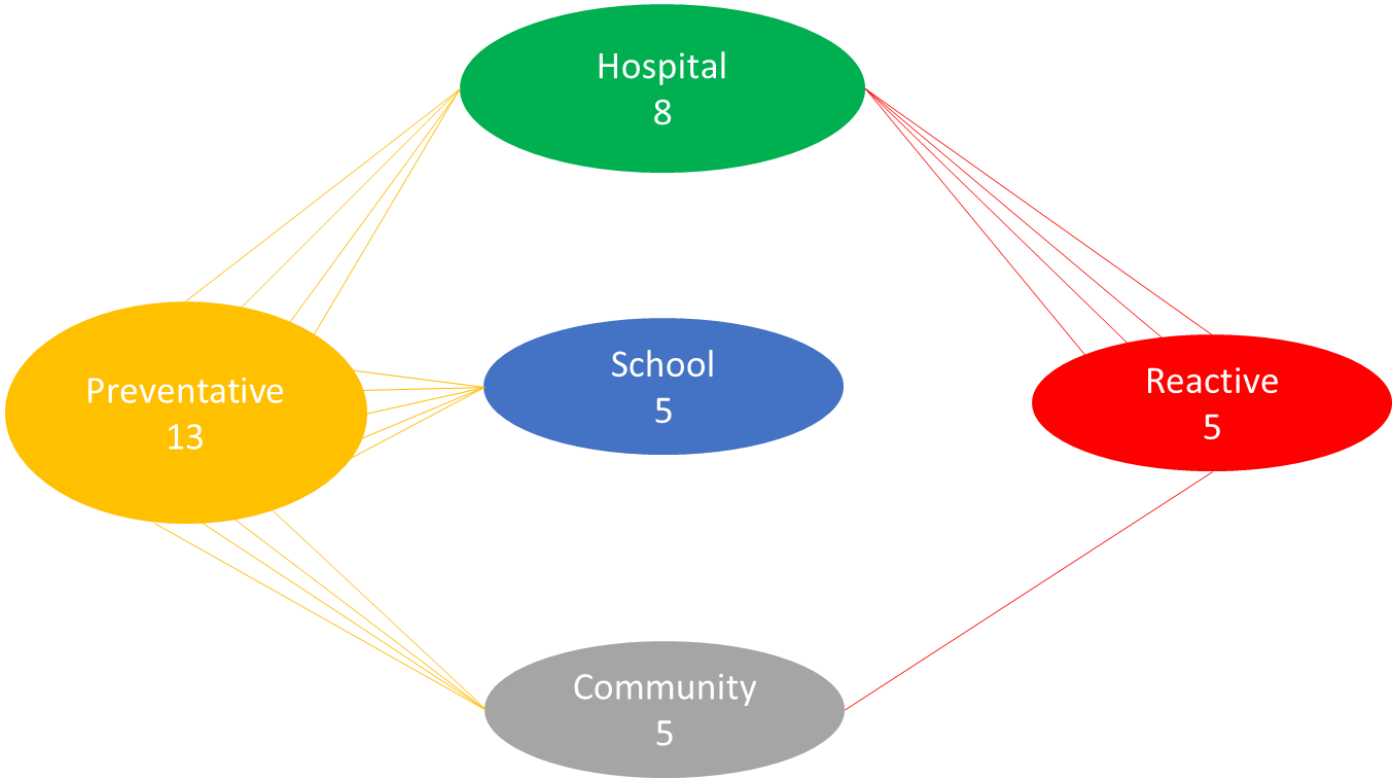



*Figure 2. Graphical Representation of Intervention Types and Settings*

A number of studies described and evaluated the restructure of care pathways. For example, one Scottish study described the re-organisation of the school nurse role, where nurses could, as part of their new focus, refer young people into one or several of nine priority areas or pathways for further care. This included a pathway for mental health and wellbeing, which was subsequently the most used pathway (68% of referrals in both test-sites) (Doi et al., 2018). Another study in the UK described the restructure of a pathway for patients with restricted eating disorder that aimed to reduce tier-4 inpatient admissions and carry out a three-week structured feeding admission on paediatric wards (Street et al., 2013).

Several other studies were qualitative in design rather than a pre/post intervention. An Australian study aimed to gain consumer perspectives of effective nursing care for inpatients with Anorexia Nervosa (Zuagi et al.,2014), a UK study analysed assessments in CAMHS to identify successful ways that nurses and mental health practitioners can ask about self-harm and suicide (O'Reilly et al., 2016), and another UK study described the impact and implementation of a journal project for young people receiving inpatient care for psychosis to recognise their early warning signs (Walker & Kelly, 2011).

### 2.3.4 Nurses' Roles

Nurses' roles varied across interventions from those studies in which nurses delivered a new intervention (Alparslan & Yildiz, 2014; Attwood et al., 2012; Bannink et al., 2014a; Bannink et al, 2014b; Bang et al., 2018; Bastida-Pozuelo et al, 2018; Dorris et al., 2017; Felluga et al, 2016; Olowokere & Okanlowen, 2014; Walker & Kelly, 2011), carried out treatment, assessment or screening as part of their usual duties (Ammitboll et al., 2019; Ammitzboll et al., 2018; Laios et al., 2010; O'Reilly et al., 2016; Zugai et al., 2014), or carried out treatment or assessment as part of a re-structure of their role, unit or care pathways (Coghill & Seth, 2015; Doi et al., 2018; Street at al., 2013).

### 2.3.5 Outcome Measures

Due to the heterogeneity between studies, a wide variety of outcomes were measured. Further, there is variation among the tools used to measure the same outcome. This can partly be accounted for by adaptations for specific countries, such as Bang et al. (2018) who used a Korean adaptation of the Children's Depression Inventory to monitor depression. It can also be explained by the wide definition of 'mental health and wellbeing'; outcomes related to anxiety, depression, and quality of life, but also to sleep behaviour (Bastida-Pozuelo et al., 2018), hyperkinetic/attention deficit disorders (Bang et al., 2018; Coghill & Seth, 2018), and epilepsy knowledge and management (Dorris et al., 2017). Within the more prevalent outcomes of anxiety, depression, quality of life, and self-esteem, the most common tools used were the Rosenberg self-esteem inventory used in three studies (Attwood et al., 2012; Bang et al., 2018; Olowokere & Okanlowen, 2014) and the Spence children's anxiety scale used in two studies (Attwood et al., 2012; Olowokere & Okanlowen, 2014). Table 2 outlines the outcome measures (and tools used) in each selected study.

*Table 2. Population and Outcomes Measures of Selected Studies*

| Author | Population | Diagnoses | Outcomes Measures |
|---|---|---|---|
| Alparslan & Yildiz | Aged 9-13 (n=26), 14-18 (n=19). Mean age of the siblings included in the study was 12.4. Male (n=18) Female (n=27) | Healthy | Anxiety (state anxiety scale, trait anxiety scale), Feelings |
| Ammitzbøll, Skovgaard, Holstein, Andersen, Kreiner & Nielsen | 3263 infants | Not reported | Risk factors for future mental health indicators |
| Ammitzbøll, Thygesen, Holstein, Andersen & Skovgaard | 2272 children, aged 9-10 months, follow up at 1.5 years | Not reported | Associations between CIMHS outcomes and risk of ICD-10 disorders |
| Attwood, Meadows, Stallard & Richardson | 9 boys and 3 girls, aged 10 to 16 years, with a mean of 12.4 years | Mild or moderate emotional problems of anxiety or low mood | Emotional health (Spence Children;s Anxiety Scale, Adolescent Well-being Scale, Schema Questionnaire for Children, Rosenberg Self Esteem Inventory, Satisfaction Questionnaire |
| Bang, Kim, Song, Kang & Jeong | 59 students, grades 4-6 | Not reported | Anthropometry, Perceived health status of participants, Self esteem (Rosenberg self-esteem scale), Depression (Korean version of Children's Depression Inventory), Peer relationships (20 questions measuring relationships), Attention Deficit and hyperactivity (the Korean version of Conners-Wells Adolescents Self-report scales (CASS) |
| Bannink, Broeren & Raat | 1087 adolescent, mean age 15.9, 15.9 and 16.0. Males 57.13%, 55.16% and 59.03% | Not reported | Evaluation of web-based tailored messages (online evaluation questionnaire), Evaluation of consultation, demographics |
| Bannink, Broeren, Joosten-van, van As, van de Looij-Jansen & Raat | 1256 adolescent, mean age 15.84, 15.95 and 15.79. Males 56.9%, 56% and 51.4%). | Not reported | Health behavior (questionnaire), Well-being (Strengths and Difficulties Questionnaire and Youth Self Report), HRQoL (Child Health Questionnaire-Child Form) |
| Bastida-Pozuelo, Sanchez-Ortuno & Meltzer | 26 children, age and gender not reported | Pervasive developmental disorders (84.6%), unspecified behavioral and emotional disorders (7.7%), hyperkinetic disorders (3.8%), specific development disorders of speec and language (3.8%) | Sleep behavior (The BEARS interview conducted with parents), the Pediatric Sleep Questionnaire Sleep-related problems - PSQ) |

| | | | |
|---|---|---|---|
| Coghill & Seth | Under 18 | ADHD or HKD | ADHD-RS-IV or SNAP-IV, administered as a semi-structured interview and rated by the clinician, Clinical Global Impression-Severity and -Improvement rating scales. Children's Global Assessment Scale. Structured assessment of 'other symptoms'. Assessment of 'other problems' (sleep, mood, psychological interventions, cognitive testing, occ. therapy) |
| Doi, Wason, Malden & Jepson | Site A - 299, 36.3% boys, Site B - 107, 46.7% boys | Not reported | Component 1 – Referral system and nine pathways. This component tested how the nine pathways, which are the key aspects of the programme, were rolled out and how school nurses viewed the referral system. |
| Dorris, Broome, Wilson, Grant, Young, Baker et al. | Mean age 14 years, range 12-17, female 65,4% and 66.7% in intervention and control | Non-clinical range of mental health difficulties | Quality of life (Paediatric Quality of Life Inventory PedsQL™ version 4.0), epilepsy self-knowledge (GOES-YP, EKP-G, SSEC-C, B-IPQ), psychological adjustment (PI-ED), subjective measures of QoL, social functioning, feasibility outcomes, experience of service and use |
| Felluga, Rabach, Minute, Montico, Giorgi, Lonciari, Taddio & Barbi | Male - clown group 65%, control group 70%), mean age 8 and 10 respectively | None | Pain perception (Numerical rating scale - children older than 8, or Wong-Backer scale for younger ones), Anxiety (Children Anxiety and Pain Scales - CAPS-Anxiety) |
| Laios, Steele & Judd | Female, up to 19 | None | Consumer experience of the PRT, audit of first 100 women to determine whether the tool was effective in reducing late or non-recognition of MH problems |
| Olowokere & Okanlawon | 38 Males,71 Females, aged 8-13 | None | Resilience (28-item scale adapted from children and youth resilience scale), Anxiety (18-item scale adapted from Spence's children anxiety scale), Depression (scale adapted from Center for Epidemiological Studies Depression scale for children), Self-esteem (Rosenberg self-esteem scale) |
| O'Reilly, Kiyimba & Karim | 36% girls, 64% boys, mean age 11 (6-17 years) | Not reported | Communication patterns between client and mental health practitioners; specifically regarding questions about self-harm and/or suicide. |
| Street, Costelloe, Wootton, Upton & Brough | 30 females, aged 10-17 years (mean 14.5) | Restrictive Eating Disorder | Length of stay, no. of NGT, no. of transferal to tier-4 unit, no. of times used the mental health act, no. of discharges, ward staff views |
| Walker & Kelly | Aged 12-18 | Psychosis, Inpatient care | Experiences of young people, Factors identified through evaluation that were considered helpful in assisting participation |
| Zugai, Stein-Parbury & Roche | Female, aged 14-16 | Anorexia Nervosa, inpatient care | Consumer perspectives of inpatient nursing care |

## 2.4 Key Findings

In line with scoping literature review guidance, no formal quality appraisal was undertaken. This means results should be interpreted with caution as the confidence in the evidence has not been established. Concepts that may affect the confidence in the evidence include sampling and recruitment procedures, statistical power of the sample, reliability and replicability of procedures, data collection, and data analysis.

### 2.4.1 Intervention Studies

Ten studies utilised an experimental design with outcomes measured pre and post-test. Table 3 outlines the aims and intervention details of each study, while table 4 provides a summary of the results. Three studies involved a computer-based intervention; two (Bannink et al, 2014a; Bannink et al, 2014a) used an e-health questionnaire that measured health behaviour alone in control groups, as well as providing tailored messages of support in experimental groups, and offering a face-to-face consultation with the school nurse for those that were flagged as at-risk. Results indicated that participants gave a positive rating for the consultation and found it a valuable addition to the tailored messages (Bannink et al, 2014a), and that those at-risk participants that were offered the consultation reported a better mental health status and health related quality of life than those that at-risk participants who were not offered the consultation (Bannink et al., 2014b).

This potentially indicates that the face-to-face aspect cannot be replaced in web-based interventions. The third study (Attwood et al, 2012) used a computerised CBT program (Think, Feel, Do) delivered weekly by a school nurse to explore the benefits to emotional health for students identified as having mild symptoms of low mood and anxiety. Results indicated significant improvements in depression, anxiety, and self-esteem scores.

Bang et al. (2018) used nursing student mentors to deliver a community health program using urban forests. This consisted of 10 sessions, encompassing lectures on health, and forest experience activities, while the control group attended only routine programs at the community centre. Despite no improvements to physical health, results showed significant improvements in depression and self-esteem scores, with no changes found in the control group. However, it is unclear whether improvements can be attributed to the forest experiences alone, as this was combined with lectures.

Four of the studies used education-based interventions to improve well-being outcomes (Alparslan & Yildiz, 2014; Bastida-Pozuelo et al. 2014; Dorris et al. 2017; Olowokere & Okanlawon, 2014). Alparlan & Yildiz (2014) implemented a nurse-delivered intervention utilising nursing support and relaxation exercises to reduce anxiety in the siblings of sick children. After the intervention, trait anxiety was significantly reduced.

Bastida-Pozuelo et al. (2014) tested the effects of a paediatric sleep-education session delivered to parents to improve sleep behaviour for children with neurodevelopmental and mental health disorders. Sleep behaviour was collected from children before and after the intervention with parents. Although the education session was delivered to parents, results indicated that all

variables on the Pediatic Sleep Questionnaire (PSQ) were improved significantly, including insomnia and daytime sleepiness, and sleep duration. Dorris et al. (2017) used a crossover RCT design to explore the feasibility of a manual-based psychosocial intervention for young people with epilepsy, delivered by epilepsy nurses. During the interactive weekly sessions, didactic psycho-education and open group discussion focused on a separate theme each week. However, although several well-being outcomes were measured, the only significant improvements were related to epilepsy knowledge and confidence in talking about epilepsy.

Olowokere & Okanlawon (2014) evaluated the impact of resilience training delivered by school nurses on vulnerable children's resilience. They received either resilience training only, peer support only (facilitated by teachers), a combination of resilience training and peer support, or were in a control group. Those in the resilience only or combined groups improved their resilience scores significantly compared to the control group or the peer support only group, although no difference was found between resilience training only and resilience and peer support combined. Other measures of depression, anxiety, and self-esteem were collected, but no differences were reported.

Felluga et al. (2016) conducted an RCT to examine whether clowns in the emergency department could reduce children's anxiety and pain during painful procedures. Participants either interacted with a clown during the procedures, or, in the control group, interacted with nurses that usually provide distraction techniques in this situation. Despite no change in pain levels, anxiety was significantly reduced in the clown group.

Finally, Walker & Kelly (2011) developed a journal project for inpatients with psychosis to identify and reflect upon their early warning signs to prevent future hospitalisation. Patients worked with their key nurse to develop and use their journal. This study did not have pre and post outcome measures, but instead reported on the successful adoption of the journal by two patients. Therefore, few conclusions can be drawn from this study.

*Table 3. Intervention Studies.*

| Author | Objective/Research Question | Intervention Studies |
|---|---|---|
| Alparslan & Yildiz | This study aimed to determine the influence of chronic disease of children admitted to hospital on their 9-18 year old siblings and mothers in the hospitals included in the study, provide training and nursing support regarding stress-anxiety management and reveal the effect of support on anxiety levels. | Intervention: a nurse-delivered intervention where the healthy siblings of sick children were taught relaxation exercises to be carried out 3x/day with 7-15 days intervals. Outcomes measured pre and post. |
| Attwood, Meadows, Stallard & Richardson | This paper reports on two proof of concept studies to explore the viability and possible immediate therapeutic benefits of one cCBT programme, Think, Feel, Do, delivered in schools as a universal and targeted emotional health intervention. | Computer-based CBT intervention, Think, Feel, Do, was delivered on a one-to-one basis by the school nurse over 6 sessions at school. These were usually delivered weekly. Assessments were completed before and after the intervention by a researcher. |
| Bang, Kim, Song, Kang & Jeong | To develop a combined health promotion program using urban forests and nursing student mentors for vulnerable school-aged children and to evaluate the effects of this program on the perceived and psychological health of elementary school students in vulnerable populations. | Experimental group: 10-session health promotion program using urban forests consisted of lectures on physical and psychosocial health and forest experience activities. Each session allocated 30 min for the lecture and 60 min for the forest activities in the urban forests, which were 10 min away from each community center for children. The control groups attending only the routine programs at the community center |
| Bannink, Broeren & Raat | The aim of this study was to evaluate the use and appreciation of the Web-based, tailored messages, and the use and appreciation of the subsequent consultation applied by the preventive youth health care in schools. | Three groups: E-Health4Uth intervention - adolescent completed a one-time 45 min self-report questionnaire via the internet to assess health-risk behaviour and well-being. E-Health4Uth and Counseling - as above but also received tailored messages, and in this group those at risk of MH problems were invited to a consultation with the nurse. Control group - The same questionnaire and could check a box for self-referral with the nurse. |
| Bannink, Broeren, Joosten-van, van As, van de Looij-Jansen & Raat | This study evaluates the effect of E-health4Uth and E-health4Uth and consultation on well-being (ie, mental health status and health-related quality of life) | Three groups: E-Health4Uth intervention - adolescent completed a one-time 45 min self-report questionnaire via the internet to assess health-risk behaviour and well-being. Messages of advice were presented for each topic based on score of each section. E-Health4Uth and Consultation - as above but invited for consultation if at risk. Control group - completed the questionnaire but no messages of advice or consultation |
| Bastida-Pozuelo, Sanchez-Ortuno & Meltzer | The aim of this pilot study was to test the effects of a pediatric nurse-led, single-session, parent sleep educational intervention on the sleep of school-aged children with neurodevelopmental and mental health disorders. | The treatment consists of 15 sessions delivered in a biweekly fashion. The treatment group typically includes 5–7 children. After collecting the sleep information, the pediatric nurse conducted a 45-min structured educational intervention for parents about sleep. At the end of the session, the pediatric nurse asked the parents to implement the good sleep practices highlighted, providing a two-page handout to serve as a reminder of the information covered. Three months after the sleep session, the pediatric nurse met individually with parents while their children were receiving their group treatment, and asked parents to complete the posttreatment assessment. |

| | | |
|---|---|---|
| Dorris, Broome, Wilson, Grant, Young, Baker et al. | Using an exploratory RCT design, the central aims of this study were to explore the feasibility and preliminary efficacy of a manual-based psychosocial group intervention for young people with epilepsy | Weekly 120 min sessions with 4-7 children per group. Each week a separate theme was focused on and delivered using a mixture of facilitator led didactic psycho-education along with open group discussion, paired work, role plays, and educational videos/audio clips |
| Felluga, Rabach, Minute, Montico, Giorgi, Lonciari, Taddio & Barbi | We conducted a randomized controlled trial to investigate if the presence of medical clowns is effective in reducing children's anxiety and pain during painful procedures in the ED. | In the intervention group, children and their parents interacted simultaneously with two clowns, both in the waiting room for a fixed 20-min period and in the ED, for the time needed to complete the medical examination and the painful procedure. Children in the control group were exposed to the distraction techniques that ED nurses usually provide in our setting with the involvement of parents. |
| Olowokere & Okanlawon | Evaluate the impact of resilience training and peer support provided by school nurses and teachers on vulnerable children's resilience and selected psychosocial outcomes | After training, nurses worked with teachers. to identify vulnerable children using the vulnerability index. Participants received either resilience training only (six session lecture package), a peer support group (no nurse involvement) or a combination of both |
| Walker & Kelly | The journal project was developed for the individuals and their key nurses to work collaboratively to recognize and understand their early warning signs and the important role this knowledge can play in the future management of their ability to stay well. | During their admission they would be encouraged to use their journal in collaboration with their key nurse to develop and reflect on their own individual early warning signs. |

*Table 4. Results of Intervention Studies.*

| Author | Intervention Studies |
|---|---|
| Alparslan & Yildiz | Trait anxiety was significantly reduced in health siblings following nursing support in healthy siblings |
| Attwood, Meadows, Stallard & Richardson | These showed that there were statistically significant improvements post-intervention on the AWS Total Score (Depression): Z = )2.09, p < .05, one-tailed, SCAS Generalised Anxiety subscale: Z = )2.07, p < .05, one-tailed, SES Total (Self Esteem) Z = )2.19, p < .05, one-tailed and SQC Total (Schemas) Z = )2.85, p < .01, one-tailed. Average satisfaction was moderate to high, with most participants rating for example that they enjoyed TFD, it helped them with their problems, and they would recommend it to a friend. |
| Bang, Kim, Song, Kang & Jeong | In the experimental group, self-esteem was significantly increased (p = 0.030, d = 0.47), and depression was significantly decreased (p = 0.020, r = −0.48) after the intervention. No statistically significant changes were found in the control group. This means that this program was partly effective in improving children's psychological health. |
| Bannink, Broeren & Raat | Of the 554 adolescents in the E-health4Uth and counseling group, 103 (18.6%) adolescents were referred to a nurse. Adolescents in the two intervention groups and the control group could also check a box for a self-referral; 44 of the 1702 adolescents checked the box for a self-referral (2.6%). Adolescents appreciated being invited for the consultation (mean 3.70, SD 1.10), found the consultation a valuable addition to the tailored messages (mean 3.86, SD 1.03), and they gave the consultation a positive mean rating of 8.07 on a 10-point scale (SD 1.21). |
| Bannink, Broeren, Joosten-van, van As, van de Looij-Jansen & Raat | Adolescents in the E-health4Uth and consultation group reported a significantly better mental health status compared to adolescents in the control group. .Adolescents in the E-health4Uth and consultation group, who were at risk of mental health problems at baseline, reported a significantly better mental health status and better HRQoL than those in the control group who were at risk at baseline.). These results were not replicated among adolescents who were at risk of mental health problems in the E-health4Uth standalone intervention group |
| Bastida-Pozuelo, Sanchez-Ortuno & Meltzer | significant improvements in nearly all variables derived from the PSQ 3 months after the delivery of the educational intervention. The Insomnia and Daytime Sleepiness composite scores decreased significantly (p < 0.03), with medium effect sizes found for both variables. Both weekday and weekend bedtimes were earlier than pretreatment (14 and 33 min, respectively), and although weekday wake times did not change, weekend wake time was later (14 min). This resulted in significant increases for both weekday sleep duration and weekend sleep duration (p < 0.01), with a large effect size found for weekend sleep duration, and a medium effect size for weekday sleep duration |
| Dorris, Broome, Wilson, Grant, Young, Baker et al. | There was a significant increase in epilepsy knowledge in the treatment group at 6 weeks (p = 0.04, d = 0.25), with an increased effect size at 3 months' follow-up (p = 0.02, d = 0.58). There was a positive trend found on the GEOS-YP, BIPQ, PI-ED and SSEC in the intervention group, however these differences were not statistically significant at post-intervention or at 3-month follow-up. it was found that after attending the PIE group, the participants in the intervention group were found to be significantly more 'confident in talking about their epilepsy' compared to participants in the control group at 6 weeks (p = 0.04) and this was sustained at 3 months (p = 0.04). |
| Felluga, Rabach, Minute, Montico, Giorgi, Lonciari, Taddio & Barbi | Pain levels did not change between the two groups while anxiety levels were significant lower in the clown group |
| Olowokere & Okanlawon | The result showed that the interventions resulted in increase in the resilience score of the children in the experimental group compared with children in the control group. A post hoc comparison using Fisher's LSD test revealed that children who received combination of resilience training and peer support did not differ significantly in their resilience scores postintervention when compared with children who received resilience training only. While children who received resilience training were significantly different from children who received peer support only and the control group in their resilience scores. The children in the resilience group displayed higher resilience scores compared with those who received peer support only and the control group. |
| Walker & Kelly | Two case studies of successful adoption of the journal, including recognising early warning signs, strategies to deal with symptoms, and continued use of the journal upon discharge |

### 2.4.2 Screening Studies

Three studies used screening tools to identify risk factors or those at risk of mental health problems (Ammitzboll et al., 2019; Ammitzboll et al., 2018; Laios et al., 2010). Table 5 outlines the details of the studies, while Table 6 outlines the results. The screening took place as part of midwives' usual duties; that is, home-visits or providing maternity care. Two of the studies used the same tool to a) test its use as an indicator of mental health problems in infants (Ammitzboll et al., 2018) and b) use it to investigate the associations between problems identified at 9-10 months and psychopathology at 1.5 years (Ammiztboll et al., 2019). The results showed that having at least three problems identified by the tool at 9-10 months was associated with a twofold increased risk of ICD-10 disorders at age 1.5 years.

Laios et al. (2010) had midwives use the Psychiatric Screening Tool (PRT) with adolescent women seeking maternity care. This was intended to identify those at-risk, and once completed, the PRT was discussed with a psychiatrist to determine the appropriate further pathway (if needed). Of the 52 women that were screened, 22 were identified as at-risk and referred to the psychiatrist. Mental illness was detected in 73% of the 22 women, with the remaining 27% flagged as at-risk for developing mental illness with their advancing pregnancy or in the postnatal period.

### 2.4.3 Re-structure Studies

Three studies (all in the UK) focused on re-structure of care pathways or the re-focusing of existing roles (Coghill & Seth, 2015; Doi et al., 2018; Street et al., 2013). The results show generally effective emergent results; however, publication bias may be a factor because of the higher likelihood that a paper describing a successful re-structure would be published in comparison to a less successful attempt. Table 7 outlines the study details, while Table 8 presents the results.

Two of the studies examined re-structured or refocused care pathways for specific conditions in hospitals in the UK. Coghill & Seth (2015) discussed the Dundee ADHD Clinical Care Pathway (DACCP), an initiative that aimed to facilitate evidence-based therapy and use staff skills and time more effectively. There were four stages that were predominantly led by specialist nurses, with doctor input at the diagnosis and treatment planning stage. Outcomes related to severity of ADHD and/or HKD were measured at baseline, after treatment planning, and then later at follow up. Results indicated a reduction in symptom severity according to the ADHD-RV-IS.

Similarly, Street et al. (2013) developed a model to safely manage young people with restricted eating disorder on a local pediatic ward, thereby using local hospitals more effectively and reducing admission to tier-4 units. The new pathway, predominantly nurse-led and facilitated, included a three-week structured feeding admission for patients at moderate/high risk, to stabilise physical risk and achieve weight gain. Of the 30 females admitted to the ward, 27 were discharged with good physical health. Additionally, only two were transferred to tier-4 units. None required the use of the Mental Health Act.

Doi et al. (2018) conducted an evaluation of the re-focusing of the school nurse role in Scotland. The new focus of the role included a greater emphasis on home-visiting and addressing wider public health priorities. The nurses could either use referral system with nine pathways or priority areas (one of which was mental health and wellbeing) or provide direct intervention themselves. The results show that the mental health and well-being pathway was by far the most used, with 68% of referrals from both sites (including 299 and 107 students respectively) to this pathway. While this indicates rising priority of this area, nurses also felt that they were inadequately trained to provide direct intervention to students with low-moderate mental health issues. This presents a further gap in knowledge; if more front-line nurses were trained to deal with low-moderate mental health issues, would referral to higher tier services be reduced.

### 2.4.4 Evaluative Studies

Two studies used a qualitative, evaluative approach to explore nursing approaches already in practice and provide nursing recommendations resultantly (O'Reilly et al., 2016, Zugai et al., 2014). Table 9 outlines the study while Table 10 shows results. O'Reilly et al. (2014) aimed to examine how psychiatric nurses in CAMHS, UK, introduce questions to young people about self-harm and suicide in their assessments. They observed assessments and reported three 'asking styles' which were found to successfully engage young people in talking about self-harm and suicide. Similarly, Zugai et al. (2014) wanted to explore what makes nursing care effective for young inpatients with Anorexia Nervosa. They did this through analysing consumer perspectives and came up with several 'themes' that contribute to either assisting in weight gain or enhancing the inpatient experience. Both studies use the consumers themselves to provide recommendations for effective nursing practice, especially the latter study, which took into account both clinical outcomes (weight gain) but also the lived experiences of the patients.

*Table 5. Screening Studies.*

| Author | Objective/Research Question | Screening Studies |
|---|---|---|
| Ammitzbøll, Skovgaard, Holstein, Andersen, Kreiner & Nielsen | The main goal of the present study is to determine 1) whether the CIMHQ can be used as a single and overall indicator of mental health problems in infants, 2) whether it collects redundant information, and 3) whether it functions equally good for children with and without mental health problems | The setting was the scheduled home visits delivered by CHNs, of which the home visit at age 8–10 months. The CHNs completed the questionnaire in cooperation with the parents at the end of the visit. |
| Ammitzbøll, Thygesen, Holstein, Andersen & Skovgaard | Investigate the prospective associations of CIMHS (Copenhagen Infant Mental Health Screening) problems at age 9–10 months and psychopathology at 1½ years. The aims are to explore the predictive validity and evaluate whether the CIMHS can be used as a starting point to guide CHNs' interventions within the general child health surveillance | The assessment comprised a parent interview and face-to face examinations of the child conducted by a research CHN and a developmental psychologist. The follow-up examinations were conducted from 1st of March 2011 to 20th of December 2013. The parents were identified via the Civil Registration System and invited to participate about 6 weeks before child's 18 months birthday. Parents, CHNs, and the examiners at follow-up were all blind to the CIMHS scores at 9–10 months. |
| Laios, Steele & Judd | The development and evaluation of a screening tool (the Psychiatric Referral Tool, PRT), designed for use with a 'high risk' demographic group – adolescent women seeking maternity care. | Questions cover past (specific enquiry is made about a range of possible mental health problems) and family psychiatric history; current psychiatric symptoms and treatment; major stressors, changes or losses in past year; history of abuse; and current supports. Once completed, the PRT checklist, in discussion with a psychiatrist, is used to determine appropriate pathway (no referral, secondary consultation, referral to social worker, no action needed). |

*Table 6. Results of Screening Studies.*

| Author | Screening Studies |
|---|---|
| Ammitzbøll, Skovgaard, Holstein, Andersen, Kreiner & Nielsen | Our main findings are that CIMHQ identify two latent classes of infants, who are qualitatively different with regard to their numbers and patterns of problems, indicating that CIMHQ can be used as an overall scale to measure infancy mental health problems |
| Ammitzbøll, Thygesen, Holstein, Andersen & Skovgaard | Overall, having 3 + problems at age 9–10 months was associated with a twofold increased risk of ICD-10 disorders at age 1½ year, within all diagnostic areas investigated except sleep disorders. In particular, sleep problems were associated with a threefold increased risk of ICD-10 sleep disorder. Feeding and eating problems were associated with a more than twofold increased risk of eating disorders. |
| Laios, Steele & Judd | Over a 6-month period, 52 women completed the feedback questionnaire. 19% were surprised to be asked about mental health problems when attending a maternity hospital, but 86% reported that they felt comfortable answering questions about their mental health. 22 women were referred to the psychiatrist in the antenatal period. Although detecting current mental illness in a large proportion of these 22 women (n = 16, 73% of the women referred), the remaining six women (27%) were flagged as 'at risk' of developing mental illness either with their advancing pregnancy, or in the postnatal period. |

*Table 7. Re-structure Studies.*

| Author | Objective/Research Question | Restructure Studies |
|---|---|---|
| Coghill & Seth | The Dundee ADHD Clinical Care Pathway (DACCP) was developed to facilitate the dynamic integration of new knowledge to provide effective, evidence based therapy; speed up the transfer of research findings into clinical practice; use staff skills and time effectively; and provide a consistent approach to the management of waiting lists and treatment. | Stages of the DACCP The pathway has four key stages: Referral and pre-assessment screening (specialist nurse conducts), Assessment, diagnosis and treatment planning (nurse collects information, doctor does diagnosis and treatment planning), Initiating treatment (reduce symptoms of ADHD, appointments nurse-led, 4 week period of titration), Continuing care/Monitoring treatment (follow up, nurse led). |
| Doi, Wason, Malden & Jepson | This study aimed to use realist evaluation to understand how the components of the contexts and mechanisms of the refocused programme influenced outcomes in both study sites. | In 2013, the Chief Nursing Officer (CNO) of Scotland recommended the re-organisation of the school nurse role. School nurses will assess children and then either refer children onto the relevant services or provide direct intervention themselves |
| Street, Costelloe, Wootton, Upton & Brough | We have developed a joint working model to safely manage young people in the community, using local hospital admissions more effectively. | Restructure of a pathway for restricted eating disorder aiming to reduce admission to tier-4 inpatient unit – focus on treatment on paediatric wards. In moderate/high-risk cases, inpatient admission to the general paediatric ward is used urgently, or semi-electively when all else has failed, to stabilise physical risk and re-establish intake of sufficient calories to achieve weight gain. This consists of a 3-week structured, supported feeding admission which is presented as a way to try and avoid otherwise inevitable tier-4 admission for young people who are not engaging, or supportively for those who have engaged but struggle to achieve adequate food intake at home. |

*Table 8. Results of Re-Structure Studies.*

| Author | Re-structure Studies |
|---|---|
| Coghill & Seth | Among the 119 patients currently in continuing care and receiving methylphenidate, their mean (SD) total ADHD-RS-IV item score at baseline was 2.5 (0.4), and none had a mean item score of ≤1. Mean (SD) item score decreased to 0.7 (0.4) at the end of titration (best dose), indicating a strong clinical response and 80 % of patients had a mean item score of ≤1. At the most recent clinic visit, mean (SD) total ADHD-RS-IV item score remained low at 0.8 (0.8), although the average score across all post-titration continuing care visits was slightly higher (1.0 [0.6]). The mean total ADHD-RS-IV score decreased by 29.4 points from baseline to their most recent visit, |
| Doi, Wason, Malden & Jepson | Descriptive - 68% of children from both sites were referred to the mental health and well-being pathway. Nurses at both sites stated that the pathway that presents in referrals most frequently was mental health and wellbeing. School nurses felt that the mental health and well-being pathway was sometimes used as a 'catch all' for occasions when an appropriate pathway was difficult to identify. In spite of this, they believed that mental health issues are increasing in children and schools see this as a key part of the school nurse's role. Nurses recognised that mental health and wellbeing was an important pathway, however a number of nurses, felt they were inadequately trained to deal with low to moderate mental health issues |
| Street, Costelloe, Wootton, Upton & Brough | The average length of stay was 20 days. Two needed NGT for one meal only, two were transferred to tier-4 units from the ward and two accessed local adult tier-4 services (1–2 years post admission) when physically safe but struggling with mental health recovery. None required use of the Mental Health Act. The remaining 27 were discharged before age 18 years with good physical health. Ward staff views, sought through focus groups, were that, time-limited admissions, with consistent and boundaried care plans, are easier to manage, they feel more supported by CAMHS and positive about their role in helping the young person |

*Table 9. Evaluative Studies.*

| Author | Objective/Research Question | Evaluative Studies |
|---|---|---|
| O'Reilly, Kiyimba & Karim | To examine the real-world practice of how psychiatric nurses and other mental health practitioners introduce questions specifically about self-harm and suicide | Initial multi-disciplinary in nature assessment, carried out by minimum two practitioners (consultant, staff grade and trainee child and adolescent psychiatrists, clinical psychologists, assistant psychologists, community psychiatric nurses (CPNs), occupational therapists and psychotherapists) |
| Zugai, Stein-Parbury & Roche | 'what do consumers perceive to be effective nursing care?' | Data were gathered through semi-structured interviews with consumers. The interviews focused on the nursing contributions that aided weight gain, and those that enhanced the inpatient experience. |

*Table 10. Evaluative Studies.*

| Author | Evaluative Studies |
|---|---|
| O'Reilly, Kiyimba & Karim | Qualitative; three "styles of asking" were identified: Incremental Approach, Normalising and externalizing, Young person volunteers information and it is pursued. Both the incremental approach and externalizing approaches were found to successfully engage young people in talking about self-harm and suicide. Therefore, by helping practitioners to learn the skills of question design in this area, is likely to increase their confidence in asking questions of this nature to children and young people. |
| Zugai, Stein-Parbury & Roche | Themes: Ensuring weight gain, Relinquishing control, Understanding the consequences for breaking the rules, Maintain a therapeutic milieu, Rules for my well-being, not my restriction, Having fun, like a regular person, The best nurses cared, My nurse; my motivator |

## 2.5 Discussion

Internationally, there is an increase in children and young people being referred for help for mental ill health is rising sharply. In the UK, this has resulted in increased demand on NHS mental health workforces, including nurses. Therefore, it is relevant to identify what current nurse-led interventions exist, as well as improvements that could be made, given this challenging context. The aim of this scoping literature review is part of a wider project exploring the reach and understanding of nurses in the UK on interventions they deliver to support children and young people's mental health. Specifically, this literature review was undertaken to identify the nature and extent of recent literature regarding nurse-led interventions in the UK, excellence in practice and gaps in provision. An initial search yielded 7999 results but only seven UK-based studies were identified for inclusion, before an additional 11 were included from other countries deemed relevant due to comparable health infrastructures. The 18 studies varied considerably in regard to type of intervention and range of nursing role, as well as level of nursing involvement and how or what outcomes were measured. The synthesis of heterogenous papers is challenging in any literature review, and here, the identification and agreement of what should be considered current 'best nursing-led practice' is a particularly acute challenge for this review.

It may be helpful to consider some of the reasons why there are a limited number of studies reporting nursing led mental health interventions amongst young people. Doing so can highlight gaps in provision and direct areas for future research. One way to do this is to look at why papers were excluded during the screening phases of this review. Many studies identified plausible interventions for children and young people's mental health or wellbeing, with the recommendation for nurses to use said intervention, but these studies were excluded from the review because there was minimal or no involvement of nurses in the research itself. A lack of direct involvement of nurses in the design of interventional research that is intended for nurses has numerous shortcomings. Firstly, the research runs the risk of becoming ecologically invalid, results may not be replicable when carried out by nurses in their work-based settings. Secondly, the feasibility of carrying out an intervention, along with all the other recommended interventions that did not include nurses in the initial design or procedure, may be unrealistic to implement in practice and suggests a lack of awareness of training needs, capacity and ability. It is possible that nurses, given increased demands on service, cutbacks on funding and smaller workforces, do not have the time or capacity to add research to their workload. A key recommendation is for researchers to identify appropriate methods in which they can include nurses directly into the development and implementation of research design. This would not only allow nurses to immediately feedback the feasibility of the proposed intervention, but would allow nurses a greater opportunity to have their lived experiences heard, and to collaborate more in the development of evidence-based practice, potentially increasing engagement and efficacy overall.

Another criterion which made papers ineligible for inclusion in the review was a lack of explicit information regarding an intervention, such as reviews, editorials, opinion pieces or case studies. Many papers appeared to reference possible interventions, but could not be substantiated by academic literature, something potentially common place amongst healthcare professions not authored by medical doctors. This suggests that nurse-led

interventions are being implemented, however the practice is not being clearly communicated through academic pathways such as scientific journals, or, the work is not meeting the level of necessary academic rigour, which raises questions about the scientific validity of apparent interventions. These are fairly superficial assumptions, and must be taken with the view that further research is needed; including clarity into the implementation of nurse-led interventions to ensure there are is a clearer understanding how these are created, evaluated and communicated to nursing staff.

### 2.5.1 Preventative versus Early Interventions with Nurse Type

Recent data of the large number of referrals (NHS Digital, 2018) and diagnoses for children and young people in the UK, highlights the increase of help-seeking behaviour and demand on services. Much of the interventional research identified in this literature review focuses on the mental health assessment, screening and consultation tools carried out by nurses. Whilst the reviewers have included these tools under the definition of an intervention, it is possible that an increase in efficiency of these preventative measures could also lead to the increase in referrals seen by NHS Digital (2018). However, what could be more pertinent is a need for more reactive interventions, ones that target the symptoms or causes of mental ill-health or poor wellbeing, not just the identification of it. For example, the Royal College of Psychiatrists (Campbell, 2018), whilst pleased to see more young people are being referred, state they are concerned the workforce is too small to treat such a large group. Effective interventions are still a necessity, and there appears to be a paucity of these according to this literature review. Whilst this literature review shows nursing staff are well placed to screen and identify mental ill health, it may be more pertinent to look at interventions that can efficiently target clinical symptoms and diagnosed conditions, given a rise in referrals will mean a rise in demand, and a need for more effective interventions if the workforce is too small.

The majority of studies included in this review are preventative interventions, as opposed to reactive. This could be due to school nurses being the most frequently occurring type of nurse involved in the interventions found in the literature review. The nature of a school nurse role is also likely to be more proactive and educational (Croghan, Johnson & Aveyard, 2004) considering the wider-teaching environment in which they are situated. School nurses could also be considered to be in a position which facilitates more proactive interventions and has the advantage of unique access to a specific community. Overall, this suggests that the type of nurse and setting is likely to influence the intervention type reported. On this basis, if more research was conducted by other types of nurses, such as paediatric or mental health nurses, the types of intervention reported may be more equitable.

### 2.5.2 Digital Interventions

Results appeared to suggest that digital interventions (such as questionnaires delivered online or web-based CBT interventions) were concurrent with a higher recruitment of participants, likely due to the efficiency of digital interventions in contrast to face-to-face interventions that are staff-, and therefore time-intensive. Given time pressures for mental health services due to small workforces struggling to meet demand from high numbers of referrals, this could be suggestive of a change in how interventions could be, or are being, provided.

More digital interventions, either for the screening or treatment of conditions, could potentially help alleviate some of this pressure if it leads to more children and young people being assessed and/or treated quicker. Often a beneficial factor in nursing interventions is the therapeutic relationship between practitioner and patient (Roberts, Fenton & Barnard, 2015); an alliance likely absent in digital interventions. However, studies comparing face-to-face and internet-delivered mental health interventions, such as CBT, have demonstrated comparable results in symptom reduction for adults (Andersson et al., 2014).

With so many young people more engaged with technology and the internet, it might be the most suitable method for access to this population. It could therefore be beneficial for future research to identify if similar comparisons exist between face-to-face and digital nurse-led interventions for children and young people. Even if so, research has found digital based psychological interventions are perceived as less favourable to face-to-face therapy by therapists, even though results are equivocal (Rochlen, Zack & Speyer, 2004). It could be that similar barriers are experienced by nurses, therefore research should also focus on the perceived benefits and limitations identified by both nurses and patients.

### 2.5.3 Limitations

A scoping review of literature is a type of synthesis of research used to identify the extent and nature of literature regarding a particular topic, to help identify key concepts and gaps in research, as well as provide potential recommendations for practice (Daudt, van Mossel & Scott, 2013). Nevertheless, there are some limitations of this approach in general and also within this particular review. It could be the scarcity of results was due to limited and insufficient date parameters. It is possible that current practice is compiled of established interventions that were evidence-based pre-2009. It is however hoped that, regardless of how well established interventions are, research continually tests their applicability and validity during such rapid change of the landscape of NHS and children and young person's mental health needs. Possibly these are conducted, but not suitable or appropriate for research journals, as discussed previously, there could be other dissemination pathways amongst nurses. Reviewer bias is also a potential limitation, however efforts were made to mitigate this by each reviewer second screening a randomly selected 10% of others' suggested included and excluded articles ($n$ = 534), to identify agreement or bias. Agreement was met in vast majority of cases, with only 7.30% ($n$ = 39) in disagreement, but subsequently discussed and agreed upon. In summary, wider, or more thorough, literature reviews could be undertaken to establish different or possibly more comprehensive results to the present scoping literature review.

In addition, the scoping literature review approach has several limitations. No formal quality appraisal was conducted on the included studies, so the confidence in the evidence has not been established. Furthermore, unlike a systematic review, the results tend to be descriptive and broad in nature rather than narrow and inferential (Sucharew & Macaluso, 2019). Despite these limitations, this literature review provides a broad perspective of the body of literature and provides a springboard for future, more beneficial research.

### 2.5.4 Suggestions for future research or practice

As it is difficult to identify current practice, making recommendations for future practice is problematic; the absence of a quality appraisal further compounds this (Peters, et al., 2015). It could be that future interventions incorporate more digital or online interventions, but further research is needed to identify the feasibility and suitability of such interactions on the therapeutic alliance between patients and nurses. Secondly, interventions identified were primarily preventative as opposed to reactive. It is not clear if this is an accurate representation of typical nurse-led interventions, therefore more research could identify if there are gaps in type of intervention for nurses to more effectively implement.

Given the large amount of excluded studies on the basis of minimal or no nurse involvement (despite recommendations that nurses carry out the intervention proposed); it is important for researchers to co-produce the design of their intervention research with nurses, and that they participate in the studies themselves. Not only could this make the results more ecologically valid, it would also enable increased engagement with continuing professional development for evidence-based practice, and ensure the intervention is feasible for nurses to be trained in and to implement in practice. Overall, greater clarity in communicating with nurses regarding research into evidenced-based practice is recommended.

Finally, an overall finding suggested a general lack of time; for nurses to carry out their role effectively, for nurses to be involved or consulted in research identifying suitable interventions, for nurses to access training for interventions and improve confidence and for nurses to meet rising demands for supporting children and young person's mental health and wellbeing. This is further suggested by included studies that identified a need for pathways to be more efficient and streamlined and for interventions to be more efficiently delivered online. It is recommended that future research explores time utilisation within nursing. For practice, it is recommended that nurses are given better, more evidence-based support and consulted appropriately about their roles.

## 2.6 Conclusion of scoping literature review

This scoping literature review yielded results of primarily preventative interventions from a handful of UK studies, more when the search was extended to countries with similar healthcare systems. By its nature, a scoping review of the literature is limited, therefore it is difficult to draw firm conclusions on effective mental health interventions for children and young people. However, this finding, in itself, is still of value in providing insight into evidence-based practice and gaps for research.

The general theme running across the studies (included or rejected), is the inefficient use of time or communication, which runs alongside the current context of the increase in demand for support of children and young people's mental health and wellbeing. Research with clear communication and dissemination is vital in the current changing landscape for the NHS and children and young people's mental health, for example, growth in digital interventions or changes in nurse roles and structure could be effectively scrutinised for the wide-reaching benefit of many. Studies, and the subsequent recommendations provided, are only helpful if they can feasibly be implemented. Nurses should be involved in any research that makes recommendations to their practice, and identified explicitly to aid clarity and communication between research and current practice

# Part 3: Modified Delphi study

## 3.1 Overview

Delphi studies are generally utilised when there is little previous work in the field; where uncertainly about approach/policy exists; and to develop practice guidelines (Mead and Moseley 2001). The method generates language for analysis, which has salience as 'the way we speak meshes with our lives, is interwoven with our behaviour, actions and reactions' (Hacker 1997, p50). Therefore, informed by the literature review, a two part modified Delphi study was subsequently undertaken.

The Delphi method is a proven method of investigation that uses an expert panel to reach a consensus via a number of iterations (Dallos and Vetere 2005, Baker et al 2006, Murphy et al 1998, Mead and Moseley 2001). Delphi is characterised as a method for managing effective group communications and is effective in allowing a group of individuals, as a whole, to deal with a complex problem (Tinstone and Murray 1975). This approach enables professionals to 'respond in their own time rather than attend meetings' and facilitates the management of 'powerful people in a group' (Cook and Birrell 2007, Beretta 1996) and frankness of panel members (Mead and Moseley 2001).

The 'expertness' of the experts (Baker et al 2006, Sumsion 1998, Jeffery et al 2000, Keeney et al 2001) relates to the survey's inclusion and exclusion criteria and is complicated by the vagaries of the terms experience and expertness. Experts in the context of this review were defined as having both relevant experience and theoretical knowledge (Scheele 1975).

## 3.2 Round 1 Delphi Survey

### 3.2.1 Round 1 method

The Round 1 survey was an open ended, semi-structured questionnaire which, after piloting, was circulated by email and made available as an online survey. The questions were informed by the findings of the literature review (outlined previously) and covered nurses' knowledge of evidence base interventions, their use of these and other helpful interventions and the blockages to their use.

Nurses were recruited using a priori inclusion and exclusion criterion, the main ones being that the respondent was a nurse and currently working with young people's emotional and psychological wellbeing. Round 1 used opportunistic sampling, with open invitations to respond made through various professional groups:

- RCN membership communications
- Health Visiting professional groups
- School nursing professional groups
- CAMHS networks
- Mental health Nursing professional groups and networks

This was augmented and facilitated by using NIHR network research centres that enabled the survey to be advertised across the four countries of the UK and within the CRN portfolio. The local CRN Yorkshire and Humber offered direct support to the research team. Multiple conversations were had across the country with NHS Trust research and development departments and the ethics bundle sent to all recruited Trusts for capacity and capability approval.

When analysing the responses, the established rules in managing qualitative data were followed ie. all blanks and repeats were deleted, 'as above' responses were populated with the relevant wording to aid coding, and to manage the location and region of the respondent. The professional groups were also cleansed in light of the respondent's primary work area. For example, several school nurses noted they were also Health Visitors, but the data clearly suggested they were working in a school, so they were coded as school nurses. Likewise the two mental health nurses who worked in schools were coded to school and so on.

Braun and Clarke (2006) outline a six phase approach to thematic analysis which includes (1) familiarisation with data, (2) coding of the data such that the entire dataset will be reviewed such that each piece of relevant text (data) is tagged with a code, (3) consideration of themes, (4) revision of themes, (5) analysis of individual themes and (6) write up. A theme is noted when something important about the data arises relating to the research question and has a recurring pattern emerging form the dataset.

Themes can be triangulated by using other researches to explore the data; they can then be revised as necessary. This process ensures scientific rigour, methodological accuracy and trustworthiness (Tavakol & Sandars, 2014; Kitto et al., 2008). In round one, the PI's initial analysis of the full data set was triangulated with the research team's school nurse and health visitor's coding and theming of their own professions' responses.

### 3.2.2 Round 1 respondents

Questionnaires (n=244) were received and sent directly to the research assistant to ensure anonymity of respondents and mitigate researcher bias during the thematic analysis.

The majority of responses were from England with the full breakdown of locations as follows:

| Country | Count | % |
|---|---|---|
| **England** | 201 | 82.4 |
| **Scotland** | 31 | 12.7 |
| **Wales** | 9 | 3.7 |
| **Northern Ireland** | 2 | 0.8 |
| **UK** | 1 | 0.4 |
| **Total** | 244 | 100.0 |

Table 11 Respondents by country

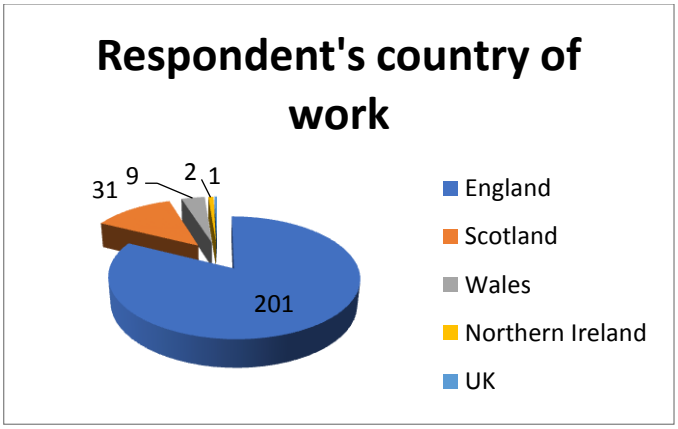



Figure 3 Respondents by country

A more detailed breakdown of the counties represented can be seen on the map below:

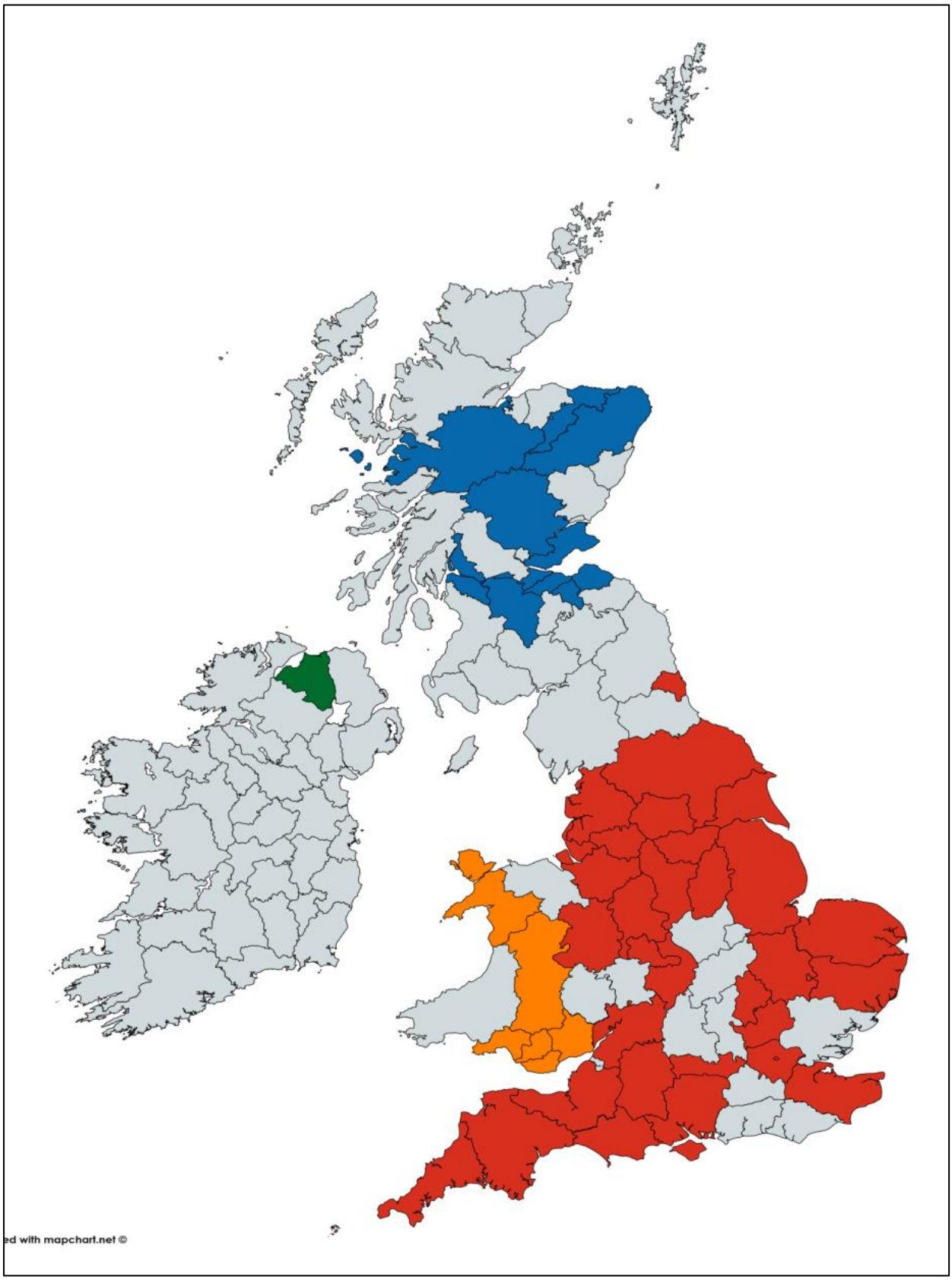



Figure 4 Respondents by county

The respondents represented a diverse range of specialisms, listing them as:

| Nursing specialism | Count | % |
|---|---|---|
| **Registered General Nurse** | 6 | 2.5 |
| **Practice nurse** | 3 | 1.2 |
| **School Nurse** | 56 | 23.0 |
| **Registered Sick Children's nurse** | 11 | 4.5 |
| **Health visitor** | 41 | 16.8 |
| **Registered Learning Disability Nurse** | 8 | 3.3 |
| **Registered Mental Health Nurse** | 91 | 37.3 |
| **Family nurse partnership nurse** | 16 | 6.6 |
| **Other** | 11 | 4.5 |
| **Blank** | 1 | 0.4 |
| **Total** | 244 | 100 |

Table 12 Respondents' specialisms

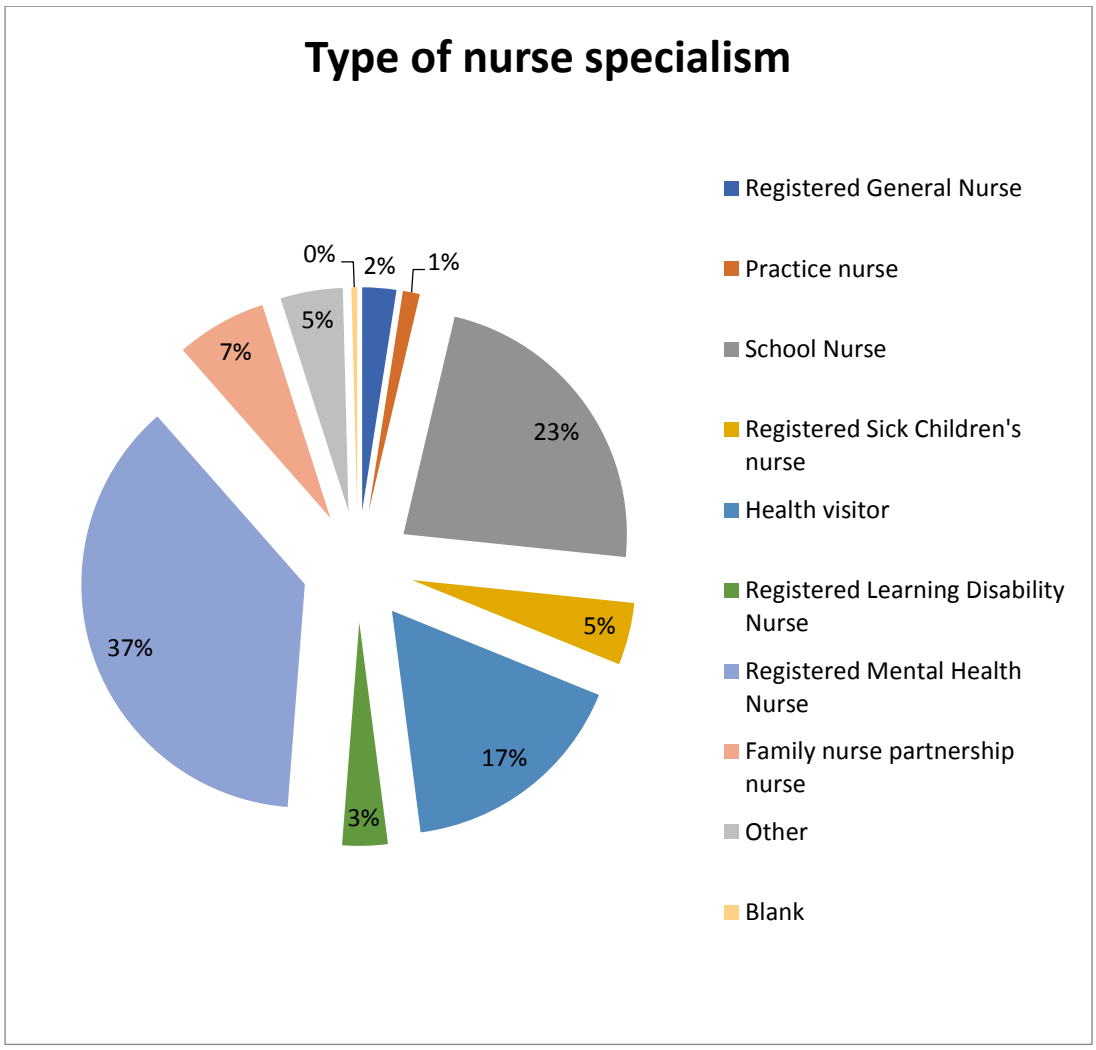



Figure 5 Respondents' specialisms

In terms of their experience, collectively the respondents had been qualified for 4,628 years with 3,073 years of these spent working with children and young people. The mean length of qualification was 19.6 years (S.D. 12.4) whilst the median was 20.0years. The mean number of years spent working with children and young people was 12.8 years (S.D. 9.3) while the median was 10.0 years.

The mean lower age of children/young people treated was 3.8 years of age (S.D. 4.6) and the mean upper age limit was 18.6 (S.D. 10.5). See figures 6 and 7.

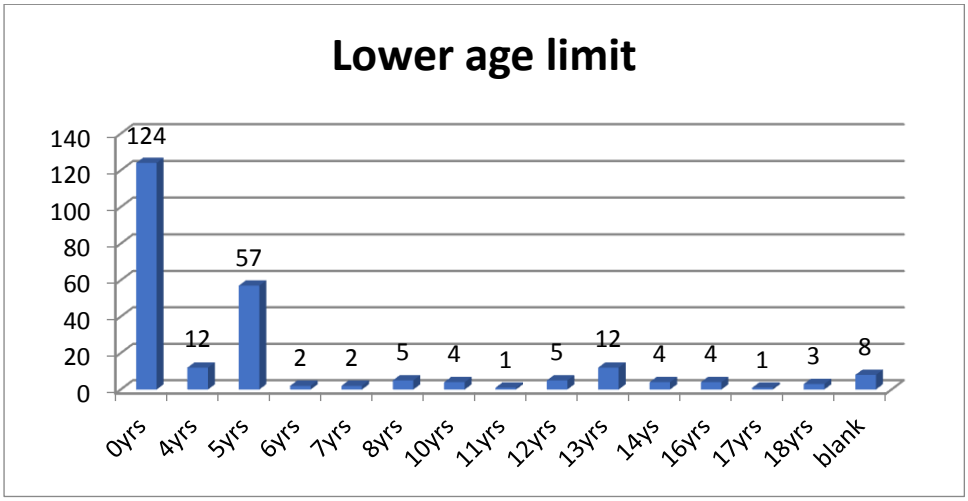



Figure 6 Lower age limit of referrals accepted by respondents

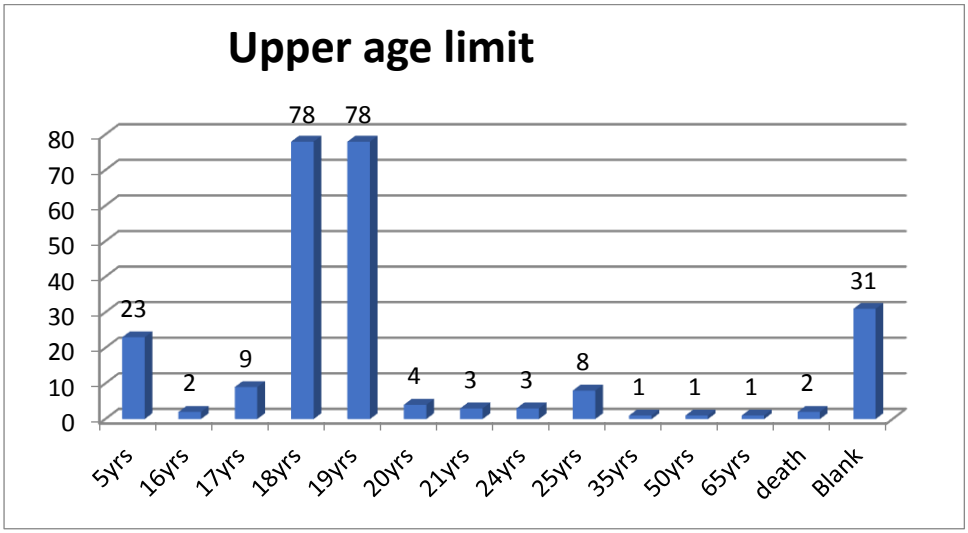



Figure 7 Upper age limit of referrals accepted by respondents

Hence, the typical age range of children/young people treated by respondents was 4-19.

After screening, the responses were reduced to n=100 with meaningful data for thematic analysis and representing nursing (as opposed to other professions). We can only speculate as to the reasons for this somewhat disappointing level of incomplete responses, nevertheless, those that did respond were generous with their time and contributions and a significant amount of data regarding nursing practice from England, Scotland, Wales and Northern Ireland was gathered for analysis.

### 3.2.3 Round 1 results

#### Question 1 what evidence-based nurse led interventions

There were 84 different codes initially attached to the data and these were organised into 15 headings (Table 13).

*Table 13. Question 1 node headings*

| CBT | DBT | Family and Systemic | SFT | Motivational Interviewing/ Motivational enhancement | Mindfulness and relaxation | Behavioural Management/ Solihull/Incredible years/resilience | Therapeutic Relationship/ Counselling | Family Nurse Partnership | Group | Other Creative | meds | Other Therapy | Manualised Approaches | Assessment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

#### Cognitive Behavioural Therapy (CBT)

CBT is a well-supported intervention for both young and adults alike and has an established evidence base. 44 comments related to CBT were coded representing 44% of the adjusted sample (table 14). CBT was simply noted three times (R204, R213, R221) but also, as in line with NICE Guidance (R34, R121, R175) and CYP-IAPT (R29). Several respondents noted CBT as effective for particular presentations (Table 12).

*Table 14. Presentations suitable for CBT*

| | | | | |
|---|---|---|---|---|
| Combined with LIAM for anxiety (R10, R39, R139 R166, R217) | Depression (R29, R30, R39, R60, R124 R166) | Trauma (R39) | OCD (R39, R60, R124) | Self-harm (R121 R166) |
| Challenge negative thoughts (R19, R30, R60) | Self-esteem or low confidence (R162) | Coping strategies to manage emotional health and wellbeing (R124, R139) | Stress (R166) | Eating disorders (217) |

The narrative comments provided useful clarification.

- R192 noted the use of CBT 'as part of evidence-based practice as common place', their services use a variety of interventions, based around the Five Ways to Wellbeing, which is CBT-based and follows a 'holistic assessment based on the Assessment Framework' (R192).
- R193 noted the use of CBT for dysregulated emotions…'a lot of young people benefit from CBT to change their thinking and improve their resilience and skills set but making better decisions'.
- Using CBT helps 'restructure thought processes and can alter core beliefs which can lead to improved self-esteem, more effective functioning in school and within their relationships' where 'graded exposure elements and Psychoeducation can improve social functioning and help young people face their fears' (R214). Altering thinking was echoed by R42 to work on irrational and/or over-reactions to situations and 'allows the young person to break the issue…so that the overall problem is no longer overwhelming' (R42).
- In managing self-harm 'The NICE guidance on self-harm (which is useful when we have children or young people who are engaging in self-injury) is clear about using

CBT/psychodynamic or 'problem solving element' and this is something that nurses are able to do well in general' (R121).

- CBT was used in combination with family based interventions 'enabling young people to get on with their lives and flourish instead of becoming disabled by these conditions' (R60) and in school based environment 'allowing children and young people to manage their needs with support from a professional' (R192).

It was also noted that the principles of CBT can be applied by practitioners in supervision for school nurses who are not trained in the approach i.e. PPEP care (R192). One creative application of CBT was in a surfing therapy school noted by (R201).

However, although it was noted that there is an evidence base (and NICE guidance) for CBT, two respondents observed a contrary position in that 'it isn't the answer for all' because children and young people 'are part of a systemic system which more often than not require changes/adaptations to result in improvement of the young person via individual work - as such family/systemic work is critical in most cases for individual therapies' (R175). R39 echoed this point finding CBT to be 'very effective for some young people who engage in it but others have not found it helpful at all and it can be difficult to identify in advance who can benefit'.

### Dialectical Behavioural Therapy (DBT)

DBT was coded 14 times. To support safety and effective management in the most impulsive high-risk patients (R30) and as a 'Distress Tolerance / DBT skills training' either in a group or individual work (R39, R49). R166 used DBT in schools for emotional regulation and to inform supervision.

However, R39 noted that they had 'worked with young people who have found this way of working really helpful but have had others really not like it and have had difficulties engaging young people with the model'.

### Family and systemic approaches

A family and systems-based approach was coded 24 times. A number of respondents noted the term (R213, R217), working on 'positive family relationships and communication' (R124) and 'work well for children who come from dysfunctional families (R162). Working with family systems was useful at supporting the young person's psychological and emotional wellbeing (R121) and R10 noted their training and that they use Family Therapy (and IPT) therapeutic approaches extensively in their clinical practice.

R30 noted family interventions as vital to be incorporated into management to ensure that Care-giver is able to gain a better understanding of the difficulties and to support young person's appropriately (R30). R62 noted that 'the ability of the nurse to also work with the support networks young people have including family members is vital in enabling ongoing recovery'.

Children and young people were considered part of a systemic system and family system which more often than not required changes and adaptations to result in improvement for the young person (R175) and that 'interventions within CAMHS are more effective if systemic elements are introduced' (R39). However, R39 commented that 'sometimes parents seem put off by the idea of family therapy and there are issues around feeling blamed so I have found it

needs to be introduced properly and sensitively… additionally a lot of young people do not want their parents to be involved in any of the offered interventions and this also needs to be respected. Where families are willing to engage and on board with the model, I have seen very positive results. This does also require the nurse to have extra training in systemic approaches'.

R218 and R219 worked within the Family Nurse Partnership (FNP) model. This intervention has been widely researched. The programme is delivered based on the evidence gathered and continuous quality assurance/improvement methods applied. The intervention is strengths based and based on the needs of the individual client and their child. There are proven outcomes in relation to the short and long term social, emotional and health of the clients and their children (R218). The family nurse partnership programme is a relationship based, psycho-educational programme and had 40 years of research based positive outcomes for children and their parents. utilising motivational interviewing skills support the clients to discuss their intrinsic motivation, life goals, readiness to change and provides a respectful conversation where new information can be provided and evaluated. the use of PIPE (partners in parenting education) within FNP is an educational resource which is nurse led, in partnership with the programme to support parenting (R219).

MECSH (Maternal Early Childhood sustained home visiting) offering regular visits and a plan of support to more complex families until the child is 2- this amount of input is not for everyone and there will be drop outs when parents feel that they are doing well and no longer need the support (R117).

### Solution Focused Therapy (SFT)

R221 noted SFT to be part of their work. R117 noted that the solution focused approach is 'useful in getting parents to think about the most important things that they would like to work on as in complex situations what you feel is most important may not necessarily be what the family thinks is'. SFT 'compliments short term support for identifying children and young people's own solutions' (R166).

### Motivational Interviewing/Motivational Enhancement Therapy

Motivational Enhancement Therapy is 'excellent as it works collaboratively with the young person and helps develop an intrinsic belief in change & recovery' (R19). Whereas 'Motivational Interviewing – to support the early conversations building trust, openness and focus' (R28).

### Mindfulness and relaxation

Nine comments relating to mindfulness and/or relaxation were coded. R11, R28, R30, R110, R124 and R215 noted the use of mindfulness either in schools, where children are excluded from schools, or mental health practice and in school where children are excluded from school. Mindfulness was noted to 'get kids integrated back into school, manage emotional wellbeing' (R28), 'skills sharing techniques to manage stress/ anxiety' (R30), and 'allows young people to calm thoughts, be in the here and now' (R124). Mindfulness was noted to help 'increase resilience, improves relationships, reduces impulsivity and helps young people regulate and manage their emotions more effectively' (R214). Relaxation was noted by R221, R124, and R23.

### Behavioural management/Incredible Years

Behavioural management, Solihull, Incredible years and resilience was coded 24 times. Behavioural activation/approaches: 'Behavioural activation techniques…does have a good evidence base for depressive presentations' (R10) and 'to manage moderate/ severe depression and to support management of risks' (R30).

### The Solihull Approach

The Solihull Approach was noted to be 'from antenatal period until 19 this can provide insight into wellbeing by parents understanding the dance of reciprocity in order to be able to support their child development, brain development and as a result this will enable the children and young person to develop resilience and self-esteem' (R22, R132). The approach supports parents in 'understanding, managing and supporting child's emotional wellbeing (R80) Solihull is useful to use when working with children and young people as it helps you understand the development of the baby brain and links in with adverse childhood experiences which can impact upon a child or young person's emotional well-being' (R186).

R117 noted that the Solihull Approach has a 'clear evidence base, uses a strengths based approach, underpins the approach for all work with families allowing them choices about the approaches they want to take without being told this is what you have to do.'

### Therapeutic relations/Counselling

The therapeutic relationship/listening comments were coded 23 times. These related to the important of understanding and managing the therapeutic relationship and Rogers' core conditions.

R121 noted that the 'development of a strong therapeutic alliance, is important at allowing children and young people to meet their needs for psychological and emotional wellbeing.' R14 noted that 'Nurses need to have additional talking therapy skills.' This was echoed by a number of respondents who had trained in differing psychological and therapeutic approaches.

The therapeutic relationship is most important because 'without that any model will be less effective' (R34). The 'Provision of an intentional, attuned adult, who with whom to forge a relationship, in which experiences can be emotionally and physically contained and made sense (R24). Finally, R62 commented that 'I think the therapeutic relationship is fundamental. Beyond this I think young people are wanting knowledge and understanding about the difficulties they are experiencing and the role of the nurse is helping to put this into context of their own situation .There is lots of information out there but hard to make sense of what is relevant and applicable. Then I think skills and coping strategies are important and for nurses to help young people think about how to use these in their life to help reduce distress and build confidence and abilities to manage stressful aspects'.

Drop in/Schools based counselling and listening emerged as a node where R16 noted that 'We recently (October 2019) weekly `drop in sessions` in each comprehensive school in Gwent to address the EWB needs of children and YP.' Schools need to 'provide counselling sessions and mentorship which supports children in school' (R162) to provide 'space for young people to discuss thoughts, feelings and experiences' (R124) in order to provide 'listening, supporting and sign posting as needed to specialist professionals (R165). An 'Opportunity for young people to be able to speak with non-school staff within a private

environment and offering a confidential service is an essential nurse- led intervention. This is evidenced not only nationally by BYC for example, however, is also the feedback from local young people' (R192). MECC (Making every Contact Count) was noted by R16 who incorporated MECC in their schools based work.

Parents counselling was included, listening visits for parents, and conflict resolution for parents of young children, emotional support for parents in the early years (R57).

Interpersonal Therapy (IPT) was noted four times, IPT for adolescents (IPT-A), an exploration of relationships and mood and how these links and impact on each other. 'Allows space to explore positive communication skills to develop more effective and positive interpersonal relationships which young people can continue to use into adulthood. Relationship context includes; family, friends, school/work. I have been offered this type of therapy for the past year and out of all clients only one did not have reduced depressive symptoms' (R124).

### Group Interventions

Groups were mentioned eight times for managing emotions, resilience, and specific topics (R192). DBT informed skills group (R49), 'groups…run by the Nurses…as an early intervention for young people referred to service' (R66), 'use for tools such as Book start for brain development and attachment'(R82).

R114 noted 'I feel that group work, in regard to any therapy, is proven to be effective within young people's mental health services. Following the groups young people find not only the skills and knowledge they have gained form the group beneficial but also the fact that no longer feel isolated in their struggles. They are able to communicate and share experiences with other young people who may be struggling with similar things.'

### Assessment

Several responses noted standardised assessments or aspects of assessment as part of their practice either once or with an increased frequency. These are collected in the table 15 below:

*Table 15. Frequency of assessment responses*

| | | | | | | |
|---|---|---|---|---|---|---|
| HADS | LAC | formulation | ORS and CORS | Emotional health | mental state exam | YP CORE |
| Holistic assessment (n=3) | Risk assessment (n=3) | Whooley (n=2) | GAD2 (n=2) | Edinburgh PNDS (n=2) | adolescent wellbeing scale (n=1) | Brazelton (n=2) |

R221 noted the relational aspects of assessment whereby 'Many patients (who are mostly HE students), find the process of nurse led psychiatric assessment and shared formulation itself to be extremely enlightening and empowering. I believe that many have not previously been involved in such a thorough process in which there is a clear partnership, with respectful honesty and clear boundaries (in an adult sense)'.

R119 noted that they 'undertake holistic health assessments for young people who are in the care system, where the focus is on listening to the young person, considering how to support them, I might suggest techniques for managing stress and anxiety which I have picked up from my CAMHS colleagues, but I have not had any specific training in these, ' and R34 commented that 'I use formulations which are fluid and evolve over time rather than fixed diagnosis'.

### Medication

Medication-focused interventions (including nurse prescribing observations and compliance support) were mentioned five times, either as an adjunct to talking therapies, or in relation to NICE guidance. Nurse prescribing 'for the group of young people who can benefit from psychotropic medication, this is an effective intervention with a good evidence base. Non-medical prescribing has increased access' (R39).

### Manualised approaches

Several responses noted interventions/approaches as part of their holistic care. There were 15 approaches coded:

*Table 16. Frequency of manualised approach responses*

| | | | | | | |
|---|---|---|---|---|---|---|
| LIAM (Lets Introduce Anxiety Management (R10, R139) | 5 ways to wellbeing (R10, R139) | Make every Contact Count (MECC) (R16, R23, | Mentalization based therapy (R34) | HAPI (Lancaster model) (R41) | 4-5-6 model (R40) | Family Nurse Partnership Programme (R46) |
| resilience toolkit (R94 and R98) | Mental health first aid (R94 and R96) | Roar in primary schools (R96) | Thrive approach (R98) | Webster Stratton Parent program (R105) | Good Lives Model (R159) | Mind resources (R171) |
| 'Self-regulation theory' which relies on the individuals own conscious personal management that relies on them directing their own thoughts beliefs and actions which will get them to their goal quicker (R161) | | | | | | |

### Creative

*Table 17. Frequency of creative approach responses*

| | | | | |
|---|---|---|---|---|
| Yoga (R26) | Social Inclusion work (R39) | Dance Movement Psychotherapy (R49) | Horticulture Based Therapy (R105) | Art therapy/Art Psychotherapy(n=3) |
| Psychodrama- (R105) | Heart of the home, Lego house, Worry boxes (R171 | Creative Therapies (R105, R124) | Surfing therapy (R201) | |

One respondent noted that creative approaches can have a 'hugely beneficial impact upon the emotional wellbeing of young people but am aware there is not a good evidence base for this type of work Psychoeducation for children / young people and their parents - this is foundational and seems to be one of the most effective interventions whatever the presentation' (R39). Whilst R124 commented that 'creative therapies largely focus on the therapeutic relationship and creative expression'.

### Other therapies

*Table 18. Frequency of other therapies responses*

| | | | | | | |
|---|---|---|---|---|---|---|
| CAT | ACT | Decider Skills (N=2) | strengths based (R20) | Reciprocity (R23) | EMDR (n=4) | Milieu therapy |
| Cycle of change | | Holism (n=2 | E-Clinics (n=2) | Brief Interventions | Resilience | Psychoeducation (n=3) |

Cognitive Analytic Therapy (CAT) and Acceptance and Commitment Therapy (ACT) were each mentioned once (R1, R10), decider skills twice (R5, R86) and strengths-based interventions three times (R20) Four respondents noted Eye Movement Desensitisation and Reprocessing (EMDR) (R34, R38 , R84, R128), Psychosocial models (PSI) once (R14). Interpersonal therapy (IPT) was a repeat (R1, R84) as was Holistic Approaches including individualised and person-centred formulations (R101).

R16, R164 and R184 noted the use of early interventions: 'We provide early interventions and prevention initiatives in schools, referring on signposting to services where appropriate' (R16). 'Early nurse intervention with emphasis on prevention. Specialist knowledge of young people's behaviour especially teenage pregnancies, pregnant young people without family support and or isolated. Early and intensive nurse input have been shown to support a positive mental wellbeing and positive parenting outcome' (R164). 'Any early intervention with the new-borns then the new-born behavioural observation is the earliest intervention' (R184).

Restorative practice 'enables relationships to be 'repaired' by understanding the issues from the person perspective and by using a process of high challenge and high support young people are able to work with the family and professionals as they are empowered to do this (R22)

Technology based interventions were noted three times, using apps, on-line - for some, and normalisation non problem related therapies (R26) and E clinics (171).

Psychoeducation regarding resilience and emotional wellbeing were noted as 'Basic strategies to improve wellbeing and resilience' (R66) but staff are 'limited in providing only 4-6 sessions of support, often young people want continued support but tier 2 and 3 mental health services are stretched with long waiting times (several months) and tier 2 only provide short-term intervention also' (R132). R192 noted that 'supporting resilience from a young age is essential to develop coping mechanisms as they transition into and out of secondary school'.

### Question 2 Important evidence-based interventions node analysis

Respondents made a significant contribution to this question. The data was coded to emerging codes that understandably mirrored the nodes in question one. Fourteen nodes emerged (Table 19).

*Table 19. Question 2 node headings*

| CBT | DBT | Systemic Family Practice | Solutioin focusse therapy | Mindfulness/relaxation | Behavioural apporaches | Motivational aproaches | Solihull | creative | Therapeutic relationship/Conselling | Assessment | group | Therapy pilot | Therapy other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

As a general comment, the respondents provided support for evidence-based and nurse-led practices, 'having an up-to-date knowledge of evidence-based practice as well as practice based evidence' (R34). R121 commented that 'nurses can use [evidence-based interventions], but I think the ability of the nurse to engage in these and to give them the attention that is necessary can sometimes be compromised by workload pressures'.

R66 commented 'Nurse led interventions are very effective and can prevent referral on to specialist services' further 'Nurses are good at meeting the young person in any environment and therefore the young person has better access to therapy at home or school rather than having to come into a clinic to be seen'. Whilst R166 noted that 'Nurse led interventions are often seen as non or less threatening than attending CAMHS or counselling, there is less stigma and children and young people can build their emotional literacy as part of understanding their; social, peer, relationships and physical well-being. Having direct access in school can aid attendance and regular ongoing follow on care'.

R84 commented that they 'believe acknowledging the importance of therapeutic attachments and the concept of the therapeutic alliance is also important before then considering progressing with other evidence-based interventions such as cognitive behavioural therapy or interpersonal therapy that nurses can be trained to use'. Therapies need to be developmentally and ability appropriate because 'the adolescence brain and child's developing brain needs action and play' therefore 'the workforce need to be confident to 'safely hold' the child. The key to using any approach is flexibility and skilled practice' (R26).

R192 commented on outcome measures whereby 'effectiveness needs to be measured by joint outcome measures, including feedback from YP/family, measurable ie RCADS and goal focused- to support the YP to see improvements/changes, to look at levels of motivation and to monitor any changes with any other aspects of life that may influence their emotional/mh difficulties.'

### Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) was frequently coded across the sample. It was noted that 'nurses can effectively use CBT and are free to use these interventions in their work' (R60). Narrative comments were supportive of CBT noting 'the majority of the needs have to do with emotional regulations…thinking processes that might need to be addressed from a cognitive aspect through CBT' (R1, R66). CBT based interventions 'have a good evidence base and are effective for a range of conditions' (R39, R42). CBT skills 'can be moderated to manage individual needs and to effect change through agreed programmes with child and family'(R30) and 'allows young people to develop coping strategies they can continue to use' (R124, R139).

CBT 'provides a structured approach that some young people find helpful to addressing Anxiety and low mood presentations' and 'OCD' (R98, R124). CBT for anxiety, very effective, particular where, for younger children parents are given the skills to use these techniques themselves (R95) and 'LIAM, developed by NES is something I have used for very anxious individuals' (R10, R139).

For 'eating disorders…recommended treatment for this is Family Based Treatment and CBT-e. All of my nursing are trained in these and they are highly effective at supporting young people to recover from their eating disorder' (R19). CBT was also combined with family based interventions, creative approaches (like surfing) (R201) plus medication (R35). Combined approaches are 'effective in CAMHS because using a family approach enlists the help of the parents as co-therapists. There is a shared understanding of the assessment and formulation and rationale for using the approach' (R35).

However, R112 noted 'I know that there is a lot of evidence for CBT interventions that nurses can employ but in my experience, there is sometimes a disconnection between the skills that the nurse has and the interventions that the young person needs.' This echoes comments in the question1 analysis i.e. that interventions are dependent on the situation. For example 'CBT is not recommended when children and young people are living in toxic or traumatic environments which is often when school nurses become involved. However, during my work as an early intervention practitioner both CBT and DBT can be effective as it provides strategies to manage well-being but also can support the identification of significant

concerns' (R166). R34 stated that 'It is also about what models suit/fit individual young people/families' (R34). Whilst R193 noted 'I do think CBT is affective for young people, but I also think they need quite intense sessions'. Hence, there was some challenge to CBT and other models that 'Simply addressing the problem using an experience perspective can be effective. As an adult professional I believe I have experienced many things in my life that enable me to impart knowledge and advice to young people who are less experienced at doing life' (R42).

### Dialectical Behavioural Therapy

Nine respondents noted DBT as an effective intervention. DBT is an approach that 'nurses can use but I think the ability of the nurse to engage in these and to give them the attention that is necessary can sometimes be compromised by workload pressures' (R121). DBT can be 'Hugely effective when delivered by a suitably skilled, experienced and resourced staff team'(R50), 'effective with the young people we work with as majority of the needs have to do with emotional regulation' (R1, R183) and 'can be effective as it provides strategies to manage well-being but also can support the identification of significant concerns' (R166).

Respondents noted various settings where DBT was practised. In an inpatient setting 'young people obviously struggle at times and we encourage them to use DBT skills as opposed to SIB. These need to be transferred to outside life, hence the work with parents also. However, managing in the moment in this setting is important' (R59). DBT Skills Groups delivered in CAMHS and into schools 'Provides young people with skills to support them in understanding and managing their emotional wellbeing. Reducing young people feeling helpless and hopeless and feeling that life is not worth living' (R98). Although young people with Learning Disability are not always subject to support (DBT) in these areas and I have found mainstream services are unable to support this client group' (R136)

### Systemic and family interventions

Twenty one comments were coded to this node under four themes; the relationship and communication, family therapy, systemic approaches and the family partnership model.

'Ensuring good communication with other professionals (R97), the therapeutic relationship and following NICE guidelines' (R34). One respondent noted they 'dabbled with (but have no formal training in) FBT…behaviour family therapy is well researched in CAMHS' (R10). R97 commented that 'nurses are in a good position to work with families because their job roles usually allow a degree of flexibility in the time they can spend with people' (R156).

Family therapy is seen as working on 'positive family relationships and communication' (R34, R124), allows the young person to 'be in a position to access individual work. This in my experience is usually key in a young person making improvements' (R175). 'Because we work with such young children, our job is to help parents to recognise early communication and emotional wellbeing in their infants and to encourage close and loving relationships' (R202).

Systemic Family Practice is recommended for Eating Disorders (R5, R19). One respondent had trained their staff in CBT and systemic FBT, viewing them as 'highly effective at supporting young people to recover from their eating disorder' (R19). Family approaches are

effective in CAMHS ‘because using a family approach enlists the help of the parents as co-therapists. There is a shared understanding of the assessment and formulation and rationale for using the approach’ (R35). ‘I know that there is good evidence (and in my experience good anecdotal evidence) for systemic practice and systemic interventions, and dyadic developmental practice for children and young people’ (R121). Systemic approaches needs to ‘include school, parents, [and] other agencies in supporting changes’ (R30). ‘I think systemic practice informed by attachment theory and a medical model approach in order to establish an effective assessment and emerging formulation is important’ (R84).

Family Partnership Model supports partnership with the YP (R28). The ‘evidence from the Scottish Government Revaluation study has shown that FNP clients are at significant risk of having multiple complex vulnerabilities that can have a profound effect on their psychological and emotional wellbeing and that of their children. I believe FNP is very effective due to the therapeutic relationship that is built up between the nurse and the client, the models that are used to deliver the programme, the training of the nurses, the importance placed on reflective and restorative supervision, motivational interviewing is used as the method of communication, strengths based approach and the client is seen as the expert in the own lives’ (R218). MI as FNP programme has also shown to increase self-efficacy (R220, R219)

### Solution Focused Therapy

Four comments pertained to SFT (R11, R128, R201 and R214). These however had no substantiating evidence or narrative just stating that this approach was an important evidence-based intervention.

### Motivational Approaches

Sixteen comments were coded to this node. There were only four comments that held any narrative for coding; the others just stated 'MI'. These noted that if ‘someone is able to create their own plan of how to address their concern they are more likely to follow that plan’ (R19), that MI helped to ‘support the early conversations building trust, openness and focus’ (R23), ‘to help young person to manage their own emotional wellbeing (R28) and was ‘non-judgemental’ (R134).

### Mindfulness and Relaxation

Seven respondents noted mindfulness or relaxation as an effective intervention. Relaxation and mindfulness provide ‘distraction techniques which allows young people to calm thoughts, be in the here and now’(R124). Mindfulness was able to help ‘children to thrive’ (R11), ‘manage their own emotional wellbeing’ (R28) and ‘used across the board with young people who are struggling to manage stresses of 21st century living’ (R30). R110 commented that ‘I have read evidence about mindfulness and practiced myself which I know work’ and R132 advocated the ‘use of apps to support them, such as SAM for anxiety, and breathing techniques apps such as calm, headspace’.

### Behavioural Approaches

Five comments were coded to this node. R10 and R26 noted the use of behavioural activation and this approach having an established evidence base. R156 commented ‘I think nurses particularly have an important role in delivering low intensity interventions specifically those

that are informed by behaviour change models. The reason for this is that they are discrete, feasible and can be packaged so that they can be delivered at scale'.

### The Solihull Approach

Two comments coded to the Solihull approach. 'Solihull Approach- from antenatal period until 19 this can provide insight into wellbeing by parents understanding the dance of reciprocity in order to be able to support their child development, brain development and as a result this will enable the children and young person to develop resilience and self-esteem (R22) and 'Availability of access to school nurses drop in and appointments, group/individual work. ie: Solihull, CBT, 5 ways to wellbeing' (R192)

### Therapeutic relationship

Nineteen comments were coded to the therapeutic relationship. These included 1-1, listening and counselling. 'Most important is the therapeutic relationship without that any model will be less effective' (R34). The therapeutic relationship building 'is core to the deployment of any therapeutic interventions' (R29) based on trust and respect (R49, R201, R211), 'confidentiality' (R63) 'to be able to be empathetic and supportive to their individual needs' (R163).

'Listening to the young person and then liaising with colleagues who can either advise me or see the young person' (R119). 'Active listening skills' (R215), listening skills for a child or young person 'to not feel judged about their worries helps them to share their concerns and be open about the impact it has on their emotional wellbeing' (R23). Listening visits are 'effective for early identification of issues, and enable signposting to appropriate services, advice and support, and prevention of escalation of risk, once involved' (R57).

Counselling has 'enabled the children to thrive' (R11), a 'space for young people to discuss thoughts, feelings and experiences' (R124). 'Working in partnership and openness builds trust with practitioner. Valuing young person and giving them a choice and ownership of their care. Information to enable them to make informed choice. Trusting and respecting their choice and if the choice is not a safe one explaining and highlighting reasons to them' (R164).

However, R208 noted 'Any evidence-based intervention is only effective if the young person engages and is motivated to work but many come seeking a magic answer and are unable to use evidence-based interventions'.

### Groups

Four respondents were coded to groups, one merely mentioned the word group (R159) and another (R132) noted ' I think a whole school approach is required to empower young people with knowledge of emotions and how to support themselves and others due to the scale of young people presenting with emotional wellbeing difficulties. Alongside regular groups that young people could access and 1:1 intervention'.

R66 commented 'Groups using principles are run by the Nurses in my team as an early intervention for young people referred to service' and R114 noted 'I feel that group work in regards to any therapy is proven to be effective within young people's mental health services. Following the groups young people find not only the skills and knowledge they have gained

form the group beneficial but also the fact that no longer feel isolated in their struggles. They are able to communicate and share experiences with other young people who may be struggling with similar things'.

### Assessment

Eight respondents noted some assessments they used in practice. These are presented in the Table 20 below:

*Table 20. Frequency of assessment responses*

| | | | |
|---|---|---|---|
| Whooley (n=2 | GAD(2) (n=2), | Edinburgh PND (n=3) | HADS (n=1) |
| General assessment (n=3) | RCADS (n=2) | ACE (n=1) | |

R221 provides a summary 'This is hard to prioritise. However, I strongly believe that thorough assessment and shared formulation, with the young person then being offered choices, undertaking shared goal and measurement criteria setting, is critical to whichever therapeutic modality is appropriate for their needs. I appreciate that I am not working with under 16s, wherein the approach is necessarily different. Having some expectations of shared working is critical, and thus may be their first experience of this'.

### Creative

Seven comments were coded that made reference to yoga (R26), on-line (R26), horticulture (R105), creative writing and drawing (R162), e-Clinic and apps (R171, R132), Art (R124 and R201) and surfing (R201)

### Therapy Pilots

Two respondents noted they were piloting or involved in newer approaches. One noted horticulture as a useful intervention (R51) and the other was involved in an ACE pilot in Wales (R16).

### Therapy Other

Twenty five miscellaneous therapy interventions were noted in this node (see table 21), including a number of repeats and it seems promising that such a range and spread of interventions are available across the countries.

*Table 21. Frequency of therapy 'other' responses*

| | | | | | | |
|---|---|---|---|---|---|---|
| Decider skills (n=1) | MECC (n=1) | Restorative practice (n=1) | Medication n=2 | Psychoeducation (n=3) | apps (n=1) | Mentoring (n=1) |
| IPT (n=3) | MDT (n=1) | EMDR (n=2) | Five-ways (n=1) | psychodrama (n=1) | NHS resources | Early intervention (n=1) |
| PSI (n= 2) | Cognitive remediation therapy (n=1) | Mentalization (n=1) | Resilience toolkit (n=1) | Art (n=1) | Strengths (n=3) | |

## Question 3 Which intervention do you practice node analysis

Each statement by respondents was coded and emerging nodes developed. These were inevitably influenced by previous coding.

### Cognitive Behavioural Therapy

Twenty five comments were coded to this node. Fifteen just mentioned using CBT or a CBT informed approach and three of these noted they had no training (R29, R34, R183) with one following a manualised approach (R66) and R221 noting the positive evidence base alongside other therapies.

The ability to personalise CBT interventions was praised. R30 commented ‘CBT skills can be moderated to manage individual needs and to effect change through agreed programmes with child and family’, in groups for ‘managing over exercise’ (R62) and ‘I use CBT and Decider Skills as the can be adapted to each individual and young people appear more willing to engage with something that isn't a script’ (R208). ‘I also use CBT approach and I think this helps restrictive thought processes and can alter core beliefs which can lead to improved self-esteem, more effective functioning in school and within their relationships. The graded exposure elements and Psychoeducation can improve social functioning and help young people face their fears’ (R214).

CBT based support. I am not a qualified CBT practitioner but use the principles effectively with secondary school aged children, they need to be willing and ready to complete all sessions. I have used this as an early intervention approach successfully with many children and young people in the community. It is evidence based, structured and with the correct explanation allows children and young people to understand and explore their own thoughts, feelings and behaviours without judgement and (for the most part) at their own pace (R166)

CBT for anxiety was (R139), ‘very effective…for younger children, parents are given the skills to use these techniques themselves’ (R95) and ‘I tend to use CBT skills mixed with some solution focused and counselling skills - an eclectic approach which young people appear to find helpful to them and less rigid’ (R98). R139 noted LIAM (Lets Introduce Anxiety Management).

### Dialectical Behaviour Therapy

Nine comments regarding DBT were coded. Four were just noting DBT, the other five made some narrative observations. R2 noted DBT ‘informed [practice] as that is my case load. I work to deliver managing emotions piece of work’ (R2), R48 ‘I believe this is a really positive model for young people with emotional regulation problems’ and ‘DBT informed skills to support young people to tolerate difficult emotions and learn more positive coping strategies’ (R30). DBT skills ‘have an evidence base within eating disorders’ (R36).

### Systemic and family Interventions

Twenty eight comments were coded to this node. These fell into three broad headings, Systemic family Therapy, Family Therapy and Family Partnership Model. It is interesting to note the prevalence of the FNP in Scotland and the emerging use of FNP in England.

**Systemic individual and family therapy:** R7 ‘practice systemic psychotherapy…and weave these into my nursing-ness. I find my nursing supports me organisationally, holistically with a family, knowledge re. assessment and risk assessment/planning’. R3 was trained by CYP-IAPT in Systemic FT and ‘systemic therapy underpins all my clinical work’(R20).

Recognition of the whole support system was important to respondents. ‘Systemic approaches to management of individual needs to include school. Not a one-size fits all approach’ (R19), systemic ‘engagement with the network (schools, families, carers)’ (R20, R22, R214). R62 uses this approach within 'eating disorder services'. Systemic practice ‘appreciates the contextual factors that inform young people's emotional wellbeing issues and allows for inter-agency working ‘(R42). ‘working with the whole system, can have greater outcomes in comparison to working with the individual only. One part of the system will have difficulties making or sustaining changes if the whole part of the system remain the

same' (R66). Research and evidence-based literature suggests the effectiveness of working with the whole family can have positive outcomes (R66, R56) and 'there is a positive response from children and families in general' (R56).

**Family therapy:** Several respondents had training in family and systemic interventions. R5 noted 'I have formal training in Family Therapy…I use these therapeutic approaches extensively in my clinical practice... I have used…Family therapy with young people with ASD…Systemic and Behavioural Family therapy is well researched in CAMHS'.

Four respondents noted family therapy as opposed to the FNP. R77 is 'part of the reflecting team for a family therapy clinic' R213 uses 'bits as I do not specialise in either 'and R65 'specifically deliver family intervention for psychosis because of my training and role'. R27 notes FT as 'address the whole problem rather than one element'.

**Family Nurse Partnership:** R18, as a manager, had 'introduced family partnership model into practice'. 'The model uses a uses a strength based, client led approach. It is based on developing a therapeutic relationship and underpinned by attachment, self-efficacy and human ecology theories' (R28), 'to support any plans in partnership with the YP' (R16), techniques from FNP (R17). R218 noted that FNP 'makes a difference. It is helping to break intergenerational cycles of inequalities in health and social wellbeing. The job satisfaction is fantastic.'

The approach of FNP was welcomed as were the component parts of 'psycho-educational manual, PIPE (partners in parenting education) as an educational, resource is nurse led, DANCE and Motivational Interviewing skills' are a foundation and have a strong evidence base (R211, R219, R220) and 'shown to increase self-efficacy' (R220). The 'strategy to look at change behaviour work in line with the FNP programme is invaluable to help support young women emotionally' (R230).

### Solution Focused Therapy

Six comments were coded here. Two just mentioned SFT (R98, R214), the other three noted that 'Mindfulness and SFT have seen some very positive results' (R11), which includes some 'scaling' (R26) and as part of the Solihull approach where 'I like the focus on listening and allowing children and young people to make choices for themselves. The approaches also give space to not be right and to try again a different way (R117).

### Motivation

Twelve comments were coded. One used Motivational Enhancement Therapy (R19), three others just mentioned the term MI (R20, R82 and R171). The remainder noted MI was used to 'support the early conversations building trust, openness and focus' (R28) and 'MI techniques when seeing/assessing young people 1:1 and then find appropriate resources' (R41).

Motivational interviewing and strength based approach build clients self-efficacy (R216, R217, R220, R240). R219 noted 'MI skills support the clients to discuss their intrinsic motivation, life goals, readiness to change and provides a respectful conversation where new information can be provided and evaluated'. R230 said 'In my opinion the strategy to look at change behaviour work in line with the FNP programme is invaluable to help support young women emotionally. The communication skills that are embedded in the spirit of

motivational interviewing is highly effective. I feel these combinations bring about the young person's self-efficacy and support their emotional wellbeing as transitioning to parenthood'.

### Mindfulness

Five comments were coded. One stated they had practiced Mindfulness (and SFT) had seen some very positive results (R11, R214), were ' used across the board with YP who are struggling to manage stresses of 21st Century living' (R30 and R110) and that the intervention helped 'YP manage their own emotional wellbeing (R28). Respondent R28 was no longer patient-facing but had introduced family partnership model and mindfulness into clinical supervision.

### The Solihull approach

Was noted as an approach to 'encourage the containment of emotions, for parents and children, and reciprocity (i.e. mutual empathy)' (R95) and R117 liked 'the focus on listening and allowing children and young people to make choices for themselves. The approaches also give space to not be right and to try again a different way'.

### Therapeutic Relationship

R62 noted 'The feedback we receive on service experience tends to consistently highlight the value of the relationships with professionals rather than individual therapies so feels like an integrated package of care'. The therapeutic relationship is a 'client led approach. It is based on developing a therapeutic relationship' (R46). R230 notices communication skills arising from motivational interviewing are effective and can 'bring about the young person's self-efficacy and support their emotional wellbeing as transitioning to parenthood' (R230).

In Wales one respondent noted they have 'School based drop in service' where 'all the young people who present are listened to…Most of the time YP just want someone to talk to (R16). The provision of informal counselling 'gives the children to talk about worries and feelings then we set goals around these the children talk about solutions and their strengths' (R11).

R23 noted 'at the level I work I have found having a listening ear for a young person to be very effective, the young people have reported back to me that they have felt the service to be very valuable and that having time to talk over their issues of concern has helped them to lift some of their burden of worry' (R23). Listening skills were noted on several occasions 'listening, positive, honest approach (R26), 'listening visits' (R57) 'face to face' (R97) 'One to One talking therapy' (R63) 'active listening skills' (R215), 'counselling skills'(R98) and 'I use the basic training I have had in listening skills, awareness of emotional wellbeing and strategies to offer 1:1' (R132).

### Groups

Only three comments were coded to groups (R29, R34 and R62). Only R62 made a qualitative comment i.e. 'We find that group, as well as individual therapies are helpful to have available as they increase choice, help reduce feelings of isolation and parents value carer support with others'.

### Assessment

Twelve comments were coded here (see table 22 for the specific clinical tools mentioned).

*Table 22. Specific clinical assessment tools cited*

| | | |
|---|---|---|
| Whooley questions | Edinburgh PND score | MECC |
| GAD 2 score | HADS | |

R221 makes an extensive comment here; 'I strongly believe that thorough assessment and shared formulation, with the young person then being offered choices, undertaking shared goal and measurement criteria setting, is critical to whichever therapeutic modality is appropriate for their needs…This is because I have learned over the years that my client group respond well, with positive results, with actual skills acquisition that empowers and leads to independent self-management in future'.

Rating scales contribute to the assessment 'however none are entirely effective and need to be used with professional judgement' (R9). Respondents noted their core training as a nurse 'supports me organisationally, holistically with a family, knowledge re. assessment and risk assessment/planning' (R7).

R16, R18 and R41 signposted clients after assessment. 'I generally do the assessment and then signposting' (R18) and 'assessing young people 1:1 and then find appropriate resources' (R41). 'All the YP who present are listened to and assessed, the school nurses either complete an intervention or signpost/refer to services (and support until seen)' (R16). Both R16 and R164 maintained support for their client they assessed until services were available; 'Referral to specialist mental health units whilst still maintain regular contact with person-talking and listening therapy visits and building trust' (R164).

R119 and R57 noted 'Health assessments…are part of my daily practice' and 'mental health assessment' (R57). Others 'risk assess young people daily and work with the young person and family to put in safety plans to try and prevent hospital admissions'(R114).

### Creative Approaches

Five comments were coded here and were noted as 'school drop in' (R16), 'ACES Pilot' (R16), 'walking and talking/drawing' (R26), 'horticulture' (R105), drama (R105), 'art' (R162), exercise' (R162), and '5-Ways' (R192).

- ACE: 'School nurses in Blaenau Gwent were involved in an ACEs pilot with Ebbw Vale Comprehensive' (R16)
- Art: 'I normally draw a house and ask a young person to write all the good things they need in their house and then ask them what they have not put down and why that way they normally tell me and then we all decide what we could do to make things better' (R162)
- Exercise: 'I normally encourage clients to join activities such as boxing gym were they can let out their anger and frustrations' (R162)

### Therapy Other

Thirty six comments were coded to this node (table 23). There were some repeats and one abbreviation (ABA) that could not be identified.

*Table 23. Frequency of 'therapy other' responses*

| | | | | | |
|---|---|---|---|---|---|
| Restorative practice (n=1) | Mentalisation (n=1) | Experienced based interventions | Positive behaviour support (n=2) | Crisis resolution (n=1) | CAT (n=1) |
| supervision (n=1) | Nurse prescribing (n=1) | sexual and reproductive health (n=1) | MH first aid (n=1) | ABA | Self-regulation (n=1) |
| Medication (n=2) | Psychoeducation (n=3) | PSHE (n=1) | Resilience toolkit (n=1) | Evidence-based (n=1) | RCADS (n=2) |
| EMDR (n=3) | Own packages (n=1) | Public health (n=1) | Brazelton NBO (n=1) | Decider skills n=2) | PIPE (n=1) |
| MDT (n=1) | Strengths (n=3) | IPT (n=3) | Triple P | Incredible years | |

Of the coded responses, seven included qualitative comments:

- 'RCADS provides a baseline of what interventions may be required and whether further advice' (R186)
- Self-regulation because ‘the individual is limited to time with us and they have to help themselves. If an intervention/theory comes out guiding us to provide quicker support then I will adopt that one’ (R161)
- Interpersonal therapy (IPT) ‘because I am trained in this and feel it is a highly effective therapy/intervention which is evidence based and recommended in NICE guidelines’ (R124).
- The Solihull Approach ‘I like the focus on listening and allowing children and young people to make choices for themselves. The approaches also give space to not be right and to try again a different way’ (R117), ‘Solihull approach to encourage the containment of emotions, for parents and children, and reciprocity (i.e. mutual empathy)’ (R95) and ‘in supervision of team members’ (R22)
- EMDR ‘effective and quick therapy. can be non-verbal and works well with young people who struggle to talk about their emotions / memories’ (R66)
- Self-developed approaches were mentioned twice. 'Experienced based approaches' (R42) due to not having any formal training in CBT and R24 noted they created their own packages of support using available resources from tier 2 services.
- Strengths based to build clients self-efficacy (R216, R240)

## Question 4 Experience to undertake intervention node analysis

### Supervision

Sixteen respondents noted supervision as part of knowledge and skills to deliver effective interventions. A number only mentioned the term supervision or continuous supervision (R5, R19, R20, R46, R82, R124, R160, R201, R214, R211). The respondents commented that supervision should be regular (R5), to examine the quality of practice (R22), effective practice application (R60) as ongoing support (R139, R156) and adequate (R183). R215 noted the support from other professions such as psychology.

### DBT

One response coded to this where the respondent stated ‘I just read the manuals and the DBT informed decider skills manual, however I am due to have intensive DBT training in February’ (R1)

### Experience

Twenty six comments were coded here and there were a number of observations by the respondents as to the importance of having experience in the field.

One comment was particularly extensive and informative ‘As an experienced nurse and health visitor I can quite often tell how my clients are feeling and use my experience to draw them out more rather than relying on a questionnaire. I work in a very deprived area and not all clients can read, understand the questions or speak English and it is difficult to support with mental health issues through an interpreter. There is no point giving the questionnaires if you have no skills to respond to the client’s response’ (R9).

Core experience in nursing was echoed by R221 who noted ‘My broad MH nursing experience has always stood me in good stead, but I firmly believe that if working in a nurse-led setting, that considerable years if experience, as well as PG training is critical’ and R218 felt the interventionist needed to ‘ Need to be qualified as a nurse or midwife. Experience of working in community setting, home visiting, child protection and vulnerable families’. R214 noted ‘confidence grows as experience grows. I'm a lot more confident in my role now, as [sic] I was 4 years ago when I started in CAMHS’.

Experience of the following were all noted as beneficial:

- Assessment in mental health (R18)
- Child safeguarding/Child protection (R26, R218).
- Vulnerable families/children, young people, and their carers (R11, R23, R26, R134, R164, R218) ‘as communication skills are different for different age groups’ (R23)
- Complex dynamics e.g. the child is the focus, the family & parental responsibility (R26, R217)
- Adolescent in-patient wards is very beneficial (R34)
- Engaging both young people and their families (R39)
- Explaining concepts in a developmentally appropriate way (R39)
- Life skills/experience (R15, R42, R163, R240)
- Various clinical practice settings (R14, R26, R98, R128) to allow practitioners to have a non- biased approach to support’ ( R166)
- Child development and the therapeutic underpinnings of the approaches…as experience grows with use of the model(R117)
- When the interventions are necessary and appropriate to use (R121)

### Therapeutic relationship

Nineteen comments were coded to this node being collapsed and condensed into three key areas: Relationships, Communication, Core conditions.

**Relationships:** R10 noted that nurses needed extensive knowledge of the TR as it is the 'bedrock of practice' ‘The importance of developing jointly agreed tasks and goals within the therapeutic alliance’ and the generic ‘skills in therapeutic relationship building’ (R29, R213, R216). ‘The ability to look at the young person holistically and be able to adapt the approach to meet the needs of the young person’ (R186). R219 noted ‘self-awareness especially in

relation to the desire to use the "right reflex" as this reduces the clients self-efficacy and ability to problem solve if as nurses we provide immediate solutions'.

**Communication**: An ability to communicate and engage with young people at their level and at their pace works best, 'A steady slow build-up of trust leads to uptake of support and engagement with services' (R47), 'good communication' (R58, R150, R212, R213, R220) and active empathic 'listening skills' (R162, R163, R164, R166). The ability to listen to a young person (R186, R218, R219) sometimes this is all they need, sometimes, a young person does not want you to be able to 'fix' things but likes to have an outlet to discuss their worries and concerns' (R186). Good communication skills, treating a young person with respect, being genuinely interested in them, persistence to try to engage/visit again and again, find innovative ways to meet with them or communicate with them (e.g. text), liaise with others who know them to get a better picture and find out how best to work with the young person' (R119).

**Core Conditions:** Relating to Rogers' humanistic approach a number of respondents noted aspects of the core conditions (R103) citing 'empathy sense of humour' (R58, R171, R218), 'not be judgemental' (R162, R186), 'honesty' (R164, R186) and 'a generic skill set of emotional capabilities. Being non-judgmental is important and open and honest, this way it enables the young person to feel like they are able to talk to professionals and build a positive relationship with them' (R186, R218). 'Many of these capabilities are borrowed from a psychodynamic framework, and I would generally make a plea that nurses (and anyone working with MH and YP, including teachers, police etc) are skilled with a capacity for understanding emotions'(R150). 'Empathy, trust and excellent communication skills, Young people want to be listened to in a non-threatening environment and not be judged' (R171).

### Training and CPD Opportunities

Forty eight responses were coded to training and continuing professional development. As one respondent noted 'Nurses are adaptable and can follow manualised approaches to offer therapeutic interventions' (R66).

**Training in conditions:** Condition-specific training was mentioned twice: R18 advocating 'training and knowledge on common childhood traumas and experiences' and R132 'Mental health and teenage brain development.'

**Training in interventions:** A number of respondents just mentioned 'training' to understand principles of interventions, at different levels, and that funding needed to be made available (R19, R20, R28, R30, R35,R40, R46, R82, R86, R94, R95, R97, R98, R124, R128, R134, R159, R160, R164, R175, R183, R201, R221, R230). This was summed up by R34 who noted 'A lot!

*Table 24. Frequency of training responses*

| | | | |
|---|---|---|---|
| Solihull (n=1) | Non-medical prescribing (n=1) | SCPHN (n=2) | Decider skills (n=1) |
| DBT (n=1) | CBT (n=3) | EMDR (n=1) | Family and Systemic practice (n=2) |
| Horticulture (n=1) | Psychodrama (n=1) | Suicide First aid (n=1) | ACES (n=1) |
| Motivational Interviewing (n=2) | Strengths-based (n=1) | FNP Training (n=1) | Mental health First Aid (n=1) |

R34 noted the NICE guidelines and that 'There needs to be transparency to young people/families about who has got what Training'. R193 felt 'unlucky that they had not been able to access CBT training to support their role' whilst R139 saw 'CAMHS services or other expert practitioners as people who could train others'.

Others mentioned specific therapies including:

- Solihull and restorative practice with regular updates/ supervision to examine the quality of practice (R22).
- Non-Medical Prescribing (R39, R84).
- SCPHN (R41, R63).
- Professional clinical degree and experience (R45).
- DBT informed skills workshop (R49) and decider Skills (R208).
- CBT training and supervision in effective practice application. (R60, R101, R136)
- EMDR (R66)
- Systemic practice training approved by Association of Family Therapy (R84)
- Horticulture based therapy, psychodrama, family therapy (R105)
- Suicide first aid training (R110)
- Behavioural family intervention for psychosis (R156)
- Mental health first aid (R215)
- Family Nurse Partnership Model (R218)
- Strengths model (R220)

'These are all post-qualifying skills but it is important that the nurse delivering has the experience to recognise when the interventions are necessary and appropriate to use. These are also supplementary to the usual work of the nurse in care planning and risk assessment. These are core skills that are incredibly important to the safe and effective provision of care' (R121).

### Reflection

Reflective practice was mentioned four times (R20, R201, R214, R219) but no accompanying narrative.

### Knowledge

Eighteen respondents noted knowledge factors (grouped in Table 25).

*Table 25 Frequency of knowledge responses*

| | | | | |
|---|---|---|---|---|
| Child development (n=7) and YP learning styles (n=1) | Legal framework (n=1) | Environmental safety (n=1) | Therapeutic relationship (n=3) | mental health (n=6) and Emotional difficulties (n=5) |
| Safeguarding (n=1) | CBT (n=1) | Assessment (n=1) | Supervision (n=1) | Local area (n=2) |

Specifically:

- Child development physical and emotional (R26, R29, R39, R117, R166, R192, R217).
- Therapeutic interventions (R26, R39, R59).
- Child safeguarding & the risks children and young people face today - when & how to refer (R26).
- The legal framework (R26).

- How to recognise mental ill health when and where to refer emotional needs and the impact of these, including triggers, signs/symptoms/ health implications and causes (R26, R161, R163, R192, R229).
- How and the importance of personal psychological supervision, maintaining safe boundaries (R26).
- Environmental safety for self and the child (R26).
- Emotional difficulties experienced by children and adolescents (R39, R62, R220, R217, R213)
- Local area/services available/ACES (R134, R161).
- Principles of CBT and the rationale for their use (R166).
- Specialist knowledge around the short/long term implications and be able to communicate this as appropriate (R192).
- Learning styles of YP (R230).
- You need to know how to take a good assessment and history (R208).

## Question 5 Obstacles node analysis

### Funding and resources

Forty comments were coded to this node. A number just mentioned the terms resource or funding but others offered a more detailed narrative:

### Funding

Lack of funding for training courses was noted. Several clinicians have been requesting various training but were informed that there was no funding for it and thus had difficulty gaining access (R1, R16, R18, R16, R10, R46, R58, R128, R193).

### Resources

Twelve responders noted that resource and capacity need to be sustained for delivery (R16, R46, R132, R156, R162, R166, R171, R183, R192, R201, R230, and R215). Financial restrictions were encountered regarding the number of sessions, pressure to see more CYP in less time and on time available (R29). It was suggested that, 'If other services such as CAMHS would accept more referrals and see more young people then this would also help the issue and ultimately help the young person' (R42, R63, R202). Others reported insufficient staff in teams (R42, R82, R86). R95 and R119 wanted 'either more staff, or work to get these skills out into the community for parents and teachers working with the young people every day'. Caseload/workload pressure was cited by eleven responders (R82, R101, R105, R121, R156, R164, R171, R192, R219, R216, R215), as were competing safeguarding priorities / 'assessment only' work (R96, R101). Resources for young people approaching 18 were specifically raised due to the different criteria adult services have for working with teenagers (R119). Others examples were a lack of resources, within their own service and other young peoples' services, waiting lists, services become saturated and increase referral thresholds (R192, R218, R217, R202).

School nurses observed limited resources, high levels of referrals and low numbers of nurses to deliver support. They also reported low confidence in their ability to deliver effective and safe support due to lack of formal training in children's mental health. It seems that many

children require tier 2 or 3 support but are on long waiting lists so are referred for school nurse support in the interim. These children require a higher level of support than they feel able to provide. This was encapsulated by R132: 'Support for children who are on waiting lists for CAMHs - More school nurses required for early intervention, formal mental health training for school nurses and nurses working within school nursing (staff nurses) and health care assistants trained to deliver talks to groups of children about emotions and how to manage these, what support is available, how to access this etc.'

### Time

Thirty four responses were coded to time. These linked to resource and funding hence most were coded there as well. Time constraints in general were raised by R5, R15, R18, R20, R39, R42, R45, R46, R57, R58, R63, R82, R86, R94, R95, R96, R97, R105, R110, R117, R134, R160, R161, R171, R192, R201, R202, R214, R216, and R220. Targets to see people (or more people) by R29 and R34, the administrative burden by (R34), a lack of ring-fenced time for psychological therapies (R156), and unhelpfully large geographical catchment areas by (R216).

### Space

Eight comments were coded to this node. Confidential space was lacking for R5, R15, R23, R139, R192, R207, R215. R166 noted a lacking of 'A safe, comfortable and private space where the nurse and child/young person will not be interrupted during appointments. An easily accessible but not obvious place where children and young people can drop-in without causing embarrassment or questioning from peers'.

### Institutional Barriers

Twenty nine comments were coded to this node. These were grouped as follows:

**Institutional barriers:** Such as 'Nurses have difficulty accessing funding for training in Psychotherapeutic interventions (R10), when nurses acquire additional therapeutic skills, their roles are not recognised within the rigid structure of "nursing job descriptions" (R39), the current "Grading system" (R156), and nursing 'is not mentioned as an evidence based therapy, often these are talking therapies and discipline based re. CBT, family therapy, child psychotherapy' (R14). 'There needs to be a framework that nurse-led programmes are part of e.g. nurse-led intervention' (R26). 'I think that one of the biggest issues is related to nurses being seen as 'unskilled' and there being a sense that nurses are not equipped to learn new skills that may fall outside of their immediate remit' (R121). 'Generic role doesn't allow for nurse led interventions' (R230). 'Other disciplines dislike nurses leading interventions' (R66).

**Understanding of working together**: Professionals apparently continue to work very much in silos rather than working together to discuss children and young people's needs and source the best placed practitioner for the need identified (R166, R175, R201). Other people's waiting lists were also problematic (R202).

**Leadership and funding: W**ithin services to support needs of nurses (R30), 'management do not recognise that nurse led intervention are important these are often allocated to psychologists' (R11, R124) and are 'more focused on KPIs' (R65). Poor commissioning was given as one of the faults here (R50, R63), lack of two-tier services (R161), and 'not

appreciating how young people are different from adults in terms of how they engage with services' (R84). R129 noted the difficulty with child protection and crisis increasing challenges in delivery.

**Understanding of role:** 'I think there is a need to be succinct and specific in CAMHS. It is not just about having a 'chat' and hoping for the best. There is a need to not enter into therapist drift and I think nursing can often fall into this and unfortunately, I see it a lot first hand' (R14). 'Nurses (such as school nurses) not feeling they have the skills/experience to offer interventions' (R124). 'Curriculum, fear of intimacy, a psychodynamic approach begins with self-searching, and there is resistance or fear' (R150).

**Integrated and collaborative working**: 'It is important, as a service to embed ourselves within the whole school approach and be recognised as a point of referral /contact' (R16) and 'Not having an integrated pathway that clients can move up and down as required… feels to much like silo working still' (R22). 'Organisational systems that try to pigeonhole young people into reductionist systems, diagnostic boxes/care pathways' (R34). 'I believe that they are unable to access early positive interventions; ending up with crisis services is unhelpful and I believe largely avoidable' (R221).

### Supervision

Eight comments coded to supervision. R208 noted 'appropriate supervision and time to think and plan interventions'. Supervision was just noted three times (R5, R35, R208) but narrative comments were forthcoming. Obtaining and prioritising supervision was raised by (R156, R160), R26 noted a need for 'oversite and links with CAMHS for supervision both psychological and clinical.' A lack of supervision was perceived by (R121). Supervision to 'ensure all nurses are supported in their decision making and feel confident and competent in their delivery of early intervention therapies and 'a trusted adult who themselves can gain supervision from a qualified professional to aid their delivery of interventions' was requested by R166.

### Stigma and engagement

Eight comments were coded to this node. Young people attaching stigma to issues of emotional wellbeing (needing evidence that the service is confidential) came from R23. Parents and/or young people not wanting to see a nurse because they do not see them as having sufficient authority or specialist skills from R39. The child's and the parent's willingness to engage was noted by R139, R165 and R117 and 'sometimes parents are not receptive to involvement of the school nurse when emotional health needs are identified which can limit the role which can be played' (R186). 'Support for parents to understand and support the changes they can make' (R192). 'There continues to be a stigma around getting help for psychological and emotional wellbeing issues, children may fear what their friends and family think' (R213).

### Lack of Training Opportunities

Four comments were coded to this node. Lack of training appeared three times (R28, R30, R183), and lack of evidence-based tools once (R41). 'Nurses are often provided with the

training for assessment but there is a gap in the intervention training. CAMHS have clear referral pathways but intervention is only provided for more specific or high need. The support conversations provided by the nurses at the early, mild to moderate stage lacks qualification, structure and measured outcome.' (R28)

### Other

Seventeen comments were coded to this node, compromising data that did not fit in any of the previously generated nodes. Language barrier: often written questionnaires and limited timely resources to refer onto (R9, R211, R211), Missed appointments (R94), Trauma (R103). We have difficulty recruiting staff (R117, R164). 'Our organisation is supporting us to be creative in trying to attract staff but it often comes down to train your own which is a slow process' (R117). Staff fearful if they are the only one seeing the child (R134). Communication difficulties for YP with Learning Disability, 'there needs to be more focus on adapting what is available for this client group' (R136). Confidence to deliver the therapy after training (R156). Trust, relationship and continuity of worker (R204, R213). Client and family factors, such as non-compliance (R207, R212, R217, R220), social crisis (R211, R219), poverty (R218), and the client's MH presentation (R212, R220).

### How can these be addressed?

Most respondents didn't offer any solutions other than R207 who noted 'Drop ins? a safe place to meet with peers or other people their age with similar experiences? Electronic apps' and R208 who noted 'More funded training and consideration given to role of mental health nurse and how it differs to physical health care'. R214 also stated 'More money and staff to help manage the demand for services'.

## Question 6 Emerging interventions node analysis

This question proved challenging to code as respondents had repeated previous answers rather than offering innovative and new approaches. This coding therefore includes some of the established interventions that nurses would like to engage in, as well as more innovative interventions that seem worthy of exploration (table 26).

*Table 26. Existing and newer interventions*

| | | | | | | |
|---|---|---|---|---|---|---|
| DBT (n=3), Decider skills (n=1) | Groups (n=3) | Outcome measures (=2) | Motivational Interviewing (n=4) | Strengths model (n=1) | Solution focused Therapy (n=2) | Counselling (n=4) |
| Healthy living advice/lifestyle choices (n=2) | CBT (n=2) | Signpost (n=1) | Incredible years (n=1) | Solihull Approach (n=1) | NVRP (n=2) | MBCT (n=1) |
| Medication mgmt. (n=2) | Family and Systemic approaches (n=2) | Apps/ E-clinic (n=1) | EMDR (n=2) | Triple P (n=1) | Schools in reach (n=2) | Mindfulness (n=2) |
| Listening visits (n=1) | Attachment work (n=1) | PSI/ Recovery (n=1) | Formulation (n=1) | Resilience toolkit (n=1) | Consultancy (n=1) | Reciprocity (n=1) |
| SMT in schools (n=1) | Forest School / Horticulture(n=2) | PBS (n=1) | ABA (n=1) | TAPP (n=1) | Surf Tonic Therapy | Stop, Think, Do (n=1) |
| ACE/Trauma (n=1) | Early Intervention (n=1) | | | | | |

**APPS/E-Clinic:** Five respondents noted the use of Apps and E-clinics. Apps recommended by the NHS were noted by R132 ‘for out of school access as young people engage with these’. R42 noted ‘This is essentially similar to our face-to-face drop-in sessions in schools whereby pupils can speak to us about any form of health issue in confidence’ and R119's team 'is engaging YP through text and I-pads'. Four comments were related to E-clinics, R171 noted E-clinics, R119 noted ‘I and my team of nurses are trying to engage young people in different venues, at different times (e.g. in the evening), by text or by I-pad questionnaires'. Conversely, R124 was in favour of reducing technology.

**DBT skills:** To inform nurses and can be utilised in the context of ‘risk to self’ concerns (R5, R14, and R221), along with 'decider skills' (R221).

**Healthy living/lifestyle advice**: Five respondents noted they offered lifestyle interventions (R121, R124) with R162 using a ‘diary and write something positive daily’. R213 used guided self-help. R124 noted ‘there is some evidence for lifestyle interventions that nurses can utilise including men's health and weight management skills. However, it is often the basic psychoeducation from the nurse involved with the child, young person or family that can be most effective at supporting them'.

**Groups:** R5 and R183 mentioned groups, R66 noted CBT groups specifically and R164 commented ‘Group led activities where experiences can be shared, and peers support given. Has been known to be quite effective in forming long friendships and support’.

**Counselling:** R16 cited schools-based counselling and R117 noted CAMHS support for secondary school. R207 advocated 'talking and referral to CAMHS'.

**Outcome measures:** Four comments related to using outcome measures over the course of therapy (R26), and using the ORS and CORS specifically (R28, R132) to enable young people to discuss aspects of their wellbeing and lives. Finally, R230 used ASQ’s.

**In-reach:** Eight comments were coded. One service ran ADHD review clinics (R208) and another wellbeing drop-ins (R215). CAMHS in-reach received mention as did a duty team with a schools based counselling service (R16 and R117). 'The CAMHS Duty Emergency liaison Team usually reviews emergency cases within 24 hours' (R16). R124 offered advice and consultation through ‘a great service being piloted which provides support to schools, advice and consultation’. Schools mental health teams existed in Slough (R166) and a six week training programme for school nurses was also mentioned (R186). SMT in schools was noted by R63.

**Attachment:** R10 was starting to explore attachment theory in FBT and IPT

**Recovery and PSI:** R14 noted the ‘recovery approach has been utilised historically for some time, but also fits in line with systemic solution-focused approaches’.

**ACE/Trauma:** noted twice.

**Outside therapies:** Were reported, for example: a forest school for mental health, horticulture and tree of life nature therapy (105) and Surf Tonic Therapy 'a 10 week programme delivered by surf instructors and staff but paid for from charitable funds' (R201)

**YP representation on health boards**: R202 explained 'I am involved with helping to embed the voice of children into *a health board*. I believe that children and young people being involved and having a say in their own care can help to enhance their psychological and emotional wellbeing. underpinned by the rights of the child.'

## Question 7 Ability to deliver node analysis

Six emerging areas were coded to this question. They included: training and funding, capacity/time, Core Training, professional issues, shared knowledge and barriers.

### Training and funding

Training and investment/funding for training was noted 30 times. A number just noted the terms (R1, R5, R14, R23, R41, R46, R60, R66, R82, R84, R95, R96, R101, R105, R117, R132, R134, R166, R175, R183 and R192, R230, R229, R221, R217, R216, R215, R207, R211, R215). Supervision was coded here with R66, R215 and R221 noting supervision and R221 commenting 'regular and truly developmental supervision'.

R24 made an extensive comment: 'If there was time available to be released for training. School nurses are on their knees as are CAMHS nurses - the referrals and work are relentless with pressure on staff to reduce waiting times. However, it is more than training. Training in itself is not enough, staff are given a day training and expected to deliver interventions which is inadequate and insulting. A lot of nurses from their fields do not receive quality clinical supervision and lack experience and confidence to work effectively with emotional health. It is not a manual it needs to be individualised and often evolves to different things as the therapeutic relationship and trust develops.'

R16 commented on the helpfulness of training 'my previous role in my local hospital highlighted the fear nurses have when confronted with children and young people with mental health needs. Again after consultation it was discovered that fear of saying or doing something that would "make it worse" was the biggest barrier to providing effective care. Training, exposure and experience has improved the care children and young people admitted with; deliberate self-harm, depression, eating disorders and emotional dis-regulation now receive.'

R221 was concerned about support, noting 'They need adequate support, ongoing training and supportive development, the knowledge that they will not be crucified if a complaint is made (notwithstanding negligence or worse, of course), and regular, truly developmental supervision. Nurses need to have the psychological and emotional capacity to be able to work effectively and enduringly in such settings.'

### Capacity/time

Nine comments were coded to 'capacity/time' (R5, R9, R26, R45, R57, R164, R204 and R215). R164 noted that resources were needed such as a safe space and availability of staff to

support and coordinate group activities, evaluation of activity from users on effectiveness and relevance of service to them'. Worthy of note is R26 comment that nurses need to be skilled and supported and 'given the capacity to provide sessions. To avoid transferring 'I am rushed and really busy', these children need undivided attention'.

### Core Training

Seven comments related to having a core training, as part of the undergraduate nursing programme (R10, R150, R156) all pre reg students in Plymouth are trained in Solihull for example (R117). Or a standardised post registration training in CAMHS; CPD; Clinical supervision; opportunities for nurses to put knowledge skills into practice (R35).

### Professional issues

Nine comments were coded here. They related to the availability of other professionals giving nurses the opportunity to lead sessions (R11), having a good skill mix (R14), not overlooking a profession such as the mental health training of practice nurses (R15), having a school link person (R.94), to 'Separate care co-ordinator role from therapist role' R160), knowing referral pathways (R162), being innovative (R201) And having adequate support and protection 'knowledge that they will not be crucified if a complaint is made (notwithstanding negligence or worse, of course)' (R221).

R162 offered a more extensive comment: 'By being wider thinking and as much as possible avoid an rigid thinking and approaches that does not take into account the full picture. General nurses teaches this in an abundance yet patient barely speak to a nurse. Mental health are instructed to take into account physical elements of a patient. Yet there are very limited care plans to suggest change. We need to go back to basics, and be given more time as this will then spiral. Causing this to be more costly.

### Shared knowledge

Eleven comments were coded here. Comments included 'information sharing and up to date resources of what's available locally' (R18), 'wider dissemination' (R20), 'manualise approaches and access to resources ' (R66, R139), a 'Framework/Network for nurses need find out what's new, share ideas, evidence and research' (R26), to 'ask a quick question/advice from a CMAHS professional' (R26, R139), have 'specialist supervision' available (R66), 'by shadowing experienced clinicians, experience is key, not all these skills can be classroom learnt but be in related discussions with children (assemblies/ group work/working with education/parents/carers)' (R124) and 'raising awareness of …emotional wellbeing' (R202), 'demonstration of knowledge around SDHD and other conditions' (R208) and online resources (R213).

R121 notes that 'basic psychoeducation is easily delivered by nurses in person through development of a brief interpersonal professional relationship. However, further work on this relationship, and ongoing psychoeducation might not be effective if delivered in short interventions (such as by practice nurses, A+E nurses, school nurses).'

### Barriers

Six comments were coded. Five noted that they can't or it would be difficult to deliver the interventions (R42, R50, R63, R65, R186 ) because of caseload or training/roles. Although R42 did suggest E-Clinics would help. R65 noted that 'It is better to have specialised serviced

that can be ring-fenced. Health Visitors have too much to do already and there is a crisis in staffing.' And as services like The Children in Care/Care Leavers team is unique within Livewell, staff are far more limited in the time they have available to see young people or carry out any ongoing work (R119). R119 noted that 'Managers need to understand the difficulties encountered and allow staff time to carry out the work. However, many areas are short staffed, so the essential work has to take priority.'

## Question 8 Initial node analysis

Early interventions (questions 1-6) received minimal comment. This node explored where early interventions were taking place, in which settings, the focus and their outcomes/impact. Some repeats and blanks were deleted as they mentioned the venue rather than the region/area. Some respondents had put a narrative in the location so these data were cleansed and added to the setting.

Figure 8. Where in the UK is EI taking place?


Scotland: 9
Wales: 5
Northern Ireland: 0
England :37
North West: 7
Yorkshire and Humber: 6
East Midlands: 2
West Midlands: 0
South West: 9
South East: 3
London: 4
Anglia: 6

Of the 49 respondents who answered the question; 37 from England, nine from Scotland and five from wales noted EI occurring in their locality. The treatment settings are grouped in table 27 (below).

*Table 27. Settings where EI are taking place*

| | | | | | |
|---|---|---|---|---|---|
| Schools (n=35) | Community: Voluntary organisations, charities, church (n=19) | CAMHS (n=17) | Home (n=9) | Family Nurse Partnership Model (n=3) | Other (children's centres early years settings, A&E liaison, clinics., Single Point of Access (SPA), Health Visiting, Children's Hospital, Hospital, Health Boards (n=9) |

## What is the focus of EI?

Forty nine comments were coded to this node with nine areas extrapolated from the narrative. R139 provided a description of EI 'To improve positive outcomes for emotional health and wellbeing by allowing the pupils to develop coping strategies to self-manage their emotions. Also, to support families to develop how to support their children and young people.' Whilst R213 posited its aim was 'To give professionals and young people an awareness of the

psychological and emotional wellbeing issues that are needing addressed and to give children, young people, parents, and all professionals that work with them some tools to help them address the issues'.

**Psychosocial education**: Appeared once purely as the term but more fully by R230 who noted 'To support change behaviour work, such as managing long term conditions , stopping smoking, reduction in obesity , improving parenting work '.

**Self-esteem:** Was mentioned four times. R5 and R132 only noted the term, R95 noted 'Increasing the child's ability to meet their full potential and be happy and confident' and R201 noted 'developing self-esteem and friendships.

**Building skills/manage emotions**: R11 noted 'managing emotions', R34 and R166 'building skills/developing strategies', R66 'emotional resilience', R103 'emotional wellbeing', and R136 'ameliorating behavioural difficulties that can be driven by emotional and psychological distress'. Five other occurrences of the word resilience were made but with no supporting narrative.

**Improve mental health and emotional wellbeing:** Twenty three comments were coded to this heading. Improving mental health and emotional wellbeing were noted by (R11, R18, R28, R30, R35, R42, R58, R63, R94, R103, R110, R124, R139, R166, R201, R213, R215, and R219). R229 noted the wellbeing of the child to keep them out of hospital. R219 noted 'EI and improvement of health and wellbeing and economic improvements' and 'The mental health of young parents' was noted by R57 and R105 noted the use of nature-based activities to develop skills and ways of managing MH and wellbeing. Finally, R132 commented on these interventions as being short term.

**Early Intervention/Prevention**: Nine comments coded here, mostly limited to a mention of the term (R16, R34, R46, R124, R161, R166) but also 'getting children and their families help and appropriate escalation' (R117) to 'prevent chronic mental health problems' (R161, R162) and to 'improve access to services' (R175).

**Parenting programmes:** For example, noticing 'mothers' (R96), 'supporting families' (R139) and 'parenting programme for first time parents and young pregnant and young mothers' (R28, R46 and R164).

**Other:** This was a list of single word comments. Words that arose only once were: reciprocity, attachment, recovery, group sessions, supervision and consultancy, managing self-harm, and person-centred compassionate care. A lengthy comment from R193 was illuminating 'We don't offer any ongoing interventions as the ideas are when young people are medically fit to discharge and have ongoing therapies in the community. We are not currently commissioned to provided treatment and ongoing work. I do think this is the direction we should go as we could prevent young people being admitted in the future and most of the young people we see don't meet the criteria for CAMHS so it would hopefully prevent young people deteriorated and avoid CAMHS referrals'.

## What are the outcomes and impact of EI?

### Improved outcomes

Good impact and improved outcomes were noted by R19, R35, R39, and R32. Good outcomes 'for children who would otherwise suffer possible neglect' by R32 and for parents by R51. R213 found children became better able to manage their wellbeing and their families more aware. R216 held a similar view but included a reduction in domestic violence. R217 noted EI could reduce child neglect, require less referrals to other services and provide more preventative work. R219 noted 'an improvement in child and mental health'. However, R17nad R54 noted varied outcome and impact depending on patient involvement, level of understanding/learning and was dependant on the child. R54 felt it was 'beginning to come together' but that it was difficult to measure outcomes consistently. Effective early intervention was vied as needing no further support or referral on (R59). Less reliance on medical intervention was noted (R230).

### Emotional and mental health

EI had improved physical and mental health, self-esteem, resilience and coping skills (R37, R44, R50, R46, R52) and the 'normalisation of many emotions, and [demonstrated] how self-management is possible in most cases without it becoming a clinical condition' (R62).

R71 noted EI as 'Positive and effective, has benefitted a lot of young persons. I am visiting a new young mother who has been identified as having anxiety issues prior to her current pregnancy. Aim is to visit her early, have open discussions listen to her feeling and fears, make plans with her towards her delivery and on-going. That way she will feel well supported and confident by the time baby arrives and she will have a good basic knowledge of who and how to access further support'.

R73 was similarly complimentary, stating that 'Early intervention support has been very successful in Surrey, reducing waiting times for CAMHS and supporting children and young people before concerns become more sever. The impact on families has been threefold; they feel supported and listened to when concerns arise rather than disregarded and devalued thus improving family cohesion when managing need, children and young people are seen earlier thus reducing symptoms and increasing self-care and as such self-esteem /self-worth and young people are not made to feel they are damaged or "freaks" (their words) as they build their understanding of mental health at a stage where they can still access and engage with support'.

### Long term management

R2 reported EI 'Can be positive and improve long term difficulties', R20 that it prevents 'problems getting worse i.e. becoming mental health problems', and R76 that it creates 'less chronic MH issues and therefore less need for adult services'. R68 noted that 'We in SPA see 3000 individuals a year and I don't have figure but very few go on to have chronic mental health disorder or tier 3 or 4 services as a child'. It also allowed R81 to see 'people who don't meet CAMHS threshold'.

### Behaviour

R37 noted improved behaviour, R6 'Calmer in the classroom, engaging with learning and managing emotions better' and R14 that the 'Young person feels they have been listened to and not judged and provides them with space to reflect on their concerns and create a plan to

address their issues of concern. 'Improved behaviour evidences less anxious children who have more effective strategies for managing their negative experiences (R61).

### Access to services

EI was thought to improve access services through signposting by R44. Similarly, 'Some young people [were] referred into CAMHS assessment process who would not otherwise have accessed this but also preventing young people from accessing assessments as a consultation approach has led to them not needing it so the impact and outcomes can be hard to measure especially in preventative orientated work. Some consultation and supervision offered has included use of routine outcome measures and other scales though this has not been formally evaluated' (R42).

R193 wrote 'I do think even though we are a small service, I would like to think [that] without our service most people we see [who] don't meet the criteria of CAMHS and would not get a service, hopefully we prevent young people deteriorating, as even though we don't offer outpatients appointments, I do telephone support and telephone follow ups with patients families and schools to support and provide advice'.

## Question 9 Training node analysis

Thirty two nodes emerged from the data. These are denoted in table 28 below, together with the frequency of coding. Most of the data coded was just a word or list of trainings but there were some qualitative comments which are represented below the table (N.B. these do not cover all the nodes as the data was insufficient to code meaningfully).

### Quantitative review

Table 28 represents the responses and frequency of coding to the question: What training do you think nurses should have when working with CYPMH?

*Table 28 Training*

| | | | | | | |
|---|---|---|---|---|---|---|
| Evidence based practice training (n=21) | Contextual (n=7) | Child development (n=11) | attachment theory (n=4) | Interpersonal theory/talking therapy (n=7) | Family Systems Theory (n=5) | Communication (n=3) |
| Assessment and risk (n=8) | CBT (n=11) | DBT/Decider skills (n=2) | Solihull (n=3) | Strengths and Resilience (n=4) | MI (n=6) | ACE (n=2) |
| Youth MH First aid/MH (N=10) | Group (n=1) | Supervision (n=3) | Marginalised groups (n=1) | Emotional regulation (n=1) | PSI (n=1) | SFT (n=2) |
| Transgender (n=1) | Creative (n=1) | Mindfulness (n=1) | Strengths (n=2) | Safeguarding (n=2) | Behaviour change (n=1) | Formulation (n=1) |
| Trauma (n=5) | MECC (n=1) | MH Conditions (n=3) | Partner violence (n=1) | | | |

### Qualitative comments

**Evidence based practice:** R19 'Training-programmes need to be comprehensive, to encompass interventions relevant to Nursing specialism and accredited to ensure Nurses are taken seriously in management and delivery of effective interventions' and R82 'a range of training to ensure holistic approach to care / treatment then more specific evidence based training.' R212 wanted more MH training in preceptorship and R215 and R229 understanding of MH conditions training and services available.

**Contextual:** R3 wanted training 'based on their current work, R8 'what signs to look for an how to manage a brief encounter', R16 'how to recognise and normalise and develop management strategies' whilst R207 commented 'Triggers, symptoms, common behaviour's to aid diagnosis and enhance referrals and ongoing care'. R219 noted 'learning from young people themselves in relation to what they are looking for from health professionals (young people interview for prospective family nurses)'.

**Child development:** R5, R13, R28, R23, R73 and R208 noted 'child and adolescent development' and 'how emotional difficulties can start', as a training need. R61 added an understanding of Learning Disabilities.

**Interpersonal and talking therapies:** R37 required training in building a 'therapeutic relationship', R70 requested 'specific training around listening and empathising.'

**Family systems theory**: R56 wrote 'I think that moving towards a relational focus and working with the wider family and professional systems would be beneficial. Training in systemic approaches to a higher level might be beneficial,' and R81 included 'trauma informed training.'

**CBT:** R68 noted that 'Nurses in this age need to come of university with at least a CBT qualification. Nurses no longer follow doctor and make tea and biscuits. IAPT is an example of [the] need and changes to services.'

**Resilience:** R13 noted 'In health visiting that early years opportunity to support parents, to enable them to build resilience in their children so that they are able to better meet the adolescent challenges of development.'

**ACES:** R16 noted 'ACES's and child experience of trauma, the effects of trauma on the child intrauterine.'

**MH First Aid/MH Knowledge:** R26 'Training in specific mental health issues in young people', R63 thought 'Nurses should have mental health as a module in their nursing training. Equip them with the knowledge and skills of early signs.'

**Access:** R204 commented 'Unfortunately training is often very brief and then we are expected to just get on and deliver. This is a huge failing of children.'

### 3.2.4 Round 1 discussion

Rather than seeking here to summarise the detailed round 1 results (above); in line with the Delphi method, suffice to say that these results were used to inform, not only the final discussion section of this report but also the second Delphi survey. This sought to confirm and/or refute experts' agreement, confidence and ability to deliver the themed interventions that have emerged above.

## 3.3 Round 2 Delphi Survey

### 3.3.1 Round 2 method

The second Delphi survey (Round 2) consisted of an online survey where all initial respondents were invited to rate their agreement with a number of statements using Likert scales. The statements were developed by condensing, collapsing and translating the findings from round 1. At this point, the findings of the literature review were also re-visited and utilised were appropriate. In order to achieve the maximum number of round 2 responses, the follow up survey was sent to all (n=244) nurses who had provided their consent and email address rather than limiting the invite to those providing complete round 1 responses.

### 3.3.2 Round 2 respondents

A total of 42 responses were gained in the two week data collection window that was set. This represents a fairly typical (19%) response rate and included at least one return from each country of the UK (see table 28).

#### Table 29. Round 2 responses by country

**Participants:**

| Round 2 Delphi responses by country | |
|---|---|
| **England** | 35 |
| **Scotland** | 2 |
| **Wales** | 4 |
| **N Ireland** | 1 |
| **Total** | 42 |

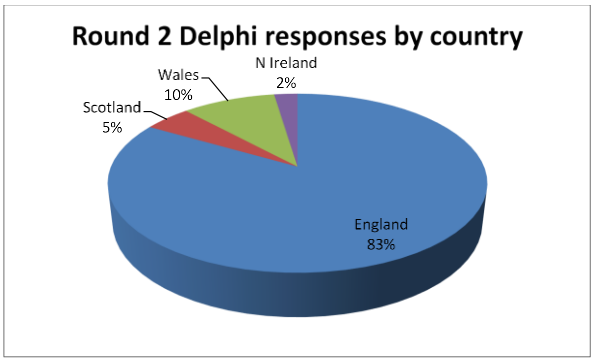



Figure 9 Round 2 responses by country

The smaller return naturally resulted in less coverage, however round 2 respondents were still geographically dispersed (figure 10)

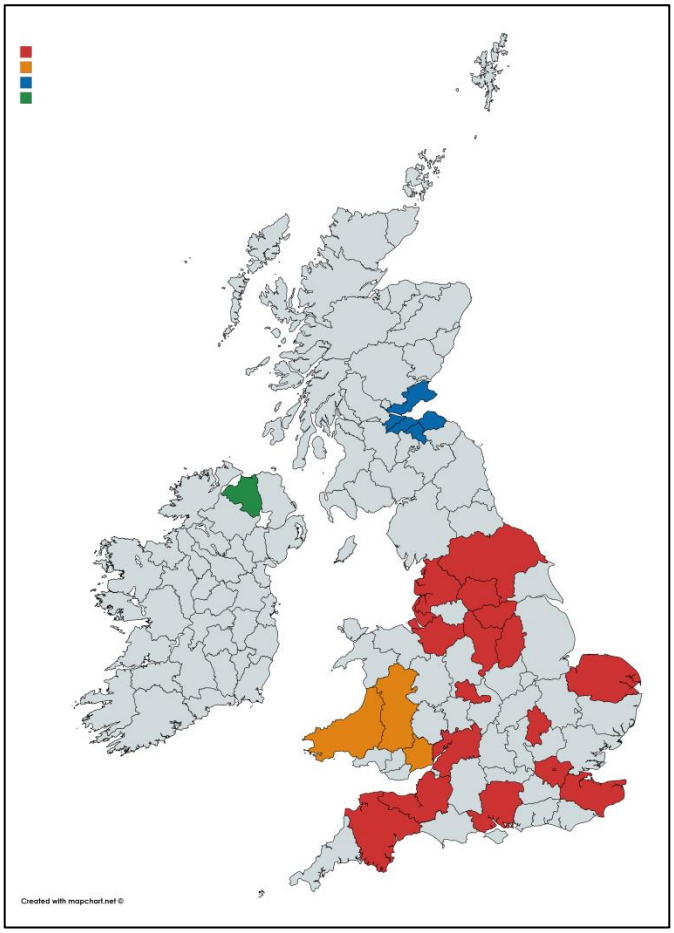



Figure 10. Round 2 respondents by county

The respondents represented a diverse range of specialisms, listing them as:

| Nursing specialism | Count | % |
|---|---|---|
| **Registered General Nurse** | 1 | 2.4 |
| **Practice nurse** | 1 | 2.4 |
| **School Nurse** | 8 | 19.0 |
| **Registered Sick Children's nurse** | 3 | 7.1 |
| **Health visitor** | 9 | 21.4 |
| **Registered Learning Disability Nurse** | 1 | 2.4 |
| **Registered Mental Health Nurse** | 18 | 42.9 |
| **Family nurse partnership nurse** | 1 | 2.4 |
| **Other** | 0 | 0.0 |
| **Blank** | 0 | 0.0 |
| **Total** | 42 | 100.0 |

Table 30 Respondents' specialisms

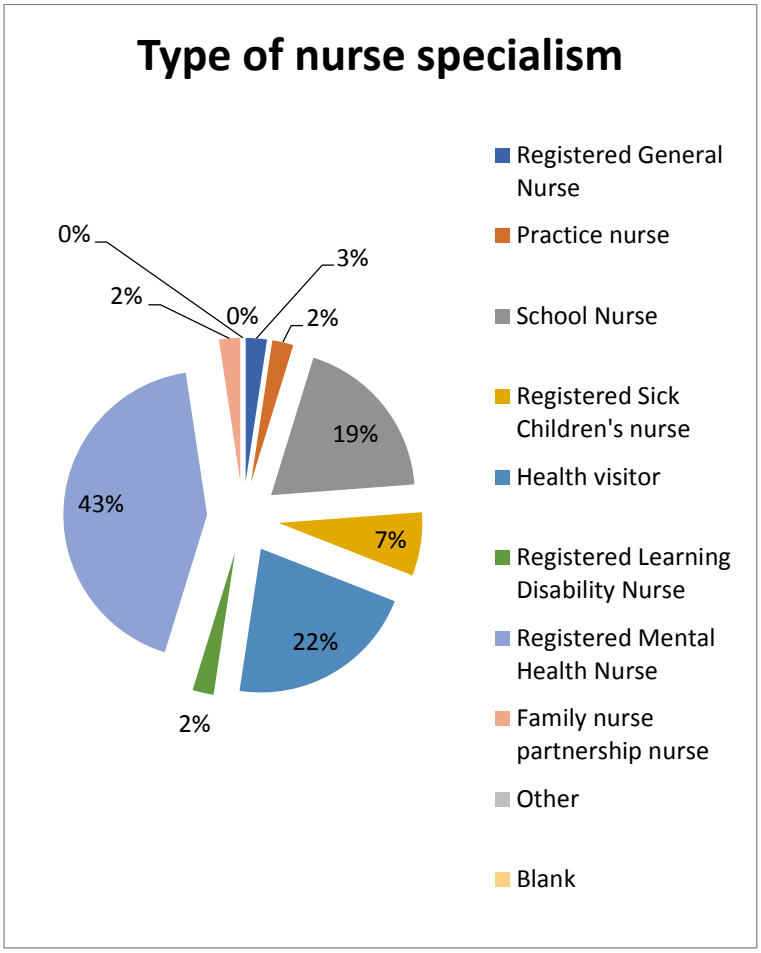



Figure 5 Respondents' specialisms

### 3.3.3 Round 2 results

A total of 68 questions were posed in this second round survey. Five of these required free text responses, the remaining 60 were Likert scales. These were structured around the findings of the literature review, and the 15 groups of interventions that had emerged from the round 1 Delphi Survey. The questions typically addressed nurse's perceptions of each intervention's effectiveness, its importance to their practice, and their confidence to deliver it. Table 29 (below) includes the frequency distributions for each Likert question. The responses to the five free text questions are presented separately.

*Table 31 Summary Table of Likert scale responses for Round Two Delphi Survey*

| Intervention | Question | Response options and frequencies | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Early Interventions | **1 Early interventions are effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 0 | 0 | 0 | 4 | 8 | 13 | 11 |
| | **2 How important is it to intervene early in a young person's wellbeing?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 0 | 0 | 0 | 1 | 4 | 11 | 20 |
| | **3 I am confident in practicing Early interventions ?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 0 | 0 | 0 | 6 | 15 | 11 | 4 |
| | **4 I am unable to practice Early interventions effectively because of time pressures?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 1 | 2 | 12 | 5 | 12 | 4 | 0 |
| Cognitive Behavioural Therapy | **5 CBT is effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 0 | 0 | 1 | 8 | 19 | 6 | 1 |
| | **6 How important is CBT to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 2 | 2 | 4 | 11 | 6 | 9 | 1 |
| | **7 I am confident in practicing CBT?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 5 | 4 | 10 | 3 | 10 | 3 | 1 |

| Intervention | Question | Response options and frequencies | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Dialectical Behavioural Therapy** | **8 DBT is effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 0 | 0 | 3 | 8 | 12 | 7 | 1 |
| | **9 How important is DBT to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 4 | 5 | 8 | 6 | 6 | 3 | 1 |
| | **10 I am confident in practicing DBT?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 11 | 6 | 10 | 4 | 4 | 0 | 0 |
| **Family & Systemic Practice** | **11 Family and systemic practice is effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 0 | 0 | 1 | 3 | 12 | 9 | 8 |
| | **12 How important is Family and systemic practice to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 1 | 0 | 3 | 4 | 10 | 10 | 5 |
| | **13 I am confident in practising Family and systemic practice?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 4 | 4 | 8 | 2 | 13 | 2 | 2 |
| **Solution-focused Therapy** | **14 Solution Focused therapy is effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 0 | 0 | 2 | 8 | 9 | 10 | 5 |
| | **15 How important is Solution Focused therapy to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 2 | 0 | 3 | 9 | 11 | 4 | 5 |
| | **16 I am confident in practicing Solution Focused therapy?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 5 | 6 | 3 | 2 | 13 | 4 | 2 |

| Intervention | Question | Response options and frequencies | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Motivational Interviewing | **17 Motivational Interviewing is effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 1 | 0 | 0 | 8 | 10 | 11 | 6 |
| | **18 How important is Motivational Interviewing to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 1 | 0 | 4 | 7 | 11 | 8 | 5 |
| | **19 I am confident in practicing Motivational Interviewing ?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 1 | 2 | 3 | 4 | 16 | 7 | 3 |
| Mindfulness | **20 Mindfulness is effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 0 | 0 | 0 | 7 | 12 | 9 | 7 |
| | **21 How important is mindfulness to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 1 | 0 | 3 | 8 | 9 | 12 | 3 |
| | **22 I am confident in practicing mindfulness?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 1 | 1 | 5 | 6 | 12 | 7 | 4 |
| Behavioural Approaches | **23 Behavioural approaches are effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 0 | 0 | 0 | 5 | 12 | 14 | 4 |
| | **24 How important are behavioural approaches to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 0 | 0 | 3 | 6 | 10 | 12 | 4 |
| | **25 I am confident in practicing behavioural approaches** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 2 | 0 | 1 | 7 | 15 | 8 | 2 |

| Intervention | Question | Response options and frequencies | | | | | | |
|---|---|---|---|---|---|---|---|---|
| The Solihull Approach | **26 The Solihull approach is effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 3 | 0 | 1 | 5 | 6 | 7 | 8 |
| | **27 How important is the Solihull approach to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 4 | 2 | 5 | 3 | 4 | 8 | 5 |
| | **28 I am confident in practicing the Solihull approach** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 9 | 5 | 6 | 1 | 6 | 4 | 2 |
| | **29 I fully understand the Solihull approach?** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually | Almost always true |
| | | 12 | 0 | 5 | 6 | 1 | 4 | 7 |
| Therapeutic Relationships | **30 The therapeutic relationship is effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 0 | 0 | 0 | 0 | 8 | 9 | 17 |
| | **31 How important is the therapeutic relationship to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 0 | 0 | 0 | 0 | 6 | 8 | 20 |
| | **32 I am confident in practicing therapeutic relationship ?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 0 | 1 | 2 | 1 | 4 | 13 | 13 |

| Intervention | Number | Response options and frequencies | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Group Interventions | **33 Group interventions are effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 0 | 0 | 1 | 10 | 10 | 11 | 2 |
| | **34 How important are group interventions to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 0 | 1 | 5 | 8 | 12 | 4 | 3 |
| | **35 am confident in practicing group interventions?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 1 | 2 | 2 | 4 | 16 | 6 | 3 |
| Creative Interventions | **36 Creative interventions such as Art, Exercise and green spaces are effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 0 | 0 | 1 | 2 | 16 | 8 | 5 |
| | **37 How important are creative interventions to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 2 | 0 | 5 | 6 | 10 | 6 | 4 |
| | **38 I am confident in practicing creative interventions?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 4 | 3 | 6 | 5 | 9 | 4 | 2 |
| **Comments** | **39 Of the creative interventions you are aware of which is the most important?** | See summary of free text responses to this question below | | | | | | |

| Intervention | Number | Response options and frequencies | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Digital Resources | **40 Digital resources are effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 1 | 0 | 0 | 5 | 11 | 12 | 4 |
| | **41 How important are digital resources to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 2 | 0 | 3 | 6 | 12 | 7 | 3 |
| | **42 I am confident in using digital resources with a young person?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 2 | 2 | 2 | 5 | 12 | 8 | 2 |
| | **43 I would like to see an increase in use of digital interventions to support the psychological and emotional wellbeing of young people** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 0 | 1 | 4 | 7 | 9 | 11 | 2 |
| | **44 I would like to see an increase in use of apps on mobile phones to support the psychological and emotional wellbeing of young people** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 0 | 1 | 4 | 4 | 11 | 13 | 2 |
| | **45 I would like to see an increase in use E-Clinics to support the psychological and emotional wellbeing of young people** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 0 | 1 | 3 | 11 | 10 | 9 | 0 |

| Intervention | Number | Response options and frequencies | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Supervision | **46 Supervision is effective in supporting nurses delivering interventions for young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 0 | 0 | 1 | 3 | 4 | 5 | 22 |
| | **47 How important is Supervision to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 0 | 0 | 1 | 2 | 5 | 7 | 19 |
| | **48 I am confident in practising supervision?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 0 | 0 | 2 | 1 | 7 | 13 | 12 |
| The Family Nurse Partnership Model | **49 The Family Nurse Partnership Model is effective in supporting young people's wellbeing** | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | 0 | 0 | 4 | 5 | 9 | 9 | 6 |
| | **50 How important is Family Nurse Partnership Model to you in your practice?** | Never important | Unimportant | Of little importance | Moderately Important | Important | Very important | Always important |
| | | 3 | 2 | 9 | 4 | 5 | 5 | 5 |
| | **51 I am confident in practising Family Nurse Partnership Model ?** | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | 11 | 7 | 2 | 4 | 7 | 4 | 0 |

| Intervention | Number | Question | Response options and frequencies | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Barriers and facilitating factors | **52 I do not feel I have enough time to adequately use nurse led interventions to support the psychological and emotional wellbeing of young people** | Lack of time use | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | | 1 | 9 | 9 | 3 | 9 | 2 | 2 |
| | **53 I do not feel they I enough time to receive training about additional interventions to support the psychological and emotional wellbeing of young people** | Lack of time to train | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | | 1 | 10 | 5 | 3 | 7 | 7 | 2 |
| | **54 I am confident in delivering effective nurse led interventions to support the psychological and emotional wellbeing of young people** | Confidence | Literally under no circumstances | Strongly disagree | Disagree | Undecided | Agree | Strongly Agree | In all cases |
| | | | 0 | 3 | 3 | 4 | 12 | 7 | 6 |
| | **55 Research into evidence-based practice by Nurses for psychological and emotional wellbeing of young people is useful to my practice** | Usefulness of research | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | | 0 | 0 | 2 | 5 | 9 | 6 | 12 |
| | **56 Have you ever been involved in research in the psychological and emotional wellbeing of young people** | Involvement in research | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | | 19 | 0 | 4 | 7 | 1 | 3 | 1 |
| | **57 Research accurately reflects what it is like for nurses working within psychological and emotional wellbeing of young people** | Research reflects routine practice | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | | 2 | 0 | 7 | 8 | 9 | 6 | 2 |
| | **58 Do you feel Nurses are / the role of the nurse is accurately represented in research?** | Research accurately represents nurses | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | | 5 | 0 | 12 | 5 | 7 | 5 | 0 |
| | **59 Do you think organisational factors at work enable nurses to be properly recognised for their unique contribution in the psychological and emotional wellbeing of young people** | Recognition of nurses' value | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | | 4 | 0 | 14 | 3 | 4 | 6 | 3 |
| | **60 Nurses should have received training in a specific therapy to work in Children and young people's services?** | Specific training should be provided | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | | 3 | 0 | 4 | 2 | 7 | 6 | 13 |

| Intervention | Number | Question | Response options and frequencies |
|---|---|---|---|

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Barriers and facilitating factors cont.** | **61 School nurses should contribute to the delivery of wellbeing lessons as part of the school curriculum as well as intervening with individual children?** | School nurses involvement in curriculum | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | | 0 | 0 | 1 | 3 | 9 | 9 | 13 |
| | **62 Given all the pressures, how likely are you to stay in the profession?** | Retention in profession | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | | 2 | 0 | 2 | 4 | 2 | 11 | 14 |
| | **63 Experience is more important than formal training?** | Importance of experience | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | | 4 | 0 | 5 | 7 | 11 | 4 | 4 |
| | **64 All nurses working in young person's wellbeing should have a good understanding of child development** | Understanding of child development | Almost never true | Usually not true | sometimes but infrequently true | Occasionally true | Often true | Usually true | Almost always true |
| | | | 1 | 0 | 1 | 2 | 1 | 6 | 24 |
| **Free text comments** | **65 How would you define or understand by the term "Evidence Based Practice"** | EBP | See summary of free text responses to this question below | | | | | | |
| | **66 How do you know that your practice is "evidence based"** | Own practice | See summary of free text responses to this question below | | | | | | |
| | **67 Do you keep up to date with research in your area? If so, how** | Contemporary research | See summary of free text responses to this question below | | | | | | |
| | **68 How do you find out about new interventions to use** | New interventions | See summary of free text responses to this question below | | | | | | |

**Q39 Of the creative interventions you are aware of which is the most important.**

Respondents' suggestions for helpful creative interventions are tabulated below.

*Table 32. Important creative interventions*

| | | | | |
|---|---|---|---|---|
| Exercise (n=3) | Art therapy (n=5) | Drama therapy (n=1) | Partners in parenting education (n=1) | Music (n=1) |
| Play/learn together (n=2) | Community activities (n=1) | Five steps to wellbeing (n=1) | Getting outside/nature/green space (n=4) | |

## Q65 How would you define or understand by the term "Evidence Based Practice"

This question was included to elicit how the respondents defined EBP as there had been some variance in the responses round one. It was clear that the majority of the respondents had a good grasp of EBP, that it was rigorously developed and applied. Of the replies, one based their observation on 'what works for whom' the others all noted the link to research and guidance (Table 31)

*Table 33 Evidence based practice responses*

| | | |
|---|---|---|
| What works best for whom (n=1) | Basing work on evidence (n=7) | NICE guidance (n=3) |
| Combination of research and practice based (n=2) | Use of literature (n-2) | Informed by outcomes of research (n=20 |

Condensing respondents' comments into a single statement, nurses understand EBP as: 'A body of evidence that repeatedly represents an outcome. Based on rigorous study that demonstrates the outcome of an intervention, and evaluation from practice to inform practice. Has a strong ethos of quality assurance and quality improvement. The process of researching, collecting, processing and implementing research findings to improve clinical practice and provide the highest quality patient care. Evidence that has been developed as a result of peer reviewed gold standard research ideally through randomised control trials.'

## Q66 How do you know that your practice is "evidence based"

*Table 34 How do you know your practice is evidence based?*

| | | | | |
|---|---|---|---|---|
| NICE Guidelines (n=14) | HCP (n=2) | Experience (n=2) | Use of literature/research (n=15 | Appropriate training (n=2) |
| Practice based guidance/protocols/SOPS (n=7) | Reflection and feedback(n=3) | Sharing of data and stories/learning organisation (n=2) | Quality assurance network/audit (n=2) | RCN |

Respondents noted that they had a quality assurance network that reviewed evidence and new ways of working and that they didn't implement new ways without considering all of the available data, or by looking at results. NICE were noted as a good source of information because their guidelines are based on systematic reviews of the available literature. One respondent stated that the 'human to human' interaction between nurse and patient was important as any therapy. Another noted the evidence base for adults but little for children and young people claiming *'evidenced based approaches like CBT need to be adapted and the effectiveness measured using outcome measures and goals'* and another encapsulated a lot of the challenges nurses are facing *'we are measured on if we are NICE compliant which suits the organisation/ commissioners, but I'm not convinced this is at all useful or helpful so I'm struggling to answer this honestly, other than as an experienced clinician (I have worked in the*

*NHS for 43 years) in my speciality I know I would not practice anything that is not safe or effective. If you work in a small team with little commissioning agreements then we cannot be NICE Compliant ,e.g. in my team (eating disorders) we are not, due to funding and staffing adhere to specific evidence based practice for ED. However, we do our utmost to deliver with the staffing funding we have to provide the best and safest practice we can with the most risky client group in CAMHS.'*

### Q67 Do you keep up to date with research in your area? If so, how

*Table 35 Methods of keeping up to date with research*

| | | | | |
|---|---|---|---|---|
| Journals/reading (n=18) | Conferences (n=4) | NICE (n=4) | CPD/Training (n=9) | Professional discussions (n=8) |
| Service Updates/learning forums (n=6) | Involvement in research (n=2) | Online community/twitter(n=2) | Supervision (n=3) | Further education (MSc) (n=1) |
| Students questioning (n=1) | Sadly by our errors (n=1) | Reflection on approach (n=2) | Not really (n=1) | Member of professional bodies (n=3) |

The anticipated range and spread of access to up to date practice was noted with a number of self-directed activities such as reading journals, attending conferences and being involved in research. There were some comments regarding the way research from across disciplines finds its way into CAMHS and finding the time to access this within working hours. Reflection and supervision were noted and an openness about reflecting on areas the respondent felt vulnerable in and either attend updates, discuss with colleagues or read around topic, or learn '*sadly by our errors'*. A lot of sharing on practice occurred through online forums, journal clubs, and professional / leadership groups.

### Q68 How do you find out about new interventions to use?

*Table 36 Ways of finding out about new interventions*

| | | | | | |
|---|---|---|---|---|---|
| Journals (n=13) | Conferences (n=4) | Training (n=6) | Professional discussions (n=8) | Accessed online (n=5) | Supervision (n=2) |
| Membership of research groups (n=3) | NICE (n=4) | Service direction/feedback (n=6) | Involvement in research | Professional Newsletters/journals (n=4) | Observe others |

Respondents noted they were able to access and engage with several resources and research informed practices, through training, reading, cascades within teams, professional discussion and supervision. There were some tensions noted about the availability of training and time to keep up to date. For example, one respondent noted *'I keep a general interest, but knowing what is available and what I am qualified to practice are 2 different things. I can only do what my organisation offers in terms of training, and this is often very limited. Also, the restrictions on my practice tend to be organisational such as lack of room space or time to run a group based intervention'.* Another respondent noted they attended a supervision group in their own time.

# Part 4: Synthesis of findings from parts 1, 2 and 3

## 4.1 Discussion

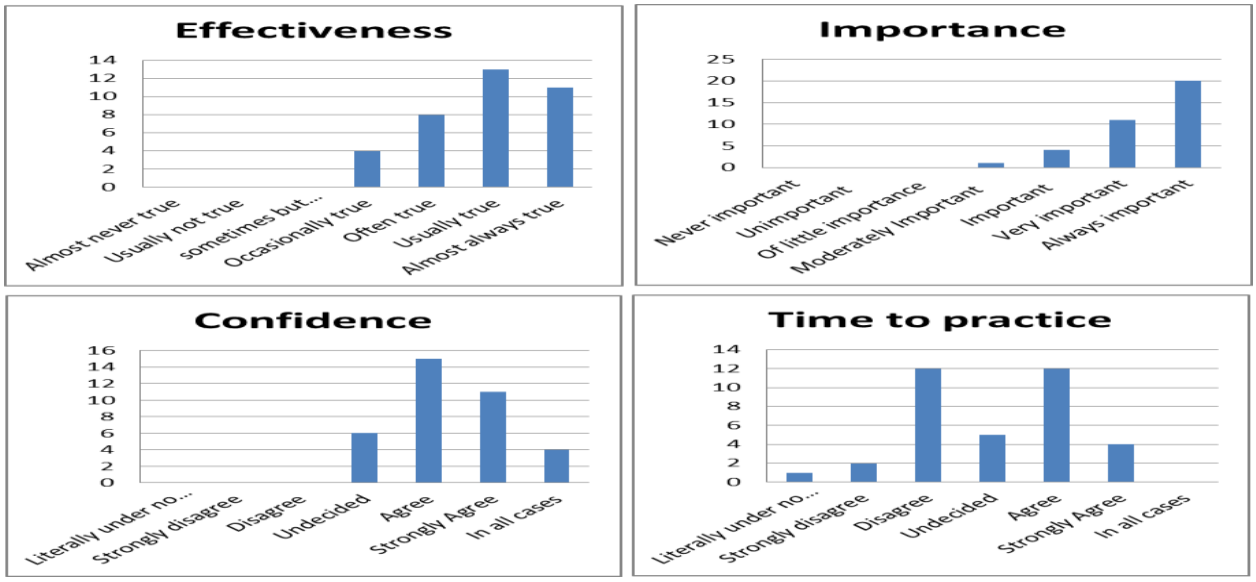
This discussion is organised around the headings that emerged from the literature combined with the headings that emerged from the Delphi surveys. Each section seeks to clarify the scope of practice and, where relevant, any differences in approach between the four countries.

It seems there is evidence and expert support for a number of interventions, and that nurses are frequently leading or at least practising these. Graphs are included to highlight the round 2 ratings and help summarise each intervention. The respondents' data and the findings of the literature are also triangulated where appropriate.

### Early interventions (EI)

Respondents scored EI effectiveness as 89% agreement, importance as 97%, and confidence as 83% but only 44% had the time to practice. This would suggest early interventions are important, but that creating time to practice requires attention (Figure 11).

*Figure 11 Early interventions*




It is clear from the spread of responses that EI are being used right across the UK (see Figure 8 for the regions and Table 27 (replicated here for ease) for the settings). Staff rated themselves as confident to practice, that the interventions were effective and important but that managing the time for the intervention was variable.

*Table 27. Settings where EIs are taking place*

| Schools | Community: Voluntary organisations, charities, church | CAMHS | Home | Family Nurse Partnership Model | Other (children's centres early years settings, A&E liaison, clinics., Single Point of Access (SPA), Health Visiting, Children's Hospital, Hospital, Health Boards |
|---|---|---|---|---|---|
| 35 | 19 | 17 | 9 | 3 | 9 |

Early nursing interventions were focused on prevention and the number of initiatives in schools was positive to see. This was also reflected in the literature where, in the majority of studies that were preventative in nature, school nurses were central to the interventions. Other respondents noted the importance of understanding young people's behaviour and of working with pregnant

teenagers who need positive behaviour support. The focus of EI was on achieving positive outcomes for young people, supporting behaviour change and other health improvements (smoking and obesity) and to help families to support their children and young people. Key elements of the EI programmes were reported as:

- Psychoeducation to increase awareness of psychological and emotional wellbeing.
- Self-esteem, increasing the child's potential to be happy and confident.
- Building emotional skills and resilience
- Behaviour management; calmer in the classroom for example.
- Improve mental health and emotional wellbeing. Nature based activities were supported on this point.
- Prevention to ameliorate chronic mental health problems and improve access.
- Parenting programme for first time parents and young pregnant and young mothers
- Other: reciprocity, attachment, recovery, group sessions, supervision and consultancy, managing self-harm, person centred compassionate care.
- Reducing waiting times and increased access through assessment, especially as YP in the service might have been missed as they didn't meet the threshold for CAMHS.

R193's comment is worthy of repetition: '*We are not currently commissioned to provided treatment and ongoing work. I do think this is the direction we should go as we could prevent young people being admitted in the future and most of the young people we see don't meet the criteria for CAMHS so it would hopefully prevent young people deteriorated and avoid CAMHS referrals'*. We note that in the new Department of Health structure for young people, young people's mental health services are to follow through to age 25.

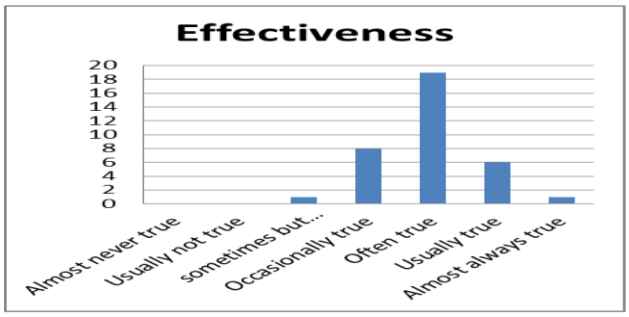
Respondents generally noted good outcomes of EI for young people, *'children better able to manage their wellbeing and families more aware'* (R213). A reduction in domestic violence, neglect, less reliance on medical interventions and less referrals on was noted. Although one respondent thought the outcome was variable depending on the young person's involvement and interaction, and another that it was difficult to measure the outcome.

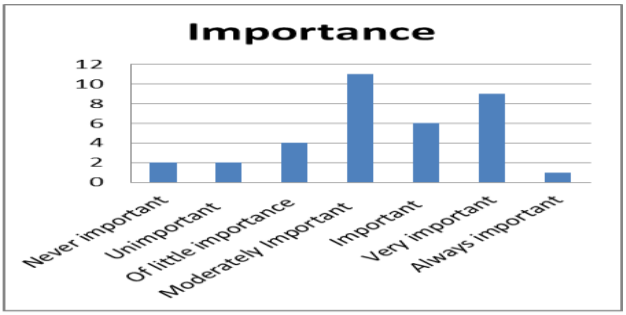
### Cognitive Behavioural Therapy (CBT)

CBT was regularly coded in round 1 with helpful and insightful comments offered that were followed up in round 2. This second survey posed three questions; whether CBT is effective in supporting young people's wellbeing; how important CBT is to their practice; and whether the nurse was confident in practicing CBT.

Figure 12 shows the responses with 74% noting CBT as effective, 46% it as important to their practice but just 39% confident in practising CBT. It seems clear from these results that there is an acknowledgement of the usefulness of CBT but a need for more training to enable the nurses to be more confident in its application.

*Figure 12. CBT Round 2 responses*





CBT is a well document intervention providing psychological support adults and young people. It was highly prevalent in the second survey's responses, representing the largest coded response overall. CBT was perceived as effective because a majority of young persons' needs concern emotional regulation. Respondents noted the use of CBT for anxiety, depression, trauma, OCD, self-harm, negative thinking, self-esteem and confidence, emotional wellbeing, stress, and eating disorders. Respondents generally valued CBT and it was seen as common place in their services.

CBT is seen to be effective with young people…*'as majority of the needs have to do with emotional regulations…thinking processes that might need to be addressed from a cognitive aspect through CBT'* (R1) allowing the young person to develop coping strategies. LIAM an approach to anxiety management developed by NES was deemed to be a useful approach.

The use of CBT by non-qualified CBT practitioners was evident, with nurses using the principles effectively with young people in schools and as an early intervention approach with many children and young people in the community. CBT was noted as evidence-based, structured and comprehensible to young people to help *'explore their own thoughts, feelings and behaviours without judgement and (for the most part) at their own pace'* (R166).

From the literature review Attwood et al (2012) explored the computer-based CBT intervention 'Think, Feel, Do' which was delivered on a one-to-one basis by the school nurse over six sessions at school. Andersson et al (2014) achieved favourable results with a CBT internet programme. The use of digital CBT was also noted by other respondents in this study.

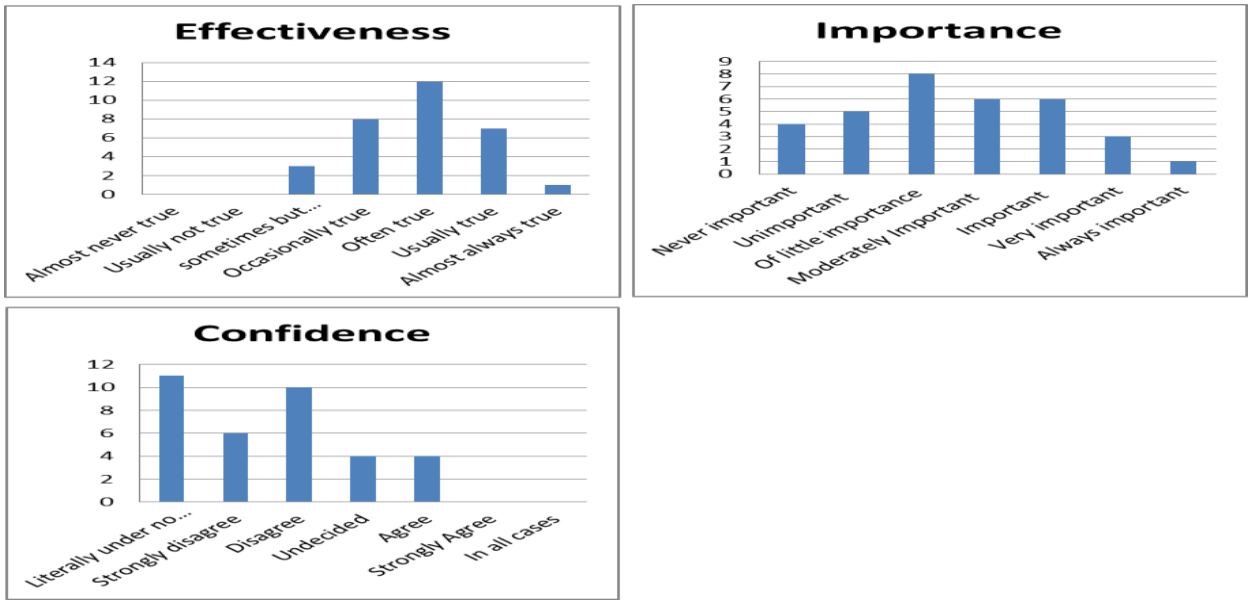
Nurses observed CBT to be: an accessible intervention with nurses free to use it in their work, as having a good evidence base, and being recommended in NICE guidelines. Respondents commented on the integration of CBT with systemic approaches where they enlist the help of parents (as co-therapists) to manage individual needs and to effect change through agreed programmes with both the child and their family. In groups, CBT can be adapted and young people were seen as more willing to engage with something that 'wasn't a script'. For some nurses, supervision was framed around CBT interventions however, there were a number of respondents who had tried unsuccessfully to access CBT training.

Although CBT was well established, some nurses cautioned that other systemic interventions were also important and that it was limited by a reliance on the young person's motivation while some had found it distinctly unhelpful. Furthermore, despite the evidence for CBT, there could be a disconnect between the skills that the nurse has and the interventions that the young person needs. A school nurse cautioned that '*CBT is not recommended when children and young people are living in toxic or traumatic environments which is often when school nurses become involved'*(R166).

### Dialectical Behavioural Therapy (DBT)

DBT was coded across the sample with a frequency of 14 for one question. Respondents rated the effectiveness of the intervention as 65%, with variable importance (30%) and with significantly less confidence in practising (77% rating for a lack of confidence in using DBT).

*Figure 13. DBT Round 2 responses*




Respondents noted the approach to be effective (hugely effective in one case) in managing impulsive high-risk patients, supporting distress tolerance, and for eating disorders. In schools DBT was employed for emotional regulation. Managing emotions was coded on a number of occasions with comments noting *'I believe this is a really positive model for young people with emotional regulation problems'* (R48) and helps them *'tolerate difficult emotions and learn more positive coping strategies*' (R30).

The therapy was practised within individual sessions, hospital based, schools, group interventions and in supervision. However, there were some concerns about engagement 'I have worked with young people who have found this way of working really helpful but have had others really not like it and have had difficulties engaging young people with the model' (R39).

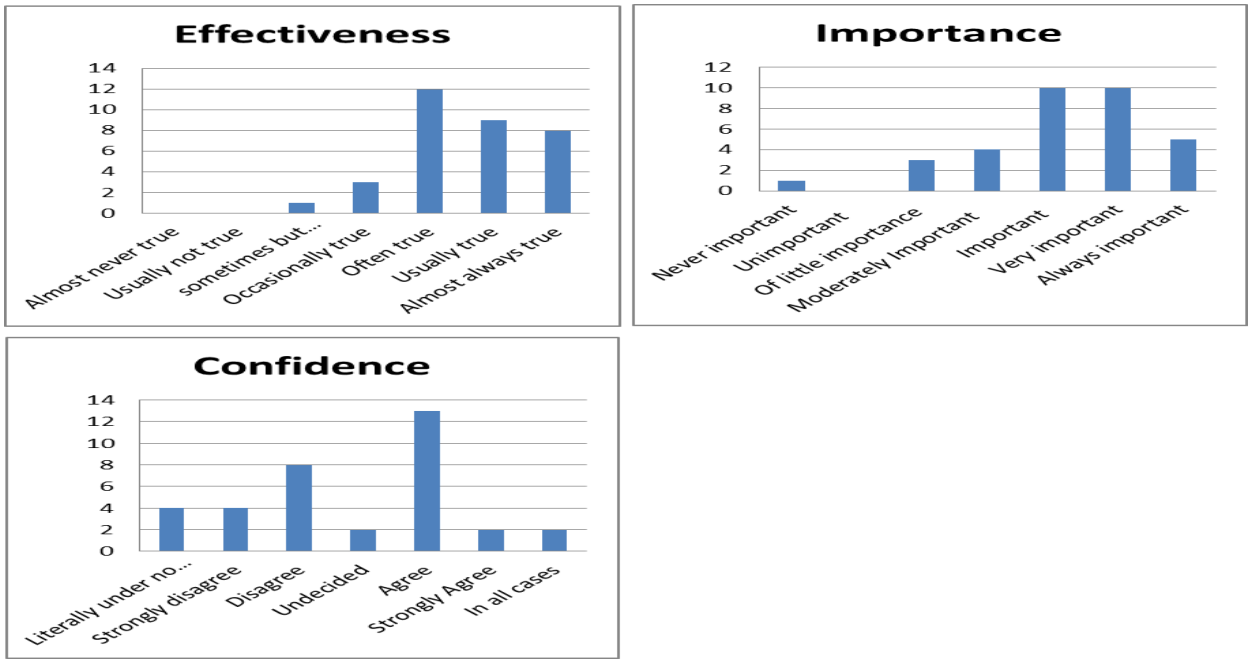
The importance of training was stressed and the responses to the round 2 survey confirm that the respondents felt it was effective and important, but they lacked confidence in practising. One respondent had '*just read the manuals and the DBT informed decider skills manual'* (R1) but was awaiting training. Decider skills were noted as being an aspect of young person's application of DBT (as well as CBT) although mentioned only a couple of times the responses

were consistent. The approach seems to be useful as an adjunct to CBT and DBT and was adaptable to the individual client.

### Family and Systemic Practice (FSP)

Family and systemic approaches had good coverage across the responses and coding. Figure 14 indicates a strong agreement as to the effectiveness of FSP (88%), a strong degree of support for the importance of the approach (76%) but a lower (49%) level of confidence in delivering the interventions with four respondents scoring Q13 'I am confident in practising Family and systemic practice' with a 1 which is 'literally under no circumstances'.

*Figure 14. Round 2 FSP responses*




The intervention was viewed as having a strong evidence base and, anecdotally as being effective and largely well-received by young people and their families. Interventions ensured that the care-giver gained an understanding of the difficulties the young person had and the '*the ability of the nurse to also work with the support networks young people have including family members is vital in enabling ongoing recovery'* (R62). Family approaches were seen to be effective because the family are enlisted as co-therapists engendering a shared understanding of the assessment, formulation and rationale for the approach.

Key aspects of SFT were

- Positive family relationships and communication
- Working with family systems useful at supporting the young person's psychological and emotional wellbeing
- Children and young people being part of a systemic system and treated as such.

Respondents noted FSP integrating with other manualised approaches or other therapies for example MECSH (Maternal Early Childhood Sustained Home visiting), behaviour therapy, therapeutic relationship, and CBT. Attachment was also noted *'I think systemic practice informed by attachment theory and a medical model approach in order to establish an effective assessment and emerging formulation is important'* (R84).

FSP has a wide application from the very young to the more mature young person, specifically there was support for the use of FT with eating disorders. This whole system approach was repeatedly advocated to manage individual needs, to include school, and families/carers and as having improved outcomes in comparison to individual work alone. Systemic practice 'appreciates the contextual factors that inform young people's emotional wellbeing issues and allows for inter-agency working '(R42).

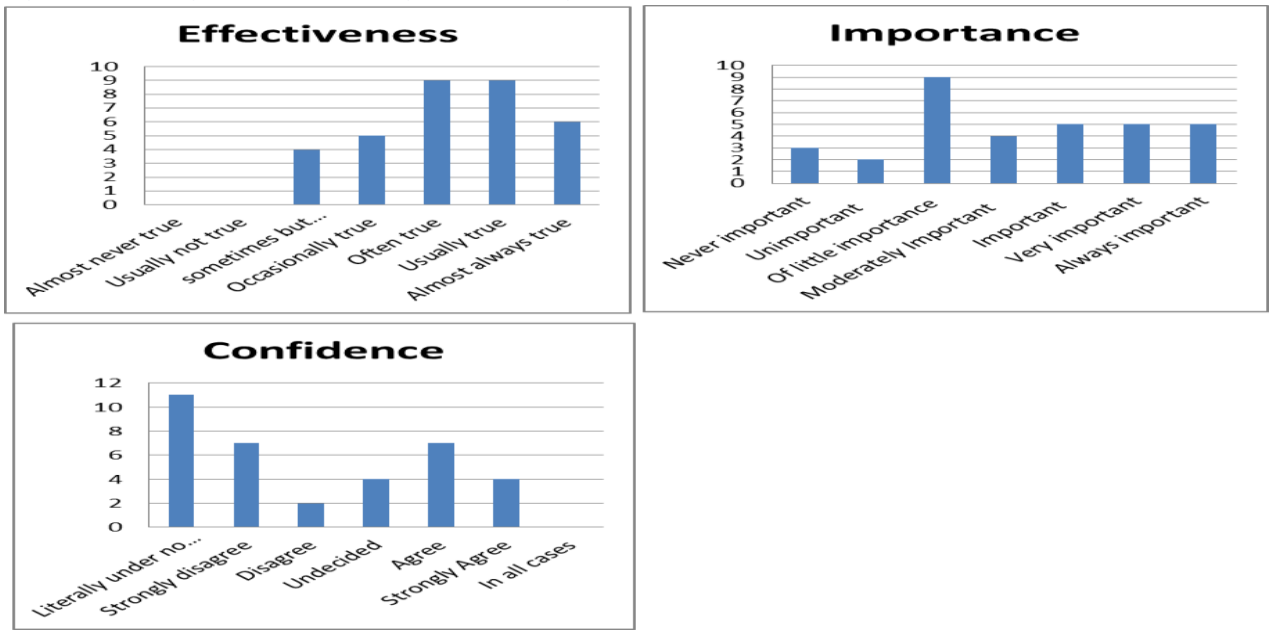
As nurses, the respondents noted; their ability to weave the model into their practice, that nurses can work well with families due to the degree of flexibility they have in managing their time. One respondent saw the organisation and basic training of nurses as influential because, whilst working holistically with a family, they could base their approach on their nursing knowledge of assessment and planning care. One nurse was trained in CYP-IAPT but even then, systemic practice underpinned their work. However, there was suggestion that some parents may be put off because of feeling blamed and that some young people may not want their parents to be involved in their treatment. Therefore, the nurse has to navigate their work sensitively.

Respondents noted the importance of training in FSP as it requires the nurse to have a significant amount of extra knowledge. One respondent was utilising the approach without formal training but most others had received formal training. The Association of Family Therapy were cited as delivering training at a range of levels. One respondent had trained their staff in CBT and systemic family-based therapy, viewing them as *'highly effective at supporting young people to recover from their eating disorder*' (R19).

## Family Nurse Partnership model (FNP)

FNP was coded across the sample; respondents rated the effectiveness of the intervention as 73%, with variable importance (45%) but again, generally less confidence in practising with 57% reporting a lack of confidence in using the technique (figure 15).

*Figure 15. Family Nurse Partnership Round 2 responses*




The FNP model supports partnership with the YP. The Scottish Government Revaluation study (https://www.gov.scot/policies/maternal-and-child-health/family-nurse-partnership/) discusses

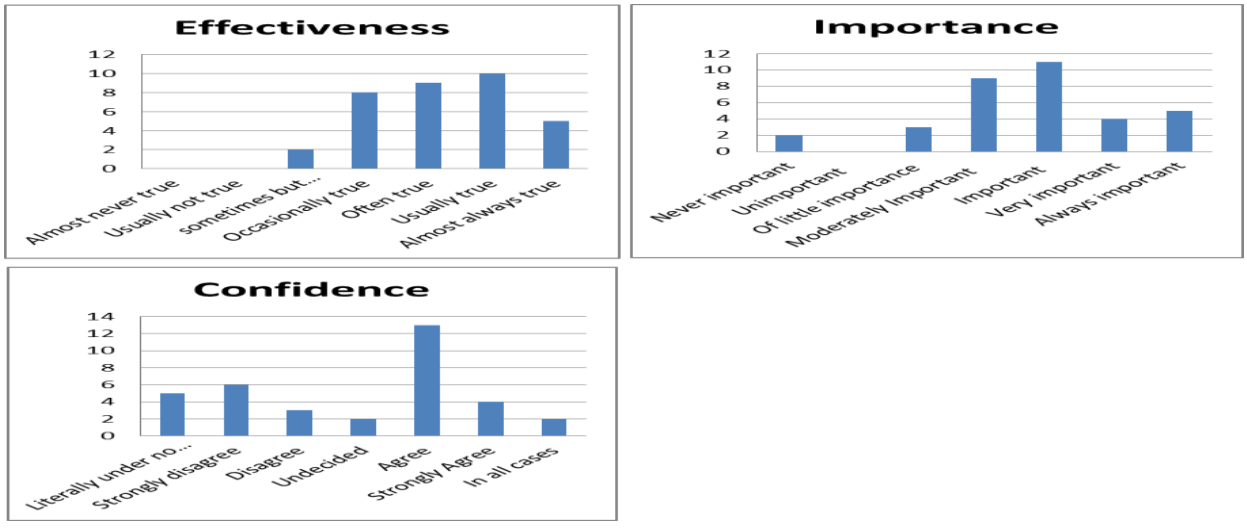
clients who are at risk of having multiple complex vulnerabilities that can affect their psychological and emotional wellbeing and that of their children. It is delivered in peoples' homes by specially trained nurses. Respondents in general were supportive of the model with one noting '*in their practice that the therapeutic relationship that is built up between the nurse and the client, the models that are used to deliver the programme, the training of the nurses, the importance placed on reflective and restorative supervision, motivational interviewing is used as the method of communication, strengths based approach and the client is seen as the expert in the own lives'* (R218).

Nurses from Scotland, in particular, recognised the influence of the FNP model in their practice, that it made a difference, and it helped to break cycles of intergenerational inequalities. The use of the model provided increased self-efficacy for young people and good job satisfaction for the nurses. Respondents commented on the continuous quality assurance/improvement methods involved and the strong evidence base. Round 2 noted a high Scottish rating for how effective the model was but a variable response as to the importance. In England services have moved away for the model and consequently, confidence in using the model was lower.

The model integrates well with other interventions such as motivational interviewing, partners in parenting education (PIPE) and DANCE. It is a strengths-based, client-led approach. It includes a number of aspects of the 'training' node (to be discussed later) that respondents thought should be offered to prepare nurses for working with young people's emotional wellbeing. For example, developing a therapeutic relationship, knowledge of attachment, strengths based, self-efficacy, human ecology theories and systemic practice. The Family Nurse Partnership model and mindfulness had also been introduced into clinical supervision and training in this was available.

## Solution focused Therapy (SFT)

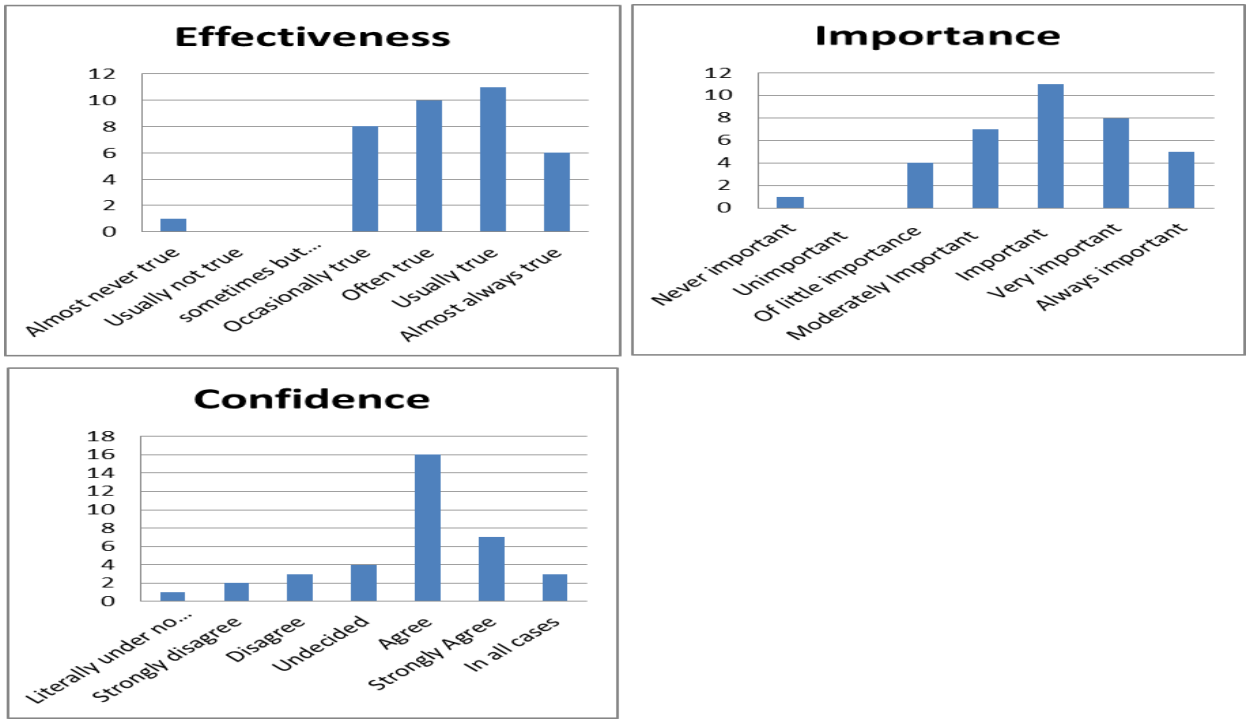
*Figure 16 Solution focused therapy round 2 responses*




SFT was noted as being useful when working with parents as well as young people, complimenting short term support for identifying children and young people's own solutions, and integrating well with counselling and CBT interventions. Six respondents noted they practised SFT. In round 2, 71% found SFT to be effective, 59% important to their practice and 54% were confident in practising it.

## Motivational Interviewing/Motivational Enhancement Therapy (MI)

*Figure 17 Motivational Interviewing Round 2 responses*




MI was rated by 75% as effective, 67% as important and 72% of respondents felt confident in practising the techniques. MET was thought of as a broad term that was collaborative with the young person, helping to develop an intrinsic belief in change and recovery. Within this (and the FNP model) MI was noted to be one of the foundation skills required to facilitate change.

Responses noted that MI had over forty years of research-based positive outcomes for children and their parents. The application of MI utilises motivational interviewing skills to support the clients to discuss their intrinsic motivation. It is a method of communication, a strengths based approach where the client is seen as the expert in the own lives and able to manage their own self efficacy and emotional wellbeing. MI skills support the clients to discuss their intrinsic motivation, life goals, readiness to change and provides a respectful conversation where new information can be provided and evaluated.

Respondents noted the way MI helped to support their early conversations; building trust, openness, focus, and to be non-judgemental. The collaborative nature was noted whereby *'someone is able to create their own plan of how to address their concern they are more likely to follow that plan'* (R19). There was a fair response from family nurse practitioners for whom MI was embedded in their treatment. They were supportive of the approach, viewing it as especially valuable when supporting young women emotionally. MI techniques were used in assessment and signposting to appropriate resources. R230 noted *'In my opinion the strategy to look at change behaviour work in line with the FNP programme is invaluable to help support young women emotionally. The communication skills that are embedded in the spirit of motivational interviewing is highly effective…I feel these combinations bring about the young person's self-efficacy and support their emotional wellbeing as transitioning to parenthood.'*

Millers (2013) states that MI addresses the fundamental values of the human experience but also notes the criticisms levelled at MI i.e. that it fails to address social impacts. It was therefore

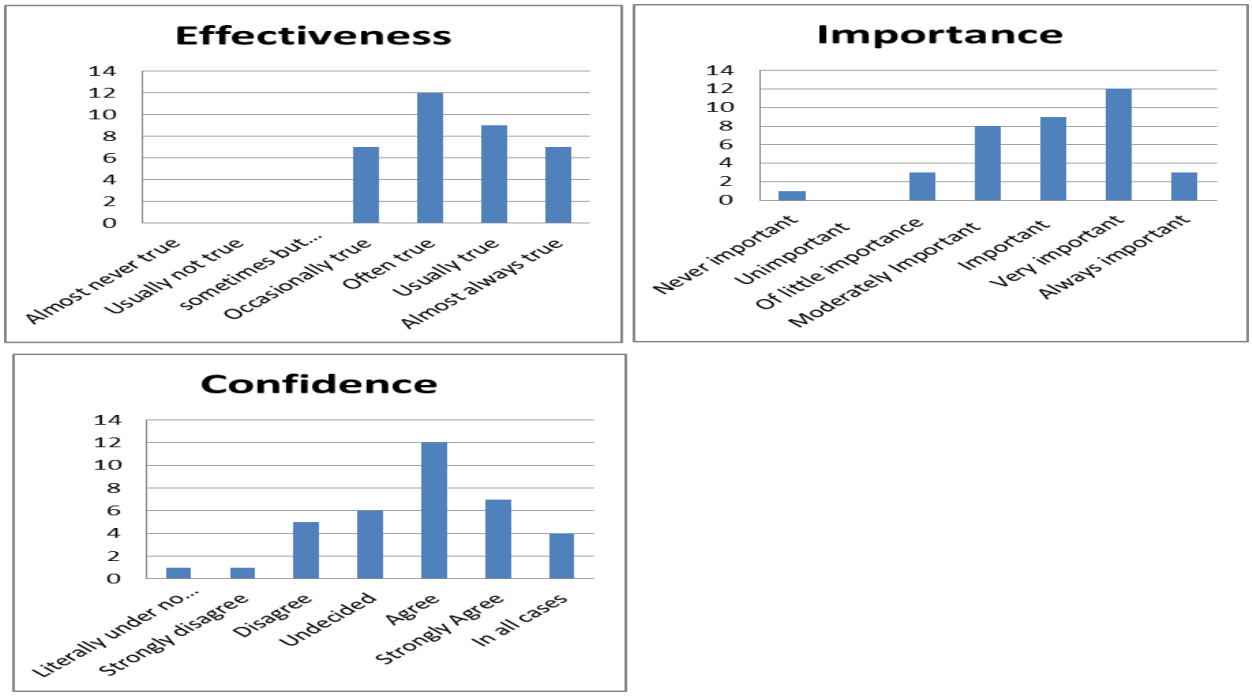
interesting to note that, unlike these adult-focused concerns, there were no reservations expressed by nurses working with children and young people regarding MI. In this respect R218 and R219 both noted an improvement in social functioning with their clients, suggesting that MI in FNP helps with some social situations and social inclusion work.

### Mindfulness and relaxation

Mindfulness and/or relaxation were coded across the responses. The use of mindfulness either in schools, where children are isolated from peers, or in mental health practice where children are excluded from school was commented upon. Mindfulness aided young people's integration back into school, to manage emotional wellbeing, facilitate skills sharing, and for young people to calm their thoughts. Mindfulness was viewed as effective and helped to increase resilience, improve relationships, reduce impulsivity and help young people regulate and generally manage their emotions more effectively.

In round 2, respondents rated the effectiveness as 80%, importance 67% and confidence in practicing mindfulness as 64% (figure 18) which suggests this might be a positive technique for all practitioners to be training in.

*Figure 18. Mindfulness Round 2 responses*



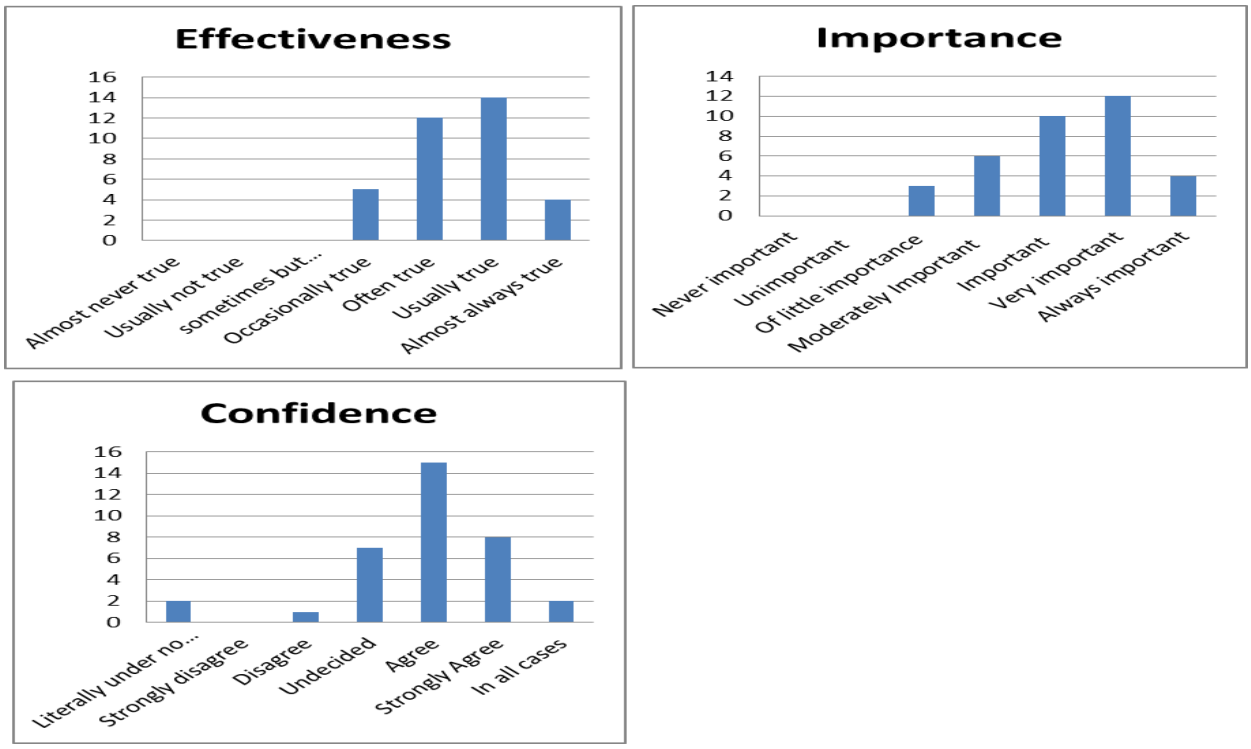

Mindfulness practitioners found positive results and that the techniques were used widely with young people when struggling to manage stresses and their own emotional wellbeing. As noted in the literature review, Alparlan & Yildiz's (2014) nurse-led study utilised nursing support and relaxation exercises to reduce anxiety, reporting significant reductions in trait anxiety. Respondents had accessed literature on mindfulness, practiced it for themselves and in supervision, and had accessed apps to support them to practice. Apps that were specifically mentioned were: SAM for anxiety (developed at the University of West of England), CALM , and Headspace. All three have a fair rating on the internet and can be easily installed on a smart phone (although there is an ongoing cost with some if the user chooses to go past the initial levels).

## Behavioural management

When asked whether behavioural approaches were effective in supporting young people's wellbeing, how important behavioural approaches were to their practice and their degree of confidence in practicing behavioural approaches; respondents rated all three highly at 86%, 74% and 71% respectively (figure 19).

Respondents noted an established evidence base, particularly for depressive presentations and in the management of risks. R156 commented '*I think nurses particularly have an important role in delivering low intensity interventions specifically those that are informed by behaviour change models. The reasons for this are that they are discrete, feasible and can be packaged so that they can be delivered at scale'.*

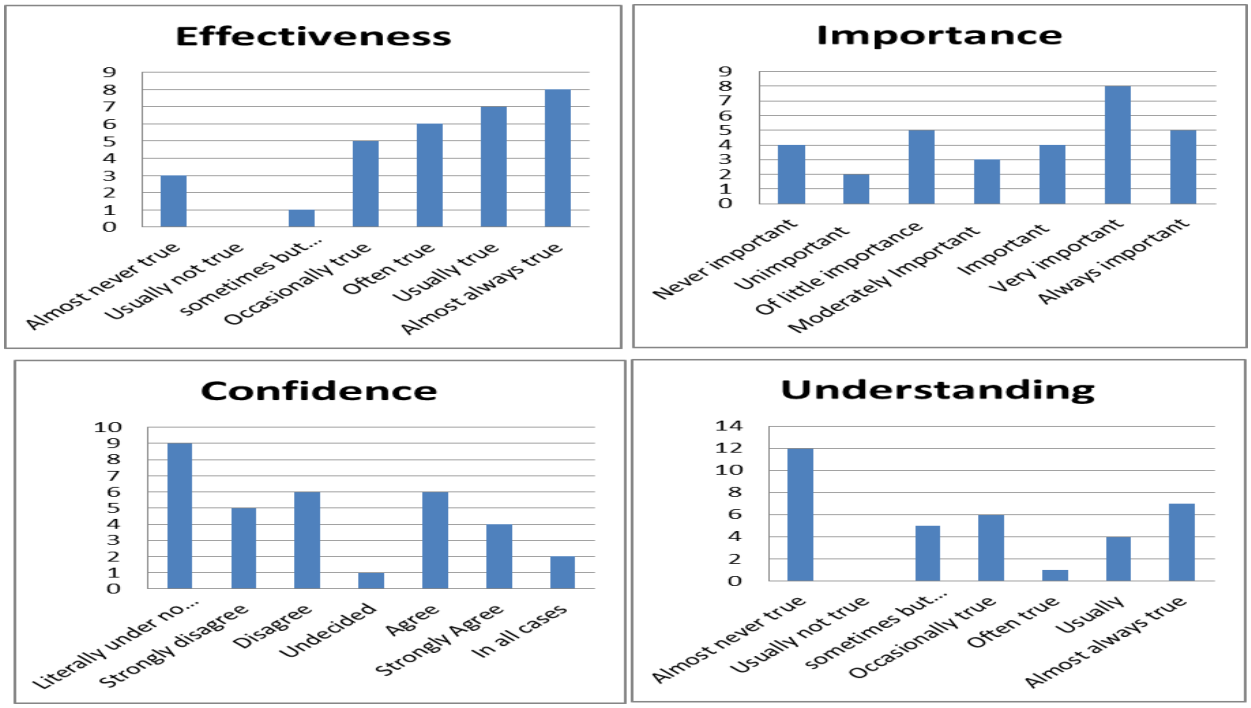
*Figure 19 Behavioural management round 2 responses*




## The Solihull Approach

Respondents scored this approach's importance as 70%, its effective as 55%, their confidence as 36%, and understanding as 34%. This would suggest the intervention is important, but that further training is needed and the approach publicised more widely (figure 20).

*Figure 20. The Solihull Approach round 2 responses*




The Solihull Approach was seen to have a clear evidence base and to use a strengths approach that includes therapeutic techniques for containment, reciprocity and behaviour management. It was thought to be a helpful conceptual framework for a wide range of professionals working with families with babies, children and young people to promote resilience.

Respondents noted its utility from the antenatal period until age nineteen and that its use improved parental insight into the young person's wellbeing, helping them to understanding the 'dance of reciprocity'. Supporting parents in general was viewed as important, to facilitate understanding, support the child's emotional wellbeing, and engender resilience. R117 noted *'the approach for all work with families allowing them choices about the approaches they want to take without being told this is what you have to do'.* Encouraging containment of emotions by parents was also noted.

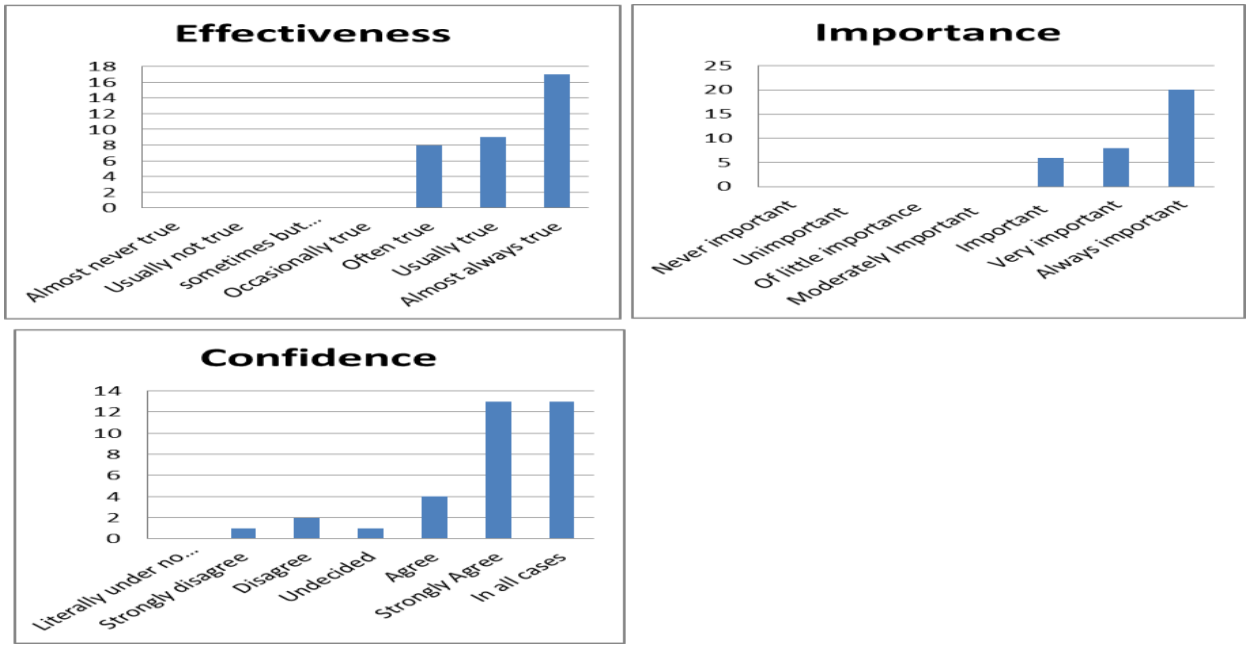
The Solihull Approach and restorative practice was embedded in the supervision of team members who used the model and, in the South West, one university includes the model in their pre-registration nurse education programme.

## Therapeutic Relationships and counselling

Respondents scored both importance and effectiveness at 100%, together with their confidence at 88%. This clearly suggests these interventions are very important to their nursing practice (figure 21).

The therapeutic relationship was noted as a fundamental component of the interventions coded, a bedrock of practice and that, a lack of focus on the therapeutic relationship made other models less effective. The therapeutic relationship and alliance were described as; jointly agreeing tasks and goals, and practising in a holistic way to build trust. Respondents considered the alliance fundamental to the facilitation of children and young people in meeting their own psychological and emotional wellbeing needs. R46 noted that client feedback '*consistently highlights the value of the relationships with professionals rather than individual therapies'*.

*Figure 21 Therapeutic Relationships and counselling Round 2 responses*




The therapeutic relationship involves good communication, empathic and active listening skills, respect, being genuinely interested, and persistent in trying to engage/visit the young person. Comments mirrored the core conditions of empathy, confidentiality, being non-judgemental, honesty, a skill set of emotional capabilities, and the use of appropriate humour. One respondent made a plea for nurses to be skilled with a capacity for understanding emotions and another for nurses to have additional talking therapy skills.

From the literature review, several studies (Bannink et al., 2014a; Bannink et al., 2014b) employed computer-based interventions that measured health behaviour and offered tailored messaged of support. Crucially, those flagged as 'at-risk' were subsequently invited to a face-to-face consultation. Participants indicated that this human interaction provided additional value to the computer-based intervention and those participants engaging with the consultations reported better mental health and quality of life than those who hadn't. This reiterates the importance of TR and again bolsters the suggestion that therapies may be less effective in the absence of a strong therapeutic alliance.

Therapeutic relationships and counselling were practised in a range of settings including clinics, homes and in schools. Weekly outreach / drop-in sessions were used in comprehensive schools in Wales to address the emotional wellbeing needs of young people. These drop-ins provided space to talk, transfer knowledge, and sign posting to specialist professionals. Face-to-face contact was not the only intervention cited, with some areas using digital technologies and other innovative ways to contact the young people. Nurses noted they were well placed to offer interventions because of their flexibility and that nurse-led interventions in schools might be seen by the young people as less stigmatising and threatening than attending CAMHS for example. This approach also helped to maintain the young peson in their normal social context.

Some services utilised specific models such as MECC (Making Every Contact Count), parents counselling, conflict resolution for parents of young children, and emotional support for parents in the early years. For example, the FNP model has a clear focus on the therapeutic relationship. IPT (Interpersonal therapy) was advocated as it explores relationships and mood and their

interaction. IPT creates a space to explore positive communication skills to develop more effective and positive interpersonal relationships which young people can continue to use into adulthood….*'I have offered this type of therapy for the past year and out of all clients only one did not have reduced depressive symptoms'* (R124).

However, evidence-based interventions are only as effective as the engagement of the young person and their motivation. A tension was noted here, in that some young people are seeking a magic answer which can be a difficult expectation to manage. That particular respondent felt they often, therefore, relied on an eclectic approach '*which young people appear to find helpful to them and less rigid'* (R98).

### Group Interventions

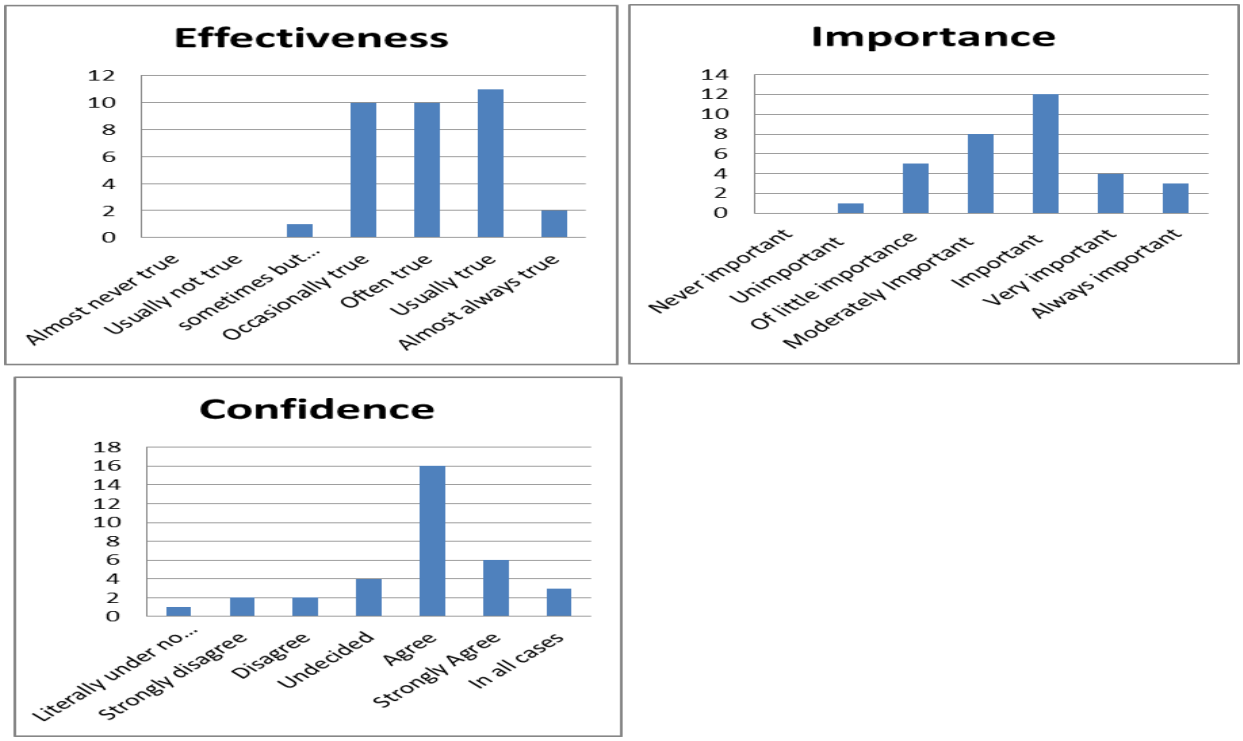
Group work was well-established within young people's mental health services. Respondents scored importance of group interventions as 68%, effectiveness as 58% and confidence as 74% (figure 22). Nurse-led groups were advocated for managing emotions, resilience, and specific conditions such as eating disorders. Groups were seen as helpful as they increase choice, help reduce feelings of isolation and provide peer support for parents. Young people were thought to find groups beneficial for the skills and knowledge they gain but also because they reduce feelings of isolation through shared experiences.

These responses echo the findings from one UK-based study identified through the literature review that examined the effects of a psycho-social group intervention for children with epilepsy (Dorris et al. 2017). Indeed, one of the most commonly cited benefits from Dorris et al's participants was meeting other young people with epilepsy. Participants remarked that they enjoyed meeting 'people like them' and felt less alone and more understood.

Groups also reportedly featured in several other specific interventions such as DBT skills groups, CBT groups, in schools, and for managing over exercise. R 164 noted that '*experiences can be shared, and peers support given. Has been known to be quite effective in forming long friendships and support'*.

One respondent went as far as to suggest a whole school approach is required to empower young people with knowledge of emotions and how to support themselves and others due to the scale of young people presenting with emotional wellbeing difficulties.

*Figure 22. Group interventions round 2 responses*




## Assessment

Assessment was coded in all main sections of the data analysis often in the context of formulation, holistic assessment, and risk assessment. Respondents noted how important assessment was due to the psychoeducation it offers the clients who therefore *'find the process of nurse led psychiatric assessment and shared formulation itself to be extremely enlightening and empowering'* (R221), particularly if they have not been heard or assessed previously.

The assessment often included elements of signposting and/or introductions to self-management techniques with two respondents stressing the importance of maintaining contact with the young person during the referral process. The scoping review of the literature found assessment had been measured in several of the studies and was 'usual practice' (Ammitboll et al, 2019; Ammitzboll et al, 2018; Laios et al, 2010; O'Reilly et al, 2016; Zugai et al, 2014).

Formulation was an emerging term whereby respondents were working more fluidly with clients' needs rather than with formal diagnoses. Shared formulation was noted to enhance collaborative working. Several responses mentioned standardised assessments in the context of other interventions. The most frequent of these are presented below (Table 37).

*Table 37 Assessment tools*

| | | | | | | |
|---|---|---|---|---|---|---|
| Whooley questions | LAC | GAD(2) | ORS and CORS | Edinburgh PND | YP CORE | Brazelton |
| Holistic assessment | Risk assessment | RCADS | HADS | ACE | Adolescent wellbeing scale | |

Whilst there were several rating scales coded there was also a cautionary note that scales contribute to the assessment but *'none are entirely effective and need to be used with professional judgement'* (R9). Interestingly, the Children's Global Assessment Scale, as noted

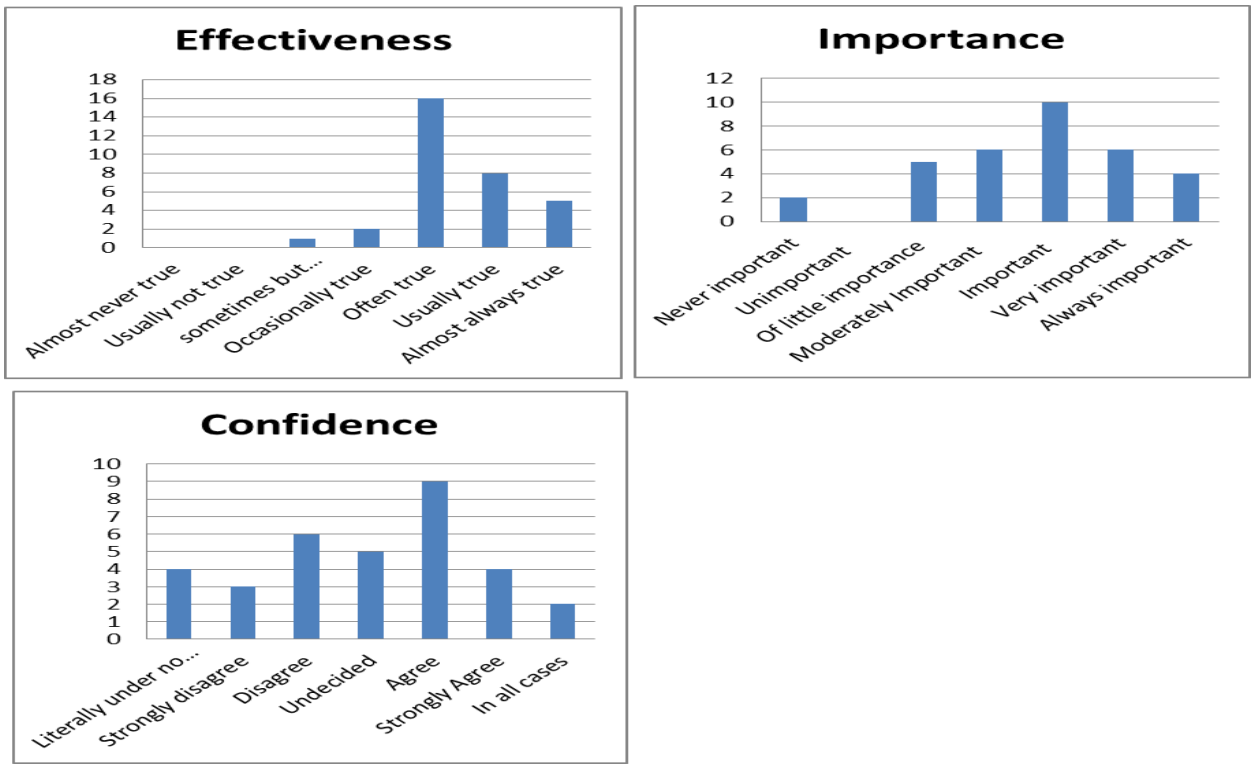
by Coghill and Seth (2015) was not coded but this may been due to a lack of data from practitioners working in ADHD services.

Many of the intervention studies identified in the literature focused on the mental health assessment, screening and consultation carried out by nurses. It has been posited elsewhere that accurate assessments can lead to increased referral rates however the Delphi respondents' anecdotal accounts suggest that a thorough assessment can be an intervention in its own right which may reduce subsequent follow-on referrals.

## Creative Interventions

The definition of creative interventions was kept deliberately broad in the second survey and included art, exercise and green spaces. These were seen to be effective (91%) in supporting young people's wellbeing. Important (61%), but staff lacked confidence (45%). This suggests the interventions to be effective and important but that the more staff training is required (figure 23).

*Figure 23. Creative approaches Round 2 responses*




Contrary to expectations, accounts of emerging creative approaches in this review were sparse. Where they did feature, they fell into four broad headings, art-based, movement-based, nature-based, and service organisation. An outlier to these three headings was social inclusion work.

- Art and art psychotherapy were a frequent coding and exercises such as 'Lego house', worry boxes, creative writing and drawing, *'I normally draw a house and ask a young person to write all the good things they need in their house and then ask them what they have not put down and why that way they normally tell me and then we all decide what we could do to make things better'* (R162)
- Movement included dance movement psychotherapy, drama and psychodrama, surf school as part of a CBT programme, yoga. Walking and talking, exercise and five ways to

wellbeing use., '*I normally encourage clients to join activities such as boxing gym were they can let out their anger and frustrations'* (R162).

- Nature included horticulture-based approaches, nature/outside experiences, like the Forest school, tree of life nature therapy, and Surf Tonic Therapy *'a 10 week programme delivered by surf instructor and staff but paid for from charitable funds'* (R201).
- Service organisation included school drop in sessions, an ACES Pilot. For example, school nurses in Gwent were involved in an ACEs pilot with a comprehensive school.

When asked to state the most important creative approach, diverse views were expressed. Responses (in rank order) were: Art-based, nature-based, playing and learning together, exercise-based, music, drama, partners in parenting, and the five ways to wellbeing. Respondent 39 noted that creative approaches can have a *'hugely beneficial impact upon the emotional wellbeing of young people'* but was unsure of the evidence base.

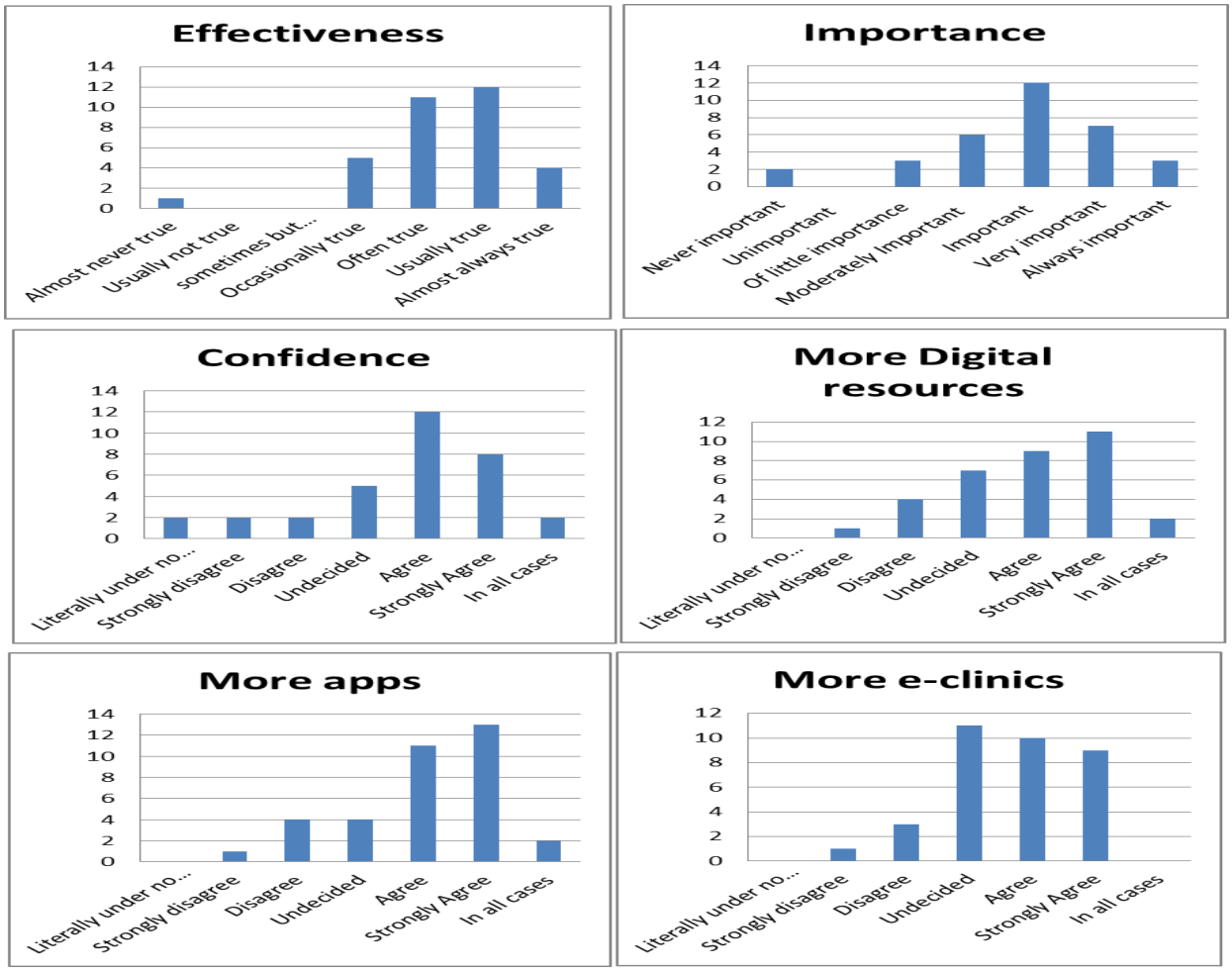
Based on the literature review, this caution was well-founded though nature-based interventions did feature in Bang et al's (2018) study that used nursing student mentors to deliver a community health program in urban forests. Despite no change in physical health, results showed significant improvements in depression and self-esteem scores, compared to the control group. However, it is unclear whether improvements can be attributed to the forest experiences alone, as these were also combined with lectures.

### Digital Resources

Respondents rated the effectiveness of digital resources as 82%, their importance as 67% and their confidence in using them as 67%. A general increase in digital resources was rated at 65%, an increase in apps specifically at 74%, and more e-Clinics at 56% (figure 24). This suggests a fair degree of support for these approaches when engaging and working with young people.

E-clinics reportedly enabled nurses to engage with patients in different venues and at different times and were noted as one way to overcome some of the time pressures and barriers that made workloads problematic. SAM for anxiety, CALM, and Headspace received specific mention.

*Figure 24. Digital resources round 2 responses*



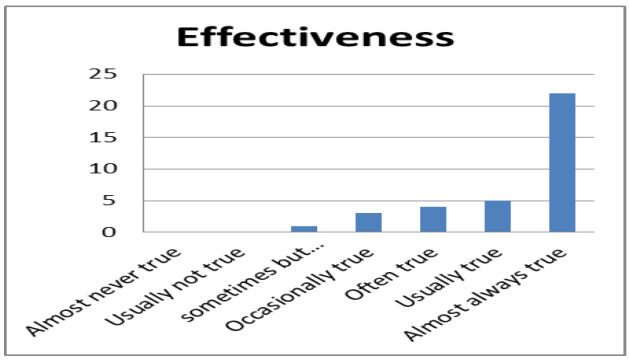

Digital resources were also well represented in the literature review. Three studies involved a computer-based intervention; two (Bannink et al, 2014a; Bannink et al, 2014b) used an e-health questionnaire that measured health behaviour. Results appeared to suggest that digital interventions (such as on-line questionnaires and web-based CBT interventions) helped with recruitment of participants, possibly due to the efficiency of digital interventions in contrast to more labour intensive face-to-face staff interventions.

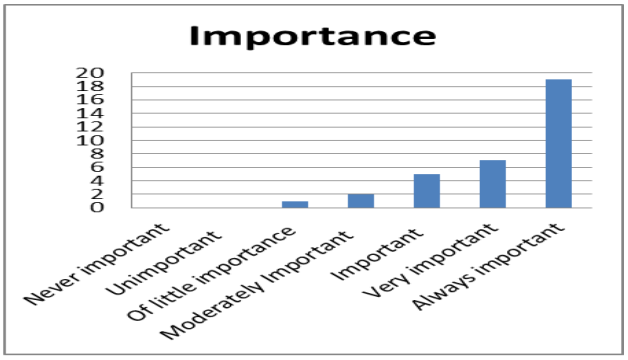
Concerns about the quality of the therapeutic alliance are often levelled at digital interventions and the relationship between practitioner and patient is often cited as vital (Roberts, Fenton & Barnard, 2015). However, studies comparing face-to-face and internet-delivered mental health interventions, such as CBT, demonstrate comparable results in symptom reduction for adults (Andersson et al., 2014) casting doubt on the validity of these concerns.

## Supervision

Respondents rated the effectiveness of supervision as 89%, its importance as 91% and their confidence in its use as 91%. This shows strong support for the practice of supervision (figure 25)

*Figure 25 Supervision round 2 responses.*





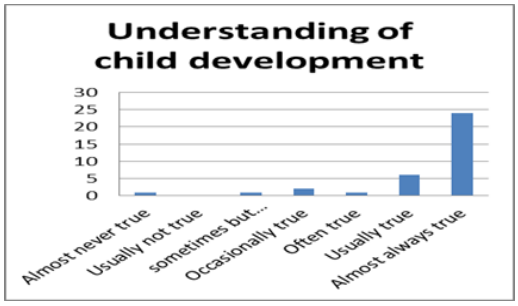
The perceived value to organisations of clinical supervision in the provision of high quality care has risen since the implementation of the NHS plan (DoH, 2000) and the Darzi report (DoH, 2008). Clinical supervision is a tangible process of professional regulation and is an important part of the clinical governance framework (Turner and Hill, 2011). There were obvious parallels between therapeutic interventions and clinical supervision with respondents commenting that supervision should be regular, practice-focused (including quality appraisal), provide ongoing support, and safeguard professional boundaries. Because supervision can *'ensure all nurses are supported in their decision making and feel confident and competent in their delivery of early intervention therapies'*(R166).

Supervision provided time to think and plan interventions and should be prioritised. It was suggested that nurses could gain supervision from a trusted psychologist within adult mental health services, or through links with CAMHS. Supervision should be truly developmental as well as restorative. However, concerns were raised about a lack of supervision, '*A lot of nurses from their fields do not receive quality clinical supervision and lack experience and confidence to work effectively with emotional health*' (R24).

## Training

In this second Delphi survey, 89% of respondents felt that all nurses working in young people's mental health services should have a thorough knowledge of child development (figure 26).

*Figure 26. Child development round 2responses*




Intervention-based suggestions, specifically for the content of pre-registration nurse training, included a CBT qualification and an early signs' module. The Solihull Approach was also posited as core training for the undergraduate nursing programme.

Recent years have seen the focus on resilience extend from clients to their nurses and even student nurses. Olowokere & Okanlawon (2014) evaluated the impact of resilience training delivered by school nurses on vulnerable children's. Those in the 'resilience only' or combined groups improved their resilience scores significantly compared to the control group and the peer support only group (although no difference was found between resilience training only and resilience and peer support combined). A health visitor respondent noted that, in early years there is an opportunity to support parents in building resilience in their children to better meet the developmental challenges of adolescence. Alparslan and Yildiz (2014) provided training and nursing support with stress/anxiety management. They achieved promising reductions in anxiety levels.

Nurses were seen as adaptable and able to follow different manualised approaches to offer therapeutic interventions but needed training and knowledge on common childhood traumas / experiences and the development of the teenage brain. However, when asked (in question 63) whether experience was more important than training, most respondents felt this to be often - almost always true. This is perhaps a reflection on the importance of having contextual knowledge of working with young people as well as appropriate training.

Nurses are often provided with training in assessment, but respondents noted a gap in training in the subsequent evidence-based interventions. Similarly, one UK-based study identified in the literature review (Doi et al, 2018), evaluated the effectiveness of a new nine-pathway referral system for school nurses. The 'mental health and well-being' pathway was most frequently used for referral however, school nurses noted that they still felt inadequately trained in dealing with low to moderate mental health needs of students below the referral threshold for specialist treatment. Training-programmes therefore need to be comprehensive, to encompass interventions relevant to the nurse's specialism and accredited to ensure nurses are taken seriously in the delivery and management of effective interventions. Respondents want training based on their current case mix and that is informed by what the young people themselves want from their health professional. In general, training in a specific therapy to work in children and young people's services was favoured, as was openness with clients about the level of training staff had received.

Through the analysis of other responses regarding training needs, in many ways, a picture of respondents' ideal training programme for children and young people's health and wellbeing has emerged. The NMC's predecessor (the ENB) oversaw a suite of standardised programmes for

community nurses, child workers, and addiction workers etc., which were delivered contextually but with a shared core content. One respondent specifically mentions this, advocating a standardised post-registration CAMHS course. The tabulated responses below (table 38) are ranked in order of frequency and, can therefore be viewed as a prioritised list of intervention-based training programmes for nurses working in services for children and young people's mental health and psychological wellbeing. Some illuminating respondent comments are also included.

*Table 38 Training*

| | | | | | |
|---|---|---|---|---|---|
| Evidence based practice training | 21 | Training to ensure holistic approach to care / treatment then more specific evidence-based training | Solihull | 3 | Solihull and restorative practice with regular updates/ supervision to examine the quality of practice. |
| Child development | 11 | How emotional difficulties can start | MH Conditions | 3 | Training in specific mental health issues in young people and services available. |
| Cognitive Behavioural Therapy | 11 | IAPT is an example of need and changes to services. CBT training and access supervision in effective practice application | Communication | 3 | |
| Youth MH First aid | 10 | How to recognise and normalise and develop management strategies. Suicide first aid training. | ACE | 2 | ACES's and child experience of trauma, the effects of trauma on the child intrauterine. |
| Holistic assessment, Risk and formulation and risk | 9 | Care planning and risk assessment are core skills that are incredibly important to the safe and effective provision of care. | Solution focused therapy | 2 | |
| Interpersonal theory (therapeutic relationship) | 7 | How to manage a brief encounter the ability to build a therapeutic relationship, training around listening and empathising appropriately. | Safeguarding | 2 | |
| Contextual | 7 | Triggers, symptoms, common behaviours to aid diagnosis and enhance referrals and ongoing care including learning disabilities | Behaviour change | 1 | |
| Strengths and Resilience | 6 | Resilience | Psychosocial interventions | 1 | Behavioural family intervention for psychosis |
| Motivational Interviewing | 5 | | Transgender | | |
| Trauma | 5 | Trauma informed training | Group | 1 | |
| Family Systems Theory | 5 | Training in systemic approaches, a relational focus, working with the wider family and professional systems. | Mindfulness | 1 | |
| Attachment theory | 4 | | Creative | | Horticulture based therapy, psychodrama, family therapy |
| Dialectical Behaviour Therapy | 4 | DBT informed skills including decider skills and emotional regulation) | MECC | 1 | |
| Supervision | 3 | Regular and truly developmental supervision. | | | |

## Barriers and facilitating factors

A consistent finding from the literature was a lack of time for nurses; to carry out their role effectively, to be involved or consulted in research into suitable interventions, to access training and, to generally meet the rising demands of supporting children and young person's mental health and wellbeing. In this survey, however there was only 46% agreement with the suggestion that nurses did not have enough time to attend training (question 53). This may of course vary between settings as R24 made an extensive comment: '*If there was time available to be released for training. School nurses are on their knees as are CAMHS nurses - the referrals and work are relentless with pressure on staff to reduce waiting times. However, it is more than training. Training in itself is not enough, staff are given a day training and expected to deliver interventions which is inadequate and insulting. A lot of nurses from their fields do not receive quality clinical supervision and lack experience and confidence to work effectively with emotional health. It is not a manual it needs to be individualised and often evolves to different things as the therapeutic relationship and trust develops*.'

Respondents also noted that training was often very brief, difficult to access, and that, when completed, they were then expected to just get on and deliver. R22's comment is instructive i.e. that staff '*need adequate support, ongoing training and supportive development, the knowledge that they will not be crucified if a complaint is made (notwithstanding negligence or worse, of course), and regular, truly developmental supervision. Nurses need to have the psychological and emotional capacity to be able to work effectively and enduringly in such settings*.'

A continued lack of confidence to deliver a therapy after training was coded, but would presumably be mitigated by the regular and structured supervision advocated elsewhere in the responses. It was also noted that staff in CAMHS generally had more of the required skills and expertise in both with R16 noting that 'Training, exposure and experience has improved the care children and young people admitted with; deliberate self-harm, depression, eating disorders and emotional dis-regulation now receive.'

Continuing with the challenges of applying their training in practice, the Likert-scale data depicted in figure 27 contradicts much of the existing literature and indeed some of the qualitative Delphi analysis above in that only 37% agreed that there was a lack of time to use evidence-based interventions. Confidence to practice the intervention was also positive, scoring 71% agreement. However, definite barriers were apparent, including financial restrictions, caseload pressures, commissioning targets and a heavy administrative burden. Despite these obvious frustrations, it is reassuring, and perhaps even surprising, that there was a 77% rating to remain in the profession (figure 28).

In general, psychological therapies were felt to require a tiered/pyramidal training model that focused on intervention as well as assessment, followed by ring fenced time for their application. Once embedded in routine practice, nurses still wanted a 'safe space' and the availability of more skilled staff to offer supervision as well as the means to obtain meaningful feedback from users on the relevance and effectiveness of their treatment. Worthy of note here is R26 comment that nurses need to be skilled and supported and '*given the capacity to provide sessions. To avoid transferring 'I am rushed and really busy', these children need undivided attention. We need to go back to basics and be given more time as this will then spiral. Causing this to be more costly*' and R204 noted the 'tension between time and meeting KPIs which take precedence'.

*Figure 27. Barriers round 2 responses*

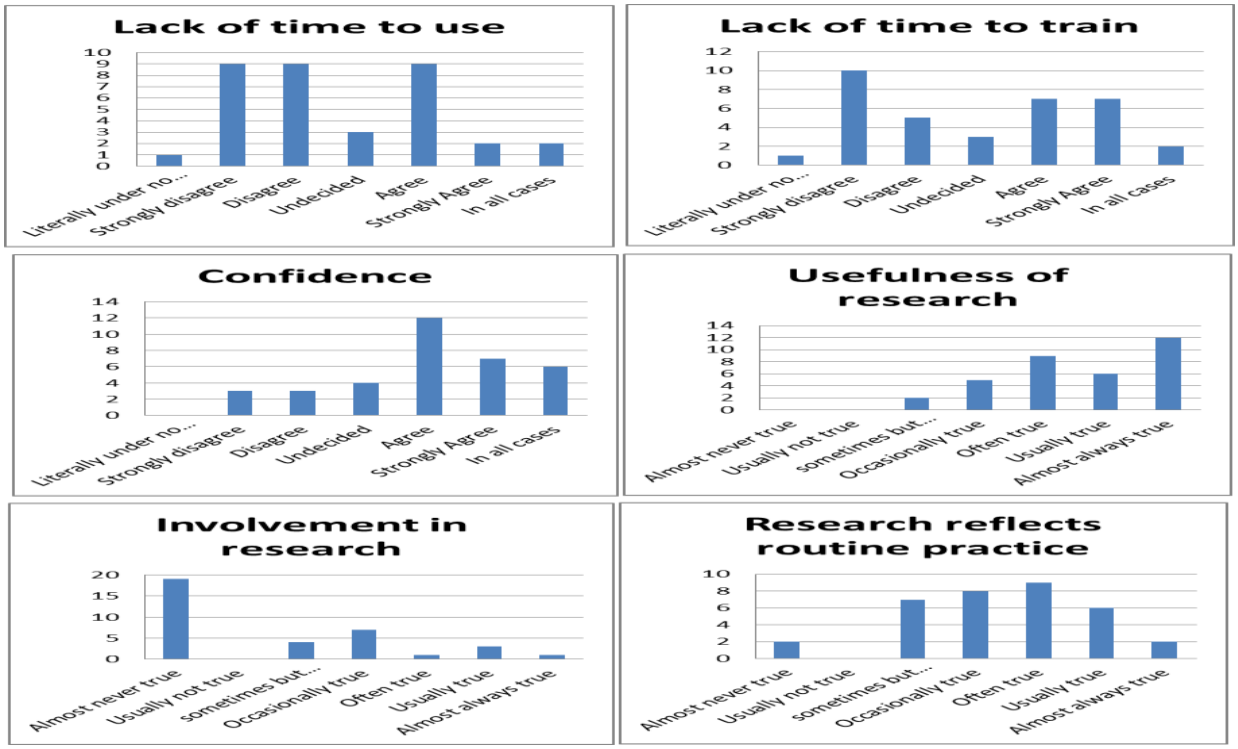
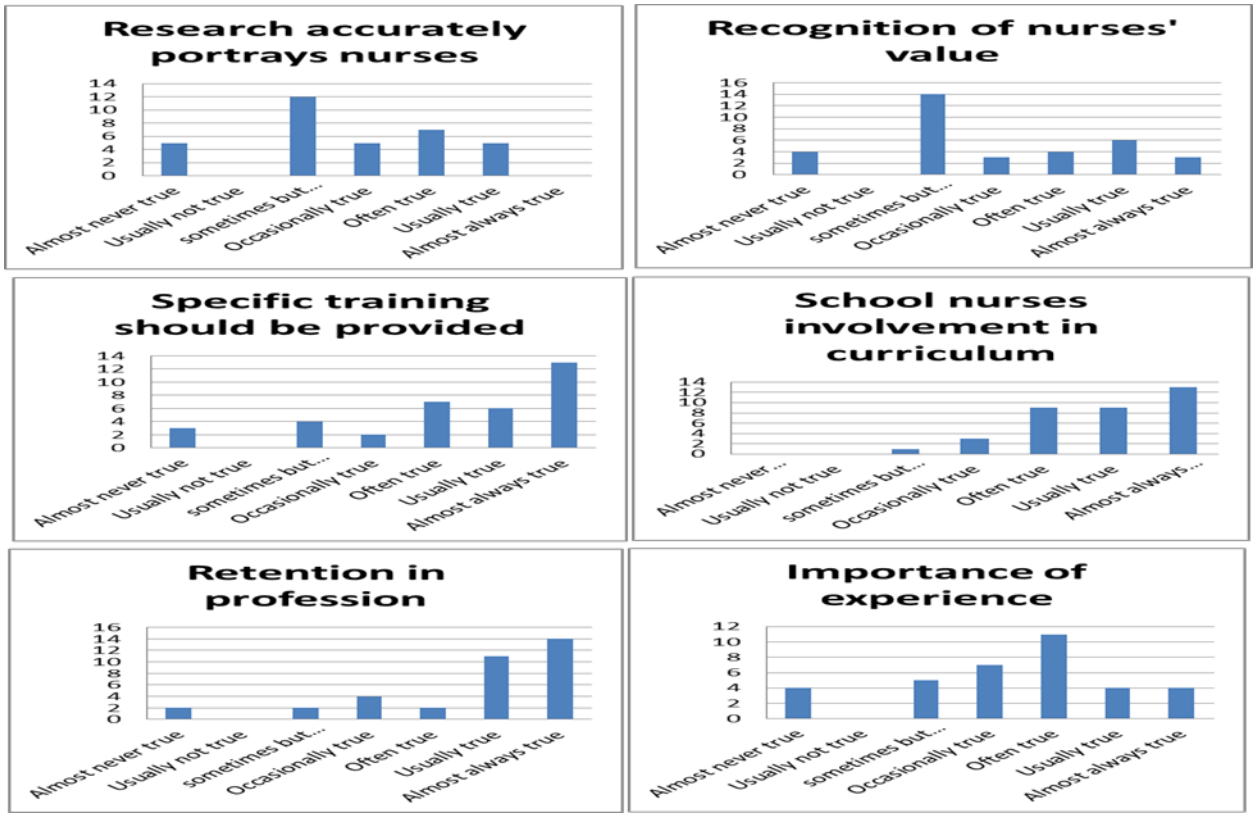



Figure 28 (question 60) shows a clear desire (89%) for specific training in effective interventions for young people. Some respondents had received training in therapies such as CBT, FNP, family and systemic therapy but others, despite their requests, had received none. In the absence of formal training, nurses relied upon their pre-registration training, reading manuals and research, and generic listening skills training. This could partially explain the 54% agreement with the statement regarding the importance of experience as opposed to training (figure 28).

Four questions nurses' involvement in research were included in round 2. Respondents noted that the research they accessed was useful (79%) and was reasonably representative of both routine practice (50%), and the role of the nurse (50% agreement, 26% disagreement) . They noted a number of ways in which they kept abreast of this research (table 33), however, there was some tension noted regarding finding sufficient time to do so. Finally, their reported involvement in research was very low (14%). These responses echo the conclusions drawn from the available literature but also from the general paucity of nursing research studies. It was hypothesised that a lack of time or the capacity to add research to their workload may be an issue (which consequently feature in this report's recommendations).

*Figure 28 Research, value, training, curriculum, retention and expereince round 2 responses*




Concern was expressed about a lack of understanding of the role of the nurse with reports that their profession is often undervalued or even perceived as unskilled (figure 28). This was apparently evident in the generic nature of many nursing job descriptions and a grading system with insufficient granularity to recognise the majority of CPD activities.

Managers sometimes dismissed nurse-led interventions in favour of other professions such as psychology and one respondent felt 'other disciplines dislike nurses leading interventions' (R66). There was, therefore, a general desire for more integrated and collaborative working within services so that everyone understands the unique contribution of nurses. But this sentiment was also extended to include the actual configuration of services which needed to be properly organised and integrated to create, not just an integrated service, but an integrated pathway and a proper sense of joint working. A tangible example of this might be the 89% support for school nurses to teach wellbeing as part of the school curriculum.

## 4.2 Summary

This mixed methods scoping project reviewed the available evidence, and surveyed nurses in the field to understand more about their role in promoting mental health and emotional wellbeing of children and young people across the UK.

There was a paucity of literature, particularly in the UK, suggesting that nurses may be under-utilised in the research seeking to make recommendations concerning their profession. In the studies that were identified, nurses were found to be well-placed to deliver screening and assessments, and relieve pressure on more specialist services. However, these nurses frequently encountered training and time-constraints, both of which were most prominent when working in schools. It was clear how hard practitioners were working to try to meet the psychological wellbeing needs of young people but that there was not enough direction and research into their practice.

Survey responses confirmed the fundamental importance of the therapeutic relationship. They also suggested that nurse-led pre-crisis and early interventions which addressed the mental health and emotional wellbeing needs of children and young people were being extensively utilised. All countries and all regions appeared to have, primarily community-based, services with school in-reach perceived to be highly beneficial. As a review team we were deeply impressed by the range and scope of interventions but did wonder about this breadth and depth of intervention and whether the key components of the analysis of the nurse activity should be a guide for training and development opportunities.

The early interventions typically targeted levels of resilience, emotional regulation and the prevention of ongoing mental health problems. Respondents viewed these (early) interventions as effective but often encountered organisational and practical challenges including access to training and ongoing supervision. These were perceived to adversely affect the effectiveness of their treatment.

Nurses had a good awareness of a range of evidence-based interventions with cognitive behavioural therapy (CBT) featuring most heavily, typically being seen as a routine and effective intervention. The review team consider that based our findings CBT should be a core and first line intervention for those involved in the psychological wellbeing of young people. This would have implications for strengthening pre-registration nurse training, as observations came across that core skills should be included in pre-registration trainings.

Digital resources were represented in the literature review and the Delphi study. These included apps and e-clinics and were seen by a number of responders as useful in-reaching to young people and also familiar to them which might encourage use. The main intervention was cognitive and behaviourally based. Despite some concerns about the quality of the therapeutic alliance responders wished for more of these to be available to them.

The Family Network Partnerships (FNP) model was popular in Scotland as was the Solihull Approach across England. The latter was posited for inclusion in pre-registration nurse training, as was CBT and early signs recognition. Other interventions that are worthy of note are Dialectical Behavioural Therapy, Motivational Interviewing, mindfulness based approaches and the emerging use of outside space.

Additional training, to augment pre-registration education in the therapeutic alliance, was viewed as important to the delivery of high quality, nurse-led interventions. However, whilst many nurses had received some form of intervention-based CPD training, the pattern was highly variable and others were reliant on their basic nurse-training and subsequent practice experience alone.

Despite the difficulties in; accessing training, ring-fencing time to deliver evidence-based therapies and receiving clinical supervision the nurses that responded to this survey remained committed to the profession and to meeting the needs of the children and young people that they worked with.

## 4.3 Recommendations

Based on a synthesis of the findings from a scoping literature review and a modified two-stage Delphi study, the following recommendations are made:

1) Nurses should be involved in any research that makes recommendations for their practice and identified explicitly to aid clarity and communication between research and current practice.
2) Consideration should be given to structuring a UK wide continuing professional development module/programme as outlined in the training discussion.
3) If a UK wide core module for nurse led young people's psychological wellbeing is initiated then this should be accompanied by a research study into its effectiveness.
4) The expansion of Solihull or the Family Nurse Partnership model should be considered whichever approach is recommended in the relevant country.
5) Resources should be made available for nurses to train in effective models for YPMH and wellbeing in particular cognitive behavioural therapy interventions.
6) Some attention would be worthwhile on deciding on a limited data set of assessment schedules for YPMH and wellbeing.
7) A review of clinical supervision arrangement for staff working in YP mental health and wellbeing would be informative
8) Research into pathways to be more efficient and streamlined and for interventions to be more efficiently delivered online.
9) Future research is warranted to identify whether time is a certain issue, and methods to manage this.
10) Nurses are given better, more evidence-based support and consulted appropriately about their roles.

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## Appendix 1 List of Tables

## Appendix 2 List of Figures

# Appendix 3 Explanation of terms

ABA (Applied Behaviour Analysis) refers to interventions that are developed from a branch of science called behaviour analysis. ABA is much more than an intervention for children with autism. https://www.childautism.org.uk/about-autism/applied-behaviour-analysis-aba-and-autism

Adolescent Wellbeing Scale lrsb.org.uk/uploads/adolescent-wellbeing-scale.pdf · PDF file. The Scale. The Adolescent Wellbeing Scale was devised by Birleson to pick up possible depression in older children and adolescents. It has been shown to be effective for this purpose. The scale has 18 questions – each relating to different aspects of an adolescent's life, and how they feel about them.

ACE Resilience research and practice — www.healthscotland.scot/population-groups/children/adverse-childhood-experiences Building on the knowledge that the brain is plastic and the body wants to heal, this part of ACEs science includes evidence-based practice, as well as practice-based evidence by people, organizations and communities that are integrating trauma-informed and resilience-building practices. The term was originally developed in the US for the Adverse Childhood Experiences survey which found that as the number of ACEs increased in the population studied, so did the risk of experiencing a range of health conditions in adulthood. ACEs research shows the correlation between early adversity and poor outcomes later in life. Toxic stress explains how ACEs "get under the skin" and trigger biological reactions that lead to those outcomes.

ACTivate: The aim of the young people's well-being indicator set is to help us better understand young people's quality of life and well-being, and to monitor it over time

ASQ https://pages.uoregon.edu/asqstudy/asq/LearningActivities/Learning Activities.pdf · PDF file The ASQ screens development in the areas of communication, gross motor, fine motor, problem solving, and personal-social skills. Because a parent or caregiver, not a professional, completes the ASQ, the ASQ provides an inexpensive method for screening and monitoring a child's develop-ment. Screening with the ASQ elicits three potential results:

CALM: A mindfulness, relaxation, and cognitive based app for mental health and wellbeing. Free to download for the initial exercises.

Decider Skills: The Decider consists of 32 skills under four core skill sets; the acceptance skills of distress tolerance and mindfulness and the change skills of emotion regulation and interpersonal effectiveness. THE DECIDER LIFE SKILLS contains 12 of The Decider skills for young people, adults and children with the aim of introducing coping skills and building resilience.

DECIPHer's core Centre resources will be focused on developing a high quality cadre of early career researchers who, with a multidisciplinary team of senior scientists will take forward four research programmes. Two progs Developing and Evaluating Complex Public Health Interventions and Process Evaluation of Complex Interventions.

EMDR | EMDR Institute – EYE MOVEMENT ...https://www.emdr.com/what-is-emdr EMDR (Eye Movement Desensitization and Reprocessing) is a psychotherapy that enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences. Repeated studies show that by using EMDR therapy people can experience the benefits of psychotherapy that once took years to make a difference.

EPDS: The Edinburgh Postnatal Depression Scale (EPDS) is not a diagnostic tool; rather it is a screening tool that aims to identify women who may benefit from follow-up care, such as mental health assessment, which may lead to a diagnosis based on accepted diagnostic criteria (DSM-IV-TR or ICD-10).

Family Partnership Model - CPCS www.cpcs.org.uk/index.php?page=about-family-partnership-model. The Family Partnership Model is an innovative approach based upon an explicit model of the helping process that demonstrates how specific helper qualities and skills, when used in partnership, enable parents and families to overcome their difficulties, build strengths.

FRIENDS For Life: Friends for Life Activity Book - FRIENDS for Life is a social skills and resilience building program that has been recognised by the World Health Organisation as an effective means to prevent anxiety for children aged 8-11.

4-5-6- model: Public Health England has published a new integrated 4-5-6 model for health visitors and school nurses. As well as the model, PHE has refreshed the "high impact areas" for early years for health visiting and for school aged years for school nursing.

Good Lives Model Centre for Youth & Criminal Justice https://www.cycj.org.uk/resource/the-good-lives-model. The Good Lives Model (GLM) is a strengths-based approach to offender rehabilitation which aims to promote the individuals' aspirations and plans for more meaningful and personally fulfilling lives.

GAD-2: Generalized Anxiety Disorder scale (GAD-2) may have clinical utility as a case identification tool for anxiety disorders, in particular generalised anxiety disorder, but there is greater uncertainly about its utility for other anxiety disorders, especially those with an element of phobic avoidance.

HAPI - Software for NHS School Nurses & NHS Trusts in the UK https://ids-group.co.uk/case-studies/tlm-nhs The Lancaster Model to helps NHS school nurses. The Lancaster Model is a system for NHS school nurses. It identifies physical and mental health issues in both pupils and families and provides appropriate support and response. HAPI ensures that ALL children, young people and families receive a Health and Development review at set transition stages.

HEADSPACE: A mindfulness and cognitive based app for mental health and wellbeing. Free to download for the initial exercise.

Incredible years: (Webster Stratton) The programs are designed to work jointly to promote emotional, social, and academic competence and to prevent, reduce, and treat behavioral and emotional problems in young children. (NB: See Webster Stratton).

LAC: https://norfolkchhomes.proceduresonline.com/chapters/p_hlth_assm_pln.html LAC Health Assessments and Plans LAC Health Assessments Each child should have a LAC Health Assessment soon after being placed and then at specified intervals; as set out below. The purpose of LAC Health

Assessments is to promote children's physical and mental health and to inform the child's Health Care Plan and ensure that the placement meets the child's holistic health needs.

LIAM : NES have developed a training programme to deliver low intensity evidence based interventions for early onset and mild anxiety problems in children and young people. This comprises an online module on anxiety disorders in children and young people and face to face training in low intensity interventions.

MECC: Making Every Contact Count (MECC) https://www.makingeverycontactcount.co.uk MECC is an approach to behaviour change that uses the millions of day-to-day interactions that organisations and people have with other people to support them in making positive changes to their physical and mental health and wellbeing.

MECSH: Maternal Early Childhood Sustained Home-visiting . The Maternal Early Childhood Sustained Home-visiting (MECSH) programme is being implemented in Australia, South Korea, the USA, the UK and the Channel Islands.

MBCT/MBT: What is Mentalisation Based Therapy? - Counselling Directory https://www.counselling-directory.org.uk/.../what-is-mentalisation-based-therapy

In Mentalisation Based Therapy (MBT), the therapist focuses on the client's understanding of their own intentions and those of others. He or she tries to help manage the client's levels of emotional arousal to enable mentalising capacity.

Newborn Behavioural Observations (NBO) system Newborn Behavioural Observations (NBO) – Brazelton Centre UK https://www.brazelton.co.uk/courses/newborn-behavioural-observations-nbo is a tool designed to help parents and practitioners share together the fascinating uniqueness of a baby, though observing their behaviour, which is their language. The Neonatal Behavioural Assessment Scale (NBAS) is the most comprehensive neurobehavioral assessment available for newborn babies, which gives a strength-based, in-depth profile of an individual baby.

Non-Violent resistant parenting (NVRP)

Nurse-Family Partnership - The Family Nurse Partnership https://www.fnp.nhs.uk A home visiting programme for first-time young mums and families Helping them enjoy a healthy pregnancy, improve their child's health and development and plan their own futures.

ORS and CORS: Outcome Rating Scale https://www.corc.uk.net/outcome-experience-measures/outcome-rating-scale The Outcome Rating Scale (ORS) and Child Outcome Rating Scale (CORS) are measures that can be used to monitor children's, young people and their families or carers feedback on progress.The ORS is a simple, four-item session-by-session measure designed to assess areas of life functioning known to change as a result of therapeutic intervention. These include: symptom distress, interpersonal well-being, social role, and overall well-being.

Positive Behavioural Support: https://www.cqc.org.uk/sites/default/files/20180705_900824_briefguide-positive. Aims of PBS The overall aim of Positive Behaviour Support (PBS) is to improve the quality of a person's life and that of the people around them. This includes children, young people adults as well as older people. PBS provides the right support for a person, their family and friends to help people. Positive behaviour support for people with behaviours that challenge Context. Positive

behaviour support (PBS) is ‘a person centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions.

PSHE: Personal, social, health and economic (PSHE) education ... https://www.gov.uk/.../personal-social-health-and-economic-pshe-education

Personal, social, health and economic (PSHE) education is an important and necessary part of all pupils’ education. All schools should teach PSHE, drawing on good practice, and this expectation is outlined in the introduction to the proposed new national curriculum.PSHE is a non-statutory subject. PSHE: Life Skills Education Resources for teachers provides a cohesive curriculum for KS1, 2 & 3. We have a range of life skills education resources for both Primary & Secondary ages.

RCADS: The Revised Children’s Anxiety and Depression Scale (RCADS) and the RCADS – Parent Version (RCADS-P) are 47-item questionnaires that measure the reported frequency of various symptoms of anxiety and low mood. They produce a total anxiety and low mood score and separate scores for each of the follow sub-scales: separation anxiety; social phobia; generalised anxiety; panic; obsessive compulsive; total anxiety; and, low mood.

Resilience toolkit: Resilience toolkit - HeadStart Kent https://www.headstartkent.org.uk/schools-and-practitioners/resilience-toolkit The Resilience Toolkit empowers individuals to choose evidence-based tools that regulate the nervous system, build capacity, and increase social engagement. A regulated nervous system means an increased ability to connect, collaborate, and creatively solve problems. This is the first step in healing individuals and systems. The Resilience toolkit was developed by HeadStart Kent as part of the BIG Lottery Investment during 2014-2016. It is based on the Young Minds Academic Resilience approach and the Public Health paper ‘Promoting children and young people’s emotional health and wellbeing - a whole school and college approach’. The Resilience Toolkit empowers individuals to choose evidence-based tools that regulate the nervous system, build capacity, and increase social engagement. A regulated nervous system means an increased ability to connect, collaborate, and creatively solve problems. This is the first step in healing individuals and systems.

ROAR: Roar Response https://www.roarresponse.com The ROAR response to Mental Health in Primary Schools, is a course which aims to help teachers and staff recognise and address the signs of mental health problems in children. It is a first line response aimed at equipping front line professionals with the tools to provide early intervention, and support to children experiencing mental distress.

SAM: Developed by the UWE an app for mindfulness and relaxation.

Self-regulation: Self-Regulation Skills in Children https://www.understood.org/.../trouble-with-self-regulation-what-you-need-to-know Self-regulation allows kids to manage their emotions, behaviour and body movement when faced with tough situations. Self-regulation isn’t the same thing as self-control. Kids with ADHD and sensory processing issues often struggle with self-regulation.

Solihull: The Solihull Approach model combines three theoretical concepts, containment (psychoanalytic theory), reciprocity (child development) and behaviour management (behaviourism). It provides a framework for thinking for a wide range of professionals working

with families with babies, children and young people. Transformation of children and young people's emotional wellbeing and mental health services. We believe that the most effective way to secure good emotional wellbeing for children and young people is to promote resilience, intervene early and prevent problems escalating. Our aim is to create a comprehensive system, designed around the needs of children and young people, ensuring that they and their families know how to get the right support, at the right time in the right place for them.

SRE: Sex relationships and education for young people

TAPP: TAPP was developed to meet the needs of young people who present at mental health services. These young people present not with 'neat diagnoses' but with 'predicaments' Which often combine social vulnerability with mental health needs. Thus, a psychosocial approach is helpful. www.stephenbriggsconsulting.co.uk/wp-content/uploads/2014/10/TA

THRIVE: The Thrive Approach https://www.thriveapproach.com The Thrive Approach uses neuroscience to help understand the impact early experiences have on the brain.The Thrive Approach is grounded in the current scientific developments in neuroscience. The field of neuroscience has undergone rapid advances in recent years, prompted by significant innovations in brain imaging. These have yielded important insights about how the brain and nervous system function and develop. In particular, scientists have discovered that the neural pathways of the brain and wider nervous system are relatively unformed at birth, undergoing much of their development during the first three years of life in response to relational experiences with primary care-givers. A key development during this period is the establishment of the body's stress-response system.

Trailblazers: Transforming children and young people's Mental Health Support Teams and pilots; Transforming children and young people's Mental Health Support Teams and pilots. In 2018/19, 25 areas were selected as trailblazers and will launch 59 Mental Health Support Teams (MHSTs) in 2019. Of these, 12 areas are piloting a four-week waiting time. Trailblazers is a team of wellbeing workers, mental health professionals and other partners who support the emotional wellbeing of children, young people and parents. The teams will act as a link with local children and young people's mental health services and be supervised by NHS staff; Trialling a four-week waiting time for access to specialist NHS children and young people's mental health services, building on the expansion of NHS services already underway. https://www.england.nhs.uk/mental-health/cyp/trailblazers

Trauma informed schools UK: Trauma Informed Schools UK is also a Big Lottery Fund winner for HeadStart in Cornwall. This has involved the implementation of Mental Health training for teachers in every school in Cornwall, which is over 270 schools involving over 44,000 children. We are also working to 'trauma inform' communities and other organisations in the area.

Whooley: The Whooley Questions originated as part of the PRIME-MD diagnostic interview which was developed by Pfizer in 1993 to help primary care physicians diagnose psychiatric disorders. Pfizer's goal was to broaden/expand prescribing of Zoloft (which Pfizer started selling in 1991) outside of psychiatry. The PRIME-MD included 5 diagnostic modules, one each for depression, anxiety, alcohol use, eating and somatoform disorders. Test characteristics of the PRIME-MD were first published by Spitzer et al in 1994.

Webster Stratton - The Incredible Years Programmes

https://www.mylifewarrington.co.uk/kb5/warrington/directory/service.page?id=_b2ml1djqpk
Parents & Toddlers programme duration and content. Ages 1-3 years. The Incredible Years Parents and Toddlers programme supports parents and builds optimal parenting skills. The Parents and Toddlers programme consists of an 8-part programme covered over 12 sessions focused on strengthening positive and nurturing parenting skills. The programs are designed to work jointly to promote emotional, social, and academic competence and to prevent, reduce, and treat behavioural and emotional problems in young children. Incredible years: The Incredible Years® is a series of interlocking, evidence-based programs for parents, children, and teachers, supported by over 30 years of research. The goal is to prevent and treat young children's behaviour problems and promote their social, emotional, and academic competence.