GROUP SOCIAL AND EMOTIONAL LEARNING INTERVENTIONS FOR YOUNG PEOPLE WITH NEURODEVELOPMENTAL CONDITIONS: A SCOPING REVIEW OF THE QUANTITATIVE AND QUALITATIVE EVIDENCE

And

HOW MENTAL HEALTH AND RESILIENCE SESSIONS SUPPORT TRANSITION FROM PRIMARY TO SECONDARY SCHOOL: EXPLORING YOUNG PEOPLE'S EXPERIENCES' TO INFORM FURTHER DEVELOPMENT AND RESEARCH

By

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A thesis submitted in partial fulfilment to the University of Birmingham for the degree of DOCTOR OF CLINICAL PSYCHOLOGY

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Thesis Overview

This thesis is submitted in partial fulfilment for the degree of Doctor of Clinical Psychology at the University of Birmingham. Containing four chapters, the first presents a scoping review exploring, mapping and summarising social and emotional learning programmes and the current evidence of their usefulness for young people with a neurodevelopmental condition. The second chapter presents an empirical qualitative study, exploring young peoples' experiences of taking part in mental health and resilience sessions and how these may support their transition to secondary school, alongside informing a further, more rigorous study of the sessions. Finally, the third and fourth chapters each provide a 'press release': one relating to the scoping review and one the empirical research, outlining the main findings of each paper in a manner that is suitable for public dissemination.

Dedication

To my wonderful family, friends and my “trainee” family for your never-ending support and belief in me, despite the ‘slight’ delay in this being completed!

And to my dream team- you are my world.

Acknowledgments

I would like to thank Dr Kate Woodcock for every bit of guidance, support and hand holding. Kate, without you I would have crumbled a long time ago. Thank you for your faith in me, your understanding and your ability to help me check myself when I was going down the self-doubt spiral. I have had incredible support from several members of Kate's research group. Alison- thank you for your amazing support from recruitment through to interviewing. You have been incredible. Grace, Claudia, Alex and Miki- thank you for being my technological/creative mind in adapting and facilitating sessions, Maxine and Katie for assisting in running the sessions, alongside Alex and Farah for all your help with screening articles. And to Yasmin for aiding in the two full on days of interviewing to ensure they were completed before the school holidays! All of you played a crucial part in this study.

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I cannot miss out a huge part of what helped me through the course and beyond- my trainee family. You were the cohort of dreams- each one of you full of warmth, kindness and compassion (as well as a cracking sense of humour!). Sharing this journey with you has been a privilege. I could not have done this without you, particularly Simone, Emily and Adele, and my wonderful reflective practice group: Sarj, Carl, Scott and Lauren. Those final six (plus!) months of my journey without you all was not as bright!

I have to say the biggest thank you to my family and dearest friends for their unwavering belief, support and strength not just during these last few years. You all know who you are, and I thank you for keeping me going. Especially my incredible mother and brother who forever believed I could and would, long before this journey began. Thank you for always being my biggest champions in everything that I do.

One person deserves this doctorate as much as me- my husband. James- thank you for taking on the role of sole parent, repeatedly, whilst I battled to get this finished. For moving and changing your life for me; for never once losing faith that I could do this, even when I was forever losing faith in myself; for being my best friend and ally through the hard times and the good. And finally, my beautiful blue-eyed boy- Jack. I hope I make you as proud as you make me, every single day.

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In Text Abbreviations

ADHD	Attention deficit hyperactivity disorder
ASD	Autism spectrum disorder
CASEL	Collaborative for Academic, Social and Emotional Learning
CBT	Cognitive Behavioural Therapy
CYP	Children and young people
EBSST	Emotion- Based Social Skills Training
ID	Intellectual disability
JBI	Joanna Briggs institute
LD	Learning disability
NDC	Neurodevelopmental Condition
NHS	National Health Service
NICE	National Institute for Clinical Excellence
PCC	Population, Concept, Context
PEERS	Programme for the Education and Enrichment of Relational Skills
PRISMA- SCR	Preferred reporting items for systematic and meta-analysis protocols extension for scoping reviews
RTA	Reflexive Thematic Analysis
SAS	Secret Agent Society
SEL	Social and emotional learning
SST	Social Skills Training Programmes
VR	Virtual Reality

Chapter 1: Literature Review

GROUP SOCIAL AND EMOTIONAL LEARNING INTERVENTIONS FOR YOUNG PEOPLE WITH NEURODEVELOPMENTAL CONDITIONS: A SCOPING REVIEW OF THE QUANTITATIVE AND QUALITATIVE EVIDENCE

1.1 Abstract

Rationale

Social-emotional skills are linked to overall positive health outcomes, and yet young people with neurodevelopmental conditions are at risk of difficulties with social-emotional skills. Despite the wealth of research investigating the positive impact of social-emotional learning programmes, there is a dearth of evidence regarding effectiveness for those with a neurodevelopmental condition. This scoping review aimed to collate the findings of studies assessing social-emotional learning programmes specifically for young people with a neurodevelopmental condition, to better understand what programmes are available and examine the evidence on effectiveness.

Method

Systematic searches of four electronic databases: PsycINFO, Web of Science, PubMed and Education Resources Information Centre [ERIC]. This scoping review framework and analysis was informed by Arksey and O'Malley (2005). Papers were screened by three independent reviewers using a pretested electronic form. Papers deemed appropriate for full review then used a pretested data extraction electronic form to extract specific variables.

Results

The search identified 2,634 studies of which 39 were included in this scoping review. The papers varied in terms of intervention focus, components, populations and constructs measured. Interventions were found to be Social Skills Training Programmes. Variation was also reflected in the outcomes for the programmes, showing a broad range of effect sizes.

Discussion

The review highlights the relative lack of evidence of non-disorder led thinking and lack of available opportunities to explore and develop strength-based approaches for young people with neurodevelopmental conditions. However, it also identified potential interventions to shift their focus to incorporate strengths-based elements and approaches, and the importance of development the individuals voice both within interventions and measures.

1.2 Introduction

Social and emotional learning (SEL) is an umbrella term that involves children and young peoples' (CYP) abilities to learn about and manage their emotions and interactions. The most well-known conceptualisation of SEL was developed by the Collaborative for Academic, Social and Emotional Learning (CASEL), an international network of educators, scientists and stakeholders whose aims are to support the translation of scientific knowledge into the creation of comprehensive, coordinated evidence based SEL learning programmes (Elias et al., 1997). They described SEL as:

"The process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions".

CASEL set out to create a framework to aid in the implementation of programmes for educators, recognising the need for consistency when designing and creating interventions that encompass crucial competencies to support the development of social and emotional skills in CYP. These were based on research that demonstrated connections between social adjustment and children's health outcomes (Payton et al., 2000). This development incorporated models specifically linked to social and emotional learning, such as emotional intelligence theory (i.e. Goleman, 1995; Payton, 2000; Salovey & Mayer, 1990) and the social developmental model (Hawkins & Weis, 1985), as well as those pertaining to behaviour change such as social learning theory (Bandura & McClelland, 1977) and the theory of reasoned action (Ajzen & Fishbein, 1980). It was acknowledged that no one model adequately captured all the elements deemed important, therefore CASEL developed a 5-point framework (Figure 1.1) which identifies target skills for individuals to encompass elements from the different theories, whilst acknowledging that this functioning occurs

amongst wider contexts and influences. The broad constructs underpinning SEL are that of intrapersonal and interpersonal skills, and the impact they have on developing meaningful and supportive social relationships (see Appendix A for further explanation and examples). The constructs highlight the complex interplay of self-skills (intrapersonal) related to the overarching skills required for global effective functioning as an individual (i.e. self-control, regulation, self-beliefs) and skills related to those needed for successful interactions with others (interpersonal), such as communication skills, or social problem solving (Domitrovich et al., 2017; Jones & Doolittle, 2017).

Figure 1.1

CASEL's SEL Framework

Aims of SEL interventions

There are three main aims to SEL interventions: "preventing mental health difficulties, promoting social-emotional competence and improving academic achievement"

(Humphrey, 2013). They are designed to be preventative and proactive, to reducing the potential for negative outcomes or difficulties later in life through the promotion of skills designed to support the development of the 'whole self' (Humphrey, 2013; Wigelsworth et al., 2022). SEL interventions are predominantly based on theories such as social learning theory by Bandura & McClelland (1977) and the cognitive-behavioural model by Beck (1979; Clarke et al., 2021). Furthermore, they are shaped by the emotional intelligence movement, which recognised that having skills in self-awareness, regulation, empathy and interpersonal skills are key to promoting and supporting prosocial interactions (Hagarty & Morgan, 2020; Weissberg et al., 2015; Wigelsworth et al., 2022).

There has been an increased focus among parents, educators and policy makers for over 20 years on SEL skills, with these skills recognised as something that can be nurtured and developed through childhood. This has coincided with an increased national concern and focus on overall mental health and wellbeing of CYP, leading to an emphasis being placed on promotion, prevention and early intervention focusing on "beyond just cognitive learning" (Gedikoglu, 2021).

This increased focus is reflected in the growing body of research into SEL and its importance in supporting mental health and wellbeing in CYP during childhood and beyond, developing their ability to "learn, thrive, and engage with the world" (Clarke et al., 2021). Research surrounding the effectiveness of these programmes is growing with several meta-analyses and systematic reviews evidencing the improvement within typically developing populations (i.e. Barry et al., 2017; Clarke et al., 2021; Corcoran et al., 2018; Taylor et al., 2017; Wigelsworth et al., 2016). Most show a positive impact on a range of personal, social and health related outcomes in the short term, with one longitudinal review indicating sustained effects up to four years post intervention and beyond (Taylor et al., 2017).

SEL recognises the impact social relationships have on cognitive development (Pollack et al., 2022). To develop, embed and strengthen SEL skills peer connectivity is necessary for not only practicing but increasing their overall confidence, impacting on their ability to thrive (Barry et al., 2017; Clarke et al., 2021; McKown et al., 2009). SEL programmes aim to increase and support peer connectivity through social exposure via group settings, which is also identified as being particularly effective for teaching and learning of specific skills (Pollack et al., 2022). Creating a shared group experience enhances key components to learning, primarily modelling, observing and imitating (Bandura & McClelland, 1977). Furthermore, it creates enhanced proximity to social opportunities with others sharing similar characteristics, again something that is highlighted as important to develop friendships (Kasari et al., 2016).

The Importance of SEL for Neurodevelopmental Conditions

Neurodevelopmental Conditions [NDC] were introduced as an overarching disorder category in the DSM-V (American Psychiatric Association [APA], 2013). These conditions include Autism Spectrum Disorder (ASD), Attention Deficit/Hyperactivity Disorder (ADHD), Intellectual Disability (ID), Communication Disorders, Learning Disorders and motor disorders. Up to 10% of children are identified as having one or more NDC (National Institute for Clinical Excellence [NICE], 2019), with ADHD being the most common in the UK (1-2%) followed by ASD (0.7- 2.2%; Francés et al., 2022). Individuals with such diagnoses can vary widely in scope, nature and impact of their differences and disabilities (Astle et al., 2022), but ultimately show impact in multiple areas of their life, which can be chronic and persist for life (Francés et al., 2022). Alongside this, NDCs quite often co-exist with each other, as well as other difficulties. For example, a study based in Scotland by Fleming and colleagues (2020) showed that ASD and ID were the most common combination of NDCs. They reported high rates of NDCs having at least one other condition, with 33% of

those who had ASD, 29.2% of ADHD and 16.5% of those with ID also having at least one other condition. Also, children with ID have been shown to be 6.5 times more likely to have a mental health difficulty compared to children without an ID (Hagarty & Morgan, 2020), and it has been indicated that 70-75% of those with ASD diagnoses will experience difficulties with mental health, or other internalising and externalising behaviours (Ratcliffe et al., 2019).

The literature reports that children with NDCs are at risk of difficulties with social-emotional skills, with emotional recognition and regulation being noted as a particularly vulnerable area (Löytömäki et al., 2023; Ratcliffe et al., 2019). As self-regulation is directly linked to overall level of self-competence in managing social interactions as well as building up coping resources (McKown et al., 2009), it highlights a potential disproportionate risk to this population to develop internalising and externalising behaviours, difficulties with creating and maintaining peer relationships, bullying or victimisation (Hogarty & Morgan, 2020).

As previously mentioned, connectedness is a key component to our ability to function, long established as a fundamental, biological human need, linked to our drive to survive. However, individuals with neurodevelopmental conditions are often excluded within society due to the differences in functioning and behaviours therefore are at higher risk of isolation or loneliness which has been shown to have a negative effect in all areas of life (Deckers et al., 2016; Hassani et al., 2022; Kwan et al., 2020).

Gaps in the Literature

Whilst there is an ever-growing body of research focused on SEL for the neurotypical population, there is a dearth of literature focusing on what SEL interventions are available and their effectiveness for individuals diagnosed with a NDC (Barry et al., 2017; Clarke et al., 2021; Wigelsworth et al., 2019). There is also lack of evidence regarding the proactive

use of these programmes in promoting SEL skills to intervene or prevent these potential additional challenges (Barry et al., 2017; Hassani & Schwab, 2020). Alongside this, the focus has been predominantly on social skills training programmes [SST], identifying the problem as being within the individual with an NDC rather than appreciating the social diversity of human beings.

A systematic review by Hassani and Schwab (2020) aimed to investigate effectiveness of SEL interventions for students with special educational needs. The review included 11 studies, finding that most studies only showed small effect sizes on any significant change on social, emotional or behavioural difficulties. The papers reviewed included many different additional needs such as physical impairments, and most studies involved participants without a professional diagnosis but were based on teacher and/or parent rating of difficulties. Therefore, it is difficult to draw any clear conclusions on the usefulness of these programmes.

Hagarty and Morgan (2020) completed a systematic review of 12 studies specifically looking at SEL interventions for children with ID only. This review used a broader definition of SEL, not focusing on only group interventions. They found that although overall there was a possible effect for children with ID in SEL, play therapy and SST interventions the effect size varied. Alongside this, all apart from one paper was found to have low methodological quality. Therefore, the authors noted a lack of strong evidence regarding SEL interventions for individuals with ID. Despite wanting to focus on the broad components of SEL interventions specifically, Hagarty and Morgan found that the studies focused primarily on social skills rather than emotions, despite emotion processing being highlighted as important to developing overall social competence.

Rationale

SEL interventions are predominantly either universal or targeted. Universal programmes use group settings aimed at supporting all CYP and are seen as positively impacting the social dynamics of the classroom, therefore increasing the social interactions and relationships within that space (Durlak et al., 2011). There is a wealth of reviews on such programmes, as they are usually for all, these reviews are likely to include those with an NDC. However, they are often in the minority of participants and therefore are going to have limited insight into this specific population. Targeted SEL interventions are similar to universal programmes as they will take place in group settings, however they are to support CYP with specific diagnoses or needs and provide a more intense intervention (Bond et al., 2023). However, the literature shows there is still low numbers of research into the effectiveness of such interventions, with concerns highlighted surrounding the generalisability of skills from a targeted intervention (i.e. Clarke et al., 2021; Hagarty & Morgan, 2020; Hassani et al., 2023). Whilst there is an ever-growing amount of information surrounding the importance of SEL skills, specific interventions and their effectiveness for typically developing children, there remains a limited focus on individuals with an NDC.

By focusing on group interventions within NDC populations this scoping review will be reflecting a core component of SEL interventions that learning happens best within a social setting, as well as creating social experiences crucial to developing relationships (Pollack et al., 2022; Wigelsworth et al., 2019). This element is crucial as increased experiences of loneliness or disconnect is highlighted as prevalent amongst the NDC population (Kwan et al., 2020). So alongside creating an environment that is conducive to specific learning purposes, group interventions aid in increasing confidence and connectivity through providing opportunities for social interactions beyond the intervention (Kasari et al., 2016; Pollack et al., 2022). This important element ultimately impacts on quality of life, and

supports positive trajectories for CYP (Gedikoglu, 2021; Mahoney et al., 2018; OECD, 2015).

Gaining an understanding surrounding the available interventions and the possible utility for those with an NDC seems particularly relevant due to the frequent research indicating the increased risks and vulnerabilities for young people with an NDC. Furthermore, by attempting to map out the interventions, components, aims alongside outcomes, it will give an opportunity to explore the nature of the concepts and how it has been studied over time, to see if there has been a shift from placing the "problems" within individual with NDC.

Objectives

In this review, the focus was on developing an overview of the literature surrounding interventions supporting social and emotional learning interventions with CYP with a neurodevelopmental condition. The objectives were:

1) Carry out a systematic search of the published literature interventions focusing on social and emotional learning programs for CYP with neurodevelopmental conditions.
2) Map out the available interventions and examine the outcomes of these interventions.
3) Examine and comment on limitations in the literature, and where future research could be directed.

1.3 Methodology

As this research aims to explore, map and summarise social and emotional learning [SEL] interventions and the state of current evidence on their usefulness for children and young people (CYP) with a neurodevelopmental condition [NDC] a scoping review was deemed most appropriate. A scoping review has broader aims than traditional systematic reviews, focusing on determining what range of evidence is available from any data source, examining gaps in the literature, summarizing and informing future research (Munn et al., 2018; Peters et al., 2015, 2020; Pham et al., 2014; Tricco et al., 2018).

After noting a lack of standardisation in how scoping reviews were conducted, Arksey and O'Malley (2005) proposed the first methodological framework. Despite this, continued concerns were raised about the consistency in how to conduct and report scoping reviews (Colquhoun et al., 2014), leading the Joanna Briggs Institute [JBI] International Scientific Committee to create a scoping review guide to address the need for rigorous, transparent and trustworthy methodology (Peters et al., 2015, 2020). To ensure the clarity and rigor of the review process, this scoping review was informed by Arksey and O'Malley's five stage framework, alongside the most up to date guidance for conducting scoping reviews (Peters et al., 2020), alongside the Preferred Reporting Items for Systematic Reviews and Meta-Analysis Extension for Scoping Reviews [PRISMA- SCR] checklist (please see Appendix B for full completed checklist; Tricco et al., 2018). Therefore, the steps undertaken were: (1) Identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data/Data extraction and (5) collating, summarising and reporting the results.

Stage 1: identifying the research question

The literature search was informed by the mnemonic PCC[1] which is recommended by the Joanna Briggs institute for conducting scoping reviews (Peters et al., 2020). This is

[1] *Population, Concept & Context (PCC)*

outlined in Appendix C. This review was guided by the question: what group interventions focusing on developing social and emotional learning are there for CYP with neurodevelopmental conditions? A secondary research question was exploring the state of current evidence on the usefulness of these interventions.

Stage 2: identifying relevant studies

Eligibility Criteria

Participants. The focus was on CYP (ages 0-18) with NDCs. To capture the concept of a NDC, 36 search terms were used describing a wide range of conditions. For this review, genetic neurodevelopmental conditions terms were guided by a previous literature review by Woodcock and Blackwell (2020) that used a list of syndrome names published by the international research association, the Society for the Study of Behavioural Phenotypes (https://ssbp.org.uk/syndrome-sheets/). The decision was made to exclude mixed populations as despite universal prevention approaches typically including those with a neurodevelopmental condition, as they are aimed at being applicable for all, the data would not reflect whether the intervention is useful for individuals with neurodevelopmental conditions as they would be in the minority.

Concept. For this scoping review, SEL interventions are defined using the over-arching components created by the Collaboration for Academic Social and Emotional Learning (CASEL). Papers were reviewed if they incorporated at least one component. Research was focused on group interventions only.

Context. There were no limitations regarding the research context (i.e. location, social, cultural, gender-based factors or study settings). CASEL formally defined SEL in 1997 in their book that created a framework in which educators in the United States of America could structure their education to encompass the components of SEL (Elias et al., 1997). As the

focus of this scoping review is shaped by this framework, a limitation was placed on the year of publication, therefore the papers needed to be from 1997- current to encompass core components of SEL interventions.

Types of evidence sources. A- priori decisions were made about the types of evidence sources applicable. Both qualitative and quantitative studies were eligible, and any study design. Limitations were placed on the type of literature during the initial stages. Due to not using quality assessments for the scoping review, only peer reviewed empirical studies were included. At the final stage of source selection, a decision was made to remove dissertations as they did not provide any novel concepts that would add information to the review. As we wanted to understand the range of SEL interventions that were being used with CYP with NDCs alongside the usefulness of those interventions, papers needed to evaluate a specific intervention focused on any of the elements core to SEL (i.e. self-awareness, self-management, responsible decision making, social awareness, relationship skills). Full inclusion and exclusion criteria are illustrated in Table 1.1.

Table 1.1

Table of Inclusion & Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Social and emotional learning interventions direct with young people (0-18) with neurodevelopmental conditions.	Studies that focus on indirect interventions i.e. through their parents/guardians, teachers) Studies in which "child" participants go over 18 years old or where the age of participants are unclear or unspecified Studies where there are mixed populations without a neurodevelopmental condition (i.e. neurotypical young people compared with autism spectrum disorders, young people with anxiety compared with young people with a learning disability)
Studies reporting original intervention data, published in	Books, book chapters/reviews, grey literature, review articles, comparison studies, assessment tool review. Dissertations reviewed for ideas not covered in the

English, using any methodology (i.e. qualitative, quantitative) Papers published between the years 1997- Current.	included- were removed subsequently due to no additional information. Papers published in languages other than English.
Group based interventions Mixed parent and child intervention, however child with neurodevelopmental condition must be focus of intervention.	Single case studies, individual therapy, indirect intervention (i.e. intervention through parents/guardians).
Interventions with a focus on social and emotional learning components, described by CASEL[2]	

Developing Search Terms

An initial preliminary scoping of the existing literature was completed to develop and filter search terms alongside removing terms found to generate too many irrelevant papers[3]. This then shaped the development of inclusion and exclusion criteria and search terms, and the systematic screening process, that aided the final study selection. The terms are shown in Table 1.2.

Table 1.2

Final Search Terms

Search String 1 (OR)	AND	String 2 (OR)	AND	String 3 (OR)	AND	String 4 (OR)
Neurodiv*		"Socio-emotional*"		Prevention*		"Young pe*"

[2] Self-Awareness, Self-Management, Social Awareness, Relationship Skills, Responsible Decision Making.
[3] *"Emotion*", "Social", "Therap*" and "Treat*" were removed.*

“neurodevelopmental disorder*”	“Social-emotional*”	Interv*	YP
“autism spectrum disorder”/ ASD	“social emotional*”	Program*	Child*
"attention deficit hyperactivity disorder"*/ ADHD		Training*	Adolescen*
“attention disorder*”		Curricul*	Teen*
"down syndrome"		Club*	“adolescent”
"intellectual disabil*"		Psychoeducation*	
“learning disabil*”		Evaluat*	
“Angelman Syndrome”		Tool*	
“developmental delay”		Learning Group	
“developmental disability”		Session	
“prader willi*”		Packag*	
same amount			
“Williams syndrome”		Promot*	
“fragile x syndrome”		Strateg*	
“CHARGE syndrome”		Support*	
“Coffin- Lowry syndrome”		Help	
“Coffin siris syndrome”		Approach*	
“Cornelia de Lange Syndrome”			
“Cri du Chat Syndrome”			
“Foetal Alcohol Syndrome”			
“Lesch-Nyhan Syndrome”			
“Mowat-Wilson Syndrome”			
“Neurofibromatosis Type 1”			
“Noonan Syndrome”			
“Rett Syndrome”			

"Rubinstein-Taybi Syndrome"
"Triple-X Syndrome"
"klinefelter syndrome"
"XXY syndrome"
"Tuberous Sclerosis Complex"
"Turner Syndrome"
"Wolf-Hirschhorn Syndrome"
"XYY Syndrome"
"22q11.2 Deletion Syndrome"

Four databases were systematically searched on the 4th of November 2022:

- Web of Science (all databases)
- PsycINFO
- PubMed (National Library of Medicine [NLM])
- Education Resources Information Centre (ERIC, via EBSCOhost)

Databases were searched for titles, abstracts and key words, concepts or topics. 'English language' limits were applied due to the researchers first language being English and limited resources regarding reviewing articles in different languages.

Citation management

Once all the searches were complete, all references were added to an online reference management software package (Endnote 20) to create a bibliography of the results. The initial screening process began with the electronic removal of duplicated papers via Endnote 20.

Stage 3: Study selection

Initially, 2634 papers were identified as potentially relevant. Once records were limited to only papers post 1997[4], and electronic removal of duplicated papers was completed, the papers underwent title and abstract screening to remove any papers not meeting the minimum inclusion criteria (Table 1.1). During which, a manual removal of any duplicated papers that were missed during the electronic removal was completed. Simultaneously, two research interns carried out respective title and abstract screens alongside the author using a Microsoft Excel spreadsheet to note decisions. This was then merged to collate all individual decisions whilst using a 'traffic light' system to indicate agreements and disagreements between raters. Any disagreements regarding consensus were discussed with the interns and the author's supervisor. Each stage of screening used a relevant screening form, to capture decision making across the reviewers. An example of this is found in Appendix D.

Any papers with inadequate information in the abstract to inform our decision went on to have a full text screen. Following the initial full screen text of the originally identified papers, reference lists for all papers (n= 24) were reviewed to identify any potentially relevant papers not yet captured. Key words were also reviewed on 3rd May 2023, as recommended by the JBI guidance (Peters et al., 2020) and compared to the original search strategy by the author and supervisor, developing an additional list of terms not used in the original search (please see Appendix E). Following which, searches were re- run on 8th May 2023 including the following additional terms:

- String 1: Special Needs
- String 2: Interpersonal Competence

[4] *The limitation on the papers was added as 1997 was when CASEL developed and promoted use of the 5 core components for SEL interventions. This was done at the same time as deduplication.*

- String 4: Students

Collectively, this captured an additional 298 papers, which were reviewed fully leading to a further 15 papers being identified. Figure 1.2 shows each stage of the screening process, as well as indicating when inclusion and exclusion criteria was applied.

Stage 4: Data extraction

A data extraction electronic form (Microsoft Excel) was jointly developed by the author and their supervisor to determine which variables to extract. It was then piloted independently by the researcher and their supervisor using five of the final papers identified for the review. The results were discussed, and the chart updated in an iterative process, as recommended when conducting scoping reviews (Peters et al., 2020). The data extraction for the 39 papers was then conducted by the researcher and one intern from the research support group. The following data was extracted: general data (title, year of publication, author(s), country of origin, research design), intervention information (intervention type, aims and purposes, duration and intensity), methodological data (participant characteristics, sample sizes, comparators and measures) and outcome details (including effect sizes if available). (see Appendix D for an example).

As scoping reviews aim at providing an overview of the evidence, the researcher did not perform any formal quality assessment of the primary studies. This is consistent with the guidelines as scoping reviews aim to map out what is available, and not produce a clinically meaningful answer (Peters et al., 2020; Tricco et al., 2018).

Stage 5: Collating, summarising and reporting

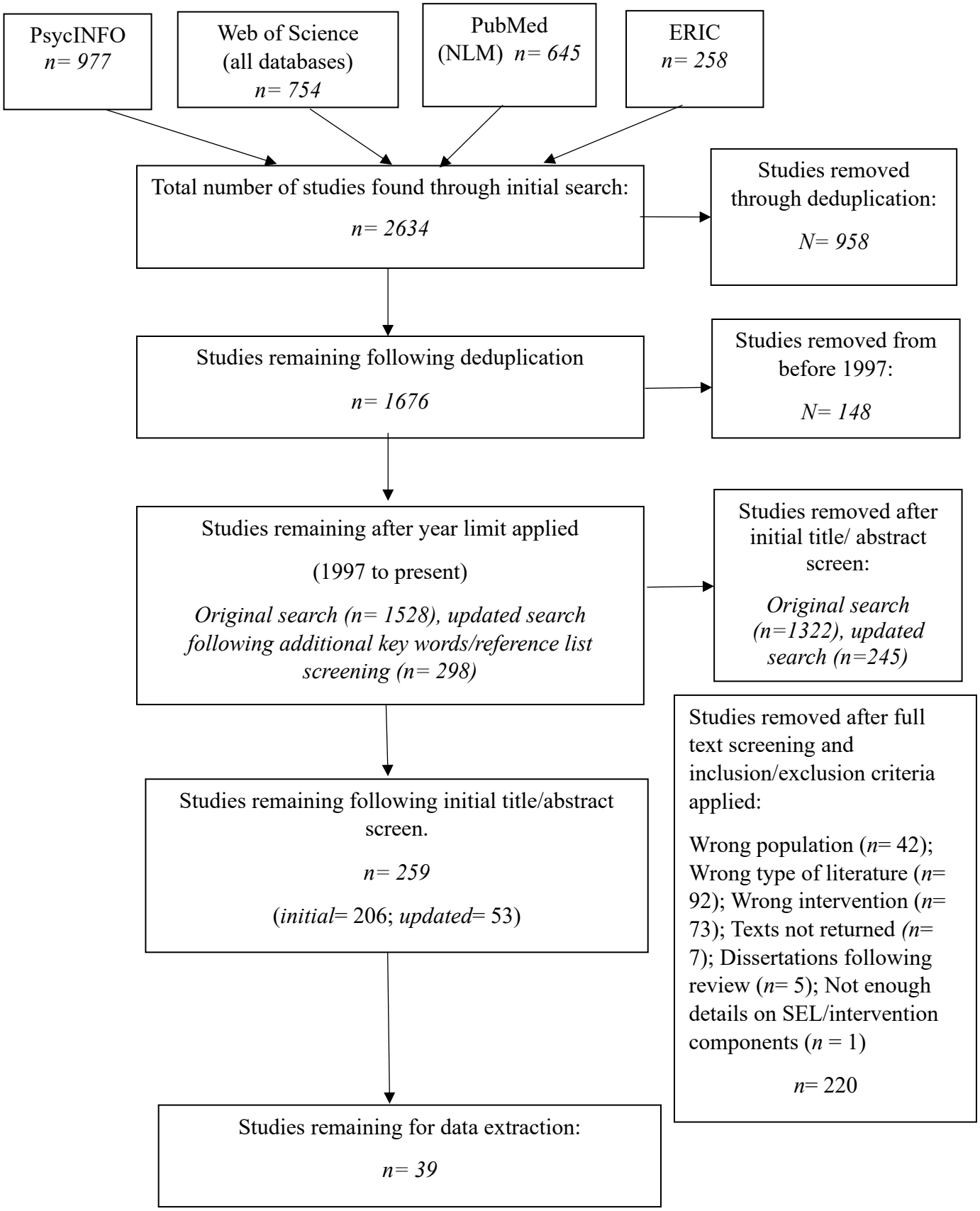
To help collate and summarise the available evidence, the author created categories to differentiate approaches to intervention, which were informed by how the individual programme authors described their interventions. This led to three groups: Social Skills

Training Programme (SST), Emotion Competence Focused programmes and Psychotherapy Groups. Although SST programmes come under the broad umbrella of SEL, SST programmes have historically focused more on reducing unwanted behaviour or teaching specific skills deemed appropriate. These programmes focused on teaching a specific group of social skills, although these slightly differed between programmes. Emotional Competence Focused groups placed a greater emphasis on improving emotional competence skills, such as understanding and expression of emotions, empathy, coping strategies and regulation (Gaffney et al., 2021). Psychotherapy group were programmes based on specific modalities of psychotherapy. It is important to note there is some overlap between categories.

Each intervention is summarised, focusing on the aims, structure and components of each intervention. The population, constructs measured, and broad findings of the research articles are then described. The author explicitly reported significant results primarily from overall scale outcomes. However, if no overall results were stated in the paper, then significant subscales were reported. The author noted if there were no significant results. The section summarising the outcomes first focuses on interventions with multiple papers, before described programmes with only single papers which were grouped by the constructs measured. This was shaped by previous work in the field looking at social and emotional competence (CASEL, 2020; Durlak et al., 2011; Wigelsworth et al., 2016) alongside some adaptations to fit with the obtained literature.

Figure 1.2

PRISMA- P Diagram of the Systematic Screening Process



1.4 Results

The reporting structure is in line with the PRISMA-SCR checklist and guidelines (Peters et al., 2020; Tricco et al., 2018).

After deduplication, the year limitation added, and a second round of searches completed following additional terms added 1826 citations were identified. Figure 1.2 illustrates the selection process, with 39 papers considered eligible for this review. The individual studies (and corresponding ID) place of origins, setting and study design are summarised in Appendix F.

Predominantly the programmes were reviewed with CYP with a diagnosis of ASD (*n*= 30) of which 25 required participants to not have an ID status. Of the remaining papers, five were with CYP with an ID diagnosis, two for ADHD, one for 22q11 deletion syndrome and one with a mixed population of ID, ADHD and ADD.

Interventions Overview

Table 1.3 describes the programmes' aims, components and structure of each intervention. Most programmes identified were Social Skills [SST] interventions (*n* =22), amongst which 11 separate programmes were identified. Six programmes were identified for emotional competence focused interventions, one with two papers, and 10 programmes reviewed within the psychotherapy group.

Table 1.3

Intervention Characteristics

Social skills Training Programmes					
Paper ID	Intervention/Aims of programme	Components of Intervention	Intervention intensity/duration	Group format	Group size
14,18,19,20,22,32,38	PEERS: Programme for the Education and Enrichment of Relational Skills aims to develop and maintain improved social competence and decrease social isolation by teaching skills focused on how to make and keep friends.	Manualised; Psychoeducation; Cognitive and Behavioural Therapy (CBT) informed; 12 modules; Rules of social etiquette; Explicit, didactic instruction; modelling, role play, behavioural rehearsal, coaching and feedback and homework; Parents group[13,17,18,23,39]	Weekly 90 minute session for 12 weeks[18] Daily 30 minute session, 5 days a week for 14 weeks[20] Weekly 90 minute session for 14 weeks[14,19,22,32,38]	Concurrent groups run separately for parents and children [14,18,19,22,32,38] Facilitated by teachers, in a school setting, no parent group[20]	Range between 5-10 young people

4,5,10	SAS: Secret Agent Society (originally called the Junior Detective Training Programmes) aims for improvement in social competence, emotion regulation, emotion recognition and social problem solving.	Manualised; Psychoeducation; CBT, Acceptance and Commitment Therapy [ACT], Behaviour Change Theory; Explicit instruction regarding social skills; multi- media social skills programme computer game; decoding suspects emotions and thoughts, discussion, role play, behavioural rehearsal, problem solving formula, regulation exercises, homework for real world practice, parental support.	Weekly 120 minute session for 7 weeks[4] Weekly 90 minute session for 10 weeks[5] Weekly 90 minute session for 9 weeks[10]	Concurrent groups run separately for parents and children by researchers[4.10] Child only group Facilitated by school staff[4] Separate 4x 2 hour parent sessions[10]	3-6
16,27,28	KONTAKT aims to improve on social interaction, communication skills, social motivation, awareness of self and others, problem solving and self-confidence.	Manualised; Psychoeducation; CBT informed; Computer based elements; Explicit; social rules and communication skills; group discussion, role plays, homework for real world practice, parental support and individual behavioural analysis.	Weekly 60-90 minute session for 12 weeks[27,28] Weekly 60-90 minute session for 24 weeks[16]	Groups separated into child (8-12) and adolescence (13-17) facilitated by clinicians.[16,27,28] Parents joined for 6 sessions[16]	4-8
6,17	SKILLS: specific set of social skills aimed at developing and maintaining friendships through developing social and emotional understanding and skills.	CBT informed; Explicit; modelling, role play, rehearsal, rewards and homework for real world practice.	Weekly 40-60 minute session for 8 weeks[6]	Children only group facilitated by trained researchers.	No data

	ENGAGE: Peer mediated mixed with typically developing young people, focusing on peer engagement and acceptance through developing social and emotional understanding and skills.	CBT informed; Mix explicit and implicit; Peer mediated; modelling, practice skills in natural setting using shared interest activities for interactions, rewards and homework for real world practice.	Twice weekly 30-45 minute session for 8 weeks.[17]		
26	Superheroes programme aims for improvement in social functioning by focusing on specific social skills improving expression of wants and needs, conversation skills and turn taking.	Manualised; Behavioural Learning theory informed; Behavioural Skills Training; Explicit teaching of skills; multimedia approach; 18 modules, 17 social skills; video modelling, visual prompts via DVD, role play, feedback, games and rewards.	Twice weekly 90 minute session for 3 weeks	Young person only groups facilitated by researchers	4
8	SS.GRIN.HFA: Social Skills Group Intervention- High Functioning Autism is a further development of the original program (SS.GRIN) aimed at socially at risk children to improve and maintain social skills and peer relationships through developing communication, working with others and friendship skills.	Manualised; CBT and social learning informed; 3 modules; Explicit specific social skills; modelling, role play, feedback, activities, rewards, homework for real world practice and parental support.	Weekly 60 minute session for 15 weeks	Young person groups facilitated by researchers. Parents joined for 4 sessions.	No data

35	NETT (Nonverbal communication Emotion recognition and theory of mind training) Social Skills Training group focused on supporting development of social cognitive and behaviour skills through developing communication, emotion recognition and regulation skills.	Manualised; CBT; 3 modules; Explicit targeting of skills; visual supports, role plays, modelling, games, homework for real life practice, rewards, parental support.	Weekly 90 minute session for 12 weeks.	Young people facilitated by 2-3 therapists (ratio of 2:1 child to therapist) Parents attend one separate group.	4- 6
2	Modified version of an existing Social skills Training intervention aimed at increasing positive prosocial behaviour through cooperation with peers, problem solving, emotion recognition and regulation assertiveness and communication.	CBT informed; 6 modules; Explicit; modelling, group games, role plays, real world application, rewards, behaviour modification techniques and parental support.	Weekly 90 minute session for 8 weeks	Young person only group facilitated by two therapists. Parents attend 3 sessions separately.	8
3	Social skills training intervention aimed at improving social functioning and reducing psychopathology by focusing on emotional regulation and identity development. emotion recognition and regulation assertiveness and communication.	CBT informed; explicit; modelling, role plays, feedback, games, rewards, behavioural modification techniques and parental support; emotional recognition and regulation; identity development.	Weekly 75 minute sessions for 8 weeks	Young person and parent groups run concurrently, facilitated by 2 therapists (for the preadolescent treatment) Adolescent parent group received 4 groups only.	6-12

7	Social Skills Training intervention designed to increase social skills and decrease loneliness whilst support the transference of the skills outside of the clinical setting.	Manualised; CBT; Explicit teaching of skills; step by step verbal guidelines of skill, role plays, feedback, personal learning goals, homework for real world practice, rewards and parental support; Parent workbook to reinforce skill learning.	Weekly 60 minute session for 12 weeks.	Young people only group facilitated by 2 therapists.	4
12	Social Skills Training intervention to improve social skills and empathy through developing mentalisation, cooperation and assertiveness skills.	CBT informed; Implicit group; adapted sessions weekly to meet needs; play, cooperative games, group discussion and feedback.	Weekly 30 minute session for 22 weeks.	Young people only group facilitated by 3 therapists.	7

Emotional Competence Focused Interventions

Paper ID	Intervention/Aims of programme	Components of intervention	Intervention intensity/duration	Group format	Group size
30, 31	EBSST: Emotion- Based Social Skills Training aims to develop relationships through targeting the emotion in social situations, learning emotion recognition, emotion regulation and problem-solving.	Manualised; Emotional Development and Emotional Intelligence informed; Positive behavioural support principles; 3 modules; multi-modal techniques; modelling, visual supports (i.e. videos, drawings), role play, activities, rewards, parental support.	Weekly 90 minute session for 16 weeks 6 month booster session	Young person group only facilitate by a school counsellor and one assistant. Teacher and parent groups had 7 groups run separately.	3-8

1	Emotional intelligence training aimed at improving adaptive behaviours in communication, socialisation and daily living skills through developing social awareness, regulation, relationship skills, insight into emotion skills.	Adapted version of Bar-On programme; Emotional intelligence informed; Explicit instructions; Activities, role play, homework, Visual prompts, communication prompts, discussion	45 minutes, 22 sessions	Young person group only[5]	8
11	"Smile, cry, scream and blush" social and emotional learning intervention aimed at improving social- emotion competencies by increasing emotional comprehension.	Emotional Development and Emotional Intelligence informed; Short stories; visual prompts; discussion; reflection; identifying emotional expression; drawing emotions; act out emotion.	Weekly, 45 minutes sessions for 8 weeks.	Young person only facilitated by researcher.	7
15	Social and emotional learning virtual reality (VR) programme aimed to improve and generalise emotional and social adaptation skills, specific emotional expression and regulation alongside increased social interactions.	Informed by cognitive theory; Explicit; 6 scenarios- one emotional regulation and relaxation, 4 social scenarios, 1 consolidation and generalisability; VR component to practice, modelling, observations, feedback, questionnaires; parental and teacher support for generalisability.	Twice weekly 40 minute sessions for 14 weeks	Young person only facilitated by 2 researchers	3-4
23	Social and emotional learning intervention aimed to improve social understanding through social-emotional perspective taking, conversation skills and friendship skills.	Explicit and implicit; modelling, role play, games, group discussion, independent choice, external to classroom/clinic environment, homework for real life practice, parental support.	Weekly 90 minute session, for 16 weeks	Young person only facilitated by a mix of internal and external facilitators.	7-8
39	Social and emotional learning intervention aimed to improve social and emotional skills through developing emotional recognition and	CBT and Behavioural Learning theory informed; Explicit; 12 units; modelling, role play, visual prompts, rehearsal, positive reinforcement.	Weekly 80 minute sessions for 13 weeks	Young person only facilitated by teachers	3-4

[5] No information on who facilitated.

	regulation, relationship and communication skills.				

Psychotherapy Based Interventions

Paper ID	Intervention/Aims of programme	Components of intervention	Intervention intensity/duration	Group format	Group size
9	Tübinger training for mindfulness aimed at increasing emotional recognition, reduction of atypical behaviours and increase in social interactions through developing skills in emotion and body perception.	Manualised; Psychoeducation; Mindfulness informed; Explicit skill teaching; role plays, group discussion, rehearsal, activities, games, homework.	Weekly 90 minute sessions for 12 weeks	Young people only group facilitated by 2 trained in the intervention. Parents attended 3 meetings separately.	5-8
37	Drums Alive Drumtastic Intervention aimed to improve relationships and mood linked to social-emotional skills and overall wellbeing through fitness, music, relaxation and physical and cognitive activities.	Manualised; Explicit and implicit; Multi-modal; physical/music education, fitness, dance, drumming, mindfulness and relaxation strategies, supporting sensory and motor memory, physical and cognitive activities; 7 sections of drumming/exercises/singing/ games/yoga elements	Twice weekly, 60 minute sessions for 4 weeks supported by student mentors	Young people only group with facilitator and individual student mentors	14
25,29	Play therapy aimed to reduce internalising and externalising behaviours by increasing social and emotional skills, to support friendship development,	Learn to Play programme; Implicit, Developing pretend play skills using 4 play stations and specific play sequences; guided by therapists.[25]	Twice weekly 60 minute session for 24 weeks	Young people only group facilitated by teacher and therapist	19

	understanding emotions in self and others, and develop social and coping skills.	Humanistic principles; Implicit; modelling, self-directed and group- directed activities, feedback, unstructured time to practice.[29]	Weekly 60 minute session for 12 weeks	Young people only group facilitated by a therapist	3
21,36	Yoga based therapy intervention aimed to improve cognitive, emotional and behavioural regulation and emotional awareness and wellbeing.	[21]Creative relaxation yoga informed; Explicit; modelling, verbal prompts, positive reinforcement, meditation.	Weekly 15 minute sessions for 5 weeks	Young person only groups facilitated by researcher	3
		[36]Manualised adapted from ; CBT informed; Explicit; modelling, visual prompts, rehearsal, games, activities, homework for real life practice.	Weekly 60 minute sessions for 6 weeks	Combined child and parent group facilitated by researchers	5
13	RBP (Resilience Builder Programme) aimed at decreasing levels of emotional and behavioural symptomology by developing emotional, social, behavioural and psychological skills.	Manualised; CBT based group; resilience based framework; Explicit; modelling, role play, unstructured play for rehearsal, feedback, homework for real world practice and parental support.	Weekly 60 minute sessions for 12 weeks	Young people only groups facilitated by one therapist.	4-6
24	CBT (Cognitive behavioural therapy) intervention using a human assisted social robot focused on increasing emotional competence and social-emotional understanding through developing emotion recognition skills, learning how contact impacts emotions, noticing difference	Manualised; CBT based on Rational Emotional Behaviour Therapy principles (REBT); Social robot assisted; Explicit; instructions, games, activities, visual and verbal prompts (robot), positive reinforcement.	Twice weekly 90 minute session for 5 weeks.	Young people only group facilitated by two therapists and a social-robot	3-4

	between thoughts and feelings, and how to create useful thoughts.				
33	Social Cognitive Training aimed at improving social cognition and functioning through interpersonal skills such as perspective taking and communication, alongside and self awareness and regulation skills.	Influenced by cognitive enhancement therapy; explicit; Manualised; structured; used scenarios; video clips; audiovisual aids; homework tasks; group discussion	Weekly 60 minute session for 26 weeks	Young people only group facilitated by researcher	3-5
34	Process orientated psychotherapy aimed at improving social competence and friendship quality through emotion recognition and expression and connection with others.	Expressive supportive modality informed; Implicit; activities, games.	Weekly 45 minute session for 15 weeks.	Young people only group facilitated by a counsellor.	4-7

Aims & Components[6]

Overall, the SSTs aimed to increase social competence by teaching targeted social skills to develop pro-social behaviours, leading to an increase in social skills, friendship quality and decreasing levels of internalising and externalising behaviours. SST programmes focus on encouraging self-control through building an understanding of appropriate and inappropriate behaviour, with most of these programmes aiming to reduce ASD symptomology. Skills taught were focused on topics such as conversational skills, planning social interactions, developing friendships, appropriate emotional expression and problem solving, primarily based on neurotypical norms.

SSTs were predominantly influenced by Cognitive and/or Behavioural Therapy [CBT] using didactic learning techniques alongside elements such as role playing, modelling, games, prizes and homework.

In comparison, Emotional Competence groups had a greater focus on emotional components, combining both social and emotional skills, to improve competence in areas such as empathy and regulation, adaptive functioning, social interactions and perspective taking. Predominantly these also used CBT techniques, however they were also informed by emotional intelligence theory, and utilised support from either parents or teachers to embed the skills.

Psychotherapeutic programmes held similar aims, focusing on increasing interoception for CYP, increasing self- regulation, awareness and linking emotions and body sensations through predominantly explicit groups shaped by CBT principles. Five programmes also aimed to reduce internalised or externalised behaviours, highlighting a focus on emotional wellbeing. The programmes were informed by a range of psychotherapy

[6] *Note: The numbers referenced in superscript in the text are linked to the coinciding paper ID number.*

models; mindfulness[9], integrated yoga therapy[21,36], music therapy[37], play therapy[25,29], CBT[13,24], Cognitive Enhancement Therapy[33] and process orientated therapy[34].

Intervention Intensity & Duration

Intensity and duration varied across all programmes. Predominantly programmes used a weekly structure for their interventions (*n*= 31), with six papers using twice weekly input, and only one paper using daily[20]. One programme only stated the number of sessions, not how often they were held[1]. Time for interventions ranged from 15- 120 minutes, and the number of weeks ranged from 3- 26.

Group Format

For SSTs 13 papers involved either separate groups or sessions or sessions where a parent, guardian or teachers joined, with varying intensity. For example, some only received one session whilst others received the same number of sessions as their young person. Predominantly the interventions were facilitated by researchers or trained therapists (*n*= 20).

For both emotional competence and psychotherapy programmes, most had child only groups, with only three holding separate groups for parents or teachers [24,30,31]. Emotional competence groups showed a mix of teaching staff or external researchers facilitating the intervention. Whereas the psychotherapy groups were facilitated by trained researchers or therapists, with one paper having a social robot as an assistant[24].

Group Size

For all types of programmes, the smallest group size was three. The largest differed slightly with SST having 12, emotional competence having eight and Psychotherapy having 19. Three papers for the social skills training did not state group size .

Outcomes

Table 1.4, 1.5 and 1.6 presents the population, sample size, comparator, constructs measured and main findings for the separate categories. The number of studies per intervention varied from one to seven. A description of the measures and respondents used in each paper can be found in Appendix G.

It is important to note that across all papers, even those reviewing the same intervention, respondents and measures were not consistent across all papers therefore the results reported are from a variety of sources such as parents, teachers, researchers or child. Variability is also identified within the results, where positive results can be related to a variety of respondents as well as subscales within the measures. The author used Cohen's criteria (Cohen, 1992) to guide interpretation of effect sizes: 0.2-0.4 regarded as small, 0.5-0.7 regarded as medium and 0.8 and above meaning large.

Outcomes for interventions that have multiple papers reviewed are presented first. Interventions from all categories with only single papers are summarised following this, with results grouped into the constructs measured, for example emotional competence.

Interventions reviewed in Multiple papers

Programme for the Education and Enrichment of Relational Skills (PEERS). Within the SST programmes, the PEERS intervention was the most studied. Overall, the PEERS papers involved 241 participants, with sample sizes ranging from 5-73 participants. Participants were a mix of male and female, with the percentage of male participants ranged from 68-88%. All participants had a diagnosis of ASD without ID, and the age range was 11-17 years.

Six papers measured internalising and externalising behaviours, focusing on difficulties such as emotional problems, withdrawal, anxiety, aggression or impulsivity. Significant positive effects were observed in four papers, with only two reporting large effect

sizes, one from a within-subjects study design[14] and one from a non-randomised control study[38]. The other two papers did not report any effect sizes. One RCT looked at social anxiety, showing a significant result with a medium effect size post intervention[32].

Six papers measured social skills, with all of them reporting a significant improvement. Three reported large effects for specific skills such as communication and motivation for a within-subjects study[14] and overall social skills for an RCT[18] and one non-randomised control study[19]. Two RCT papers indicated medium- large effect for increased number of social gatherings[20,32]. All papers showed a large effect for knowledge increase in the specific skills taught in the intervention, however this was using a non-standardised measure for CYP that was created by the original authors of the PEERS intervention.

All papers measuring specific symptomology of ASD showed significant positive effects. As has been noted, these results had a nuance due to effects only being significant with certain informants or subscales. Three showed large effects, one from a with-subjects study[14], one from a non-randomised controlled study[38] and one for an RCT[32], with two not reporting effect sizes.

Two papers looked at emotional competence in various formats, however no significant findings were found. One paper focused on adaptive functioning skills aimed at increasing quality of life using a non-randomised control trial[38]. There was significant increase in skills in the intervention group, however the effect was small when compared with the control group.

Secret Agent Society [SAS]. The SAS intervention was reviewed in three papers, covering a total of 202 participants, with sample sizes ranging from 49- 84. Participants were a mix of males and females, with the percentage of male participants ranging from 88- 93%. Two papers focused on CYP with an ASD diagnosis without ID, and one was ASD with a mix of

ID and no ID (i.e. IQ measure at both above and below 70). The age range was between 7- 12 years.

All papers reported a significant improvement on social skills both post intervention and at follow up. One paper was an RCT[4] indicated a large effect for improvements in social skills, the other two displayed small- medium effects with a non- randomised controlled design. All outcomes for emotional competence and social problem-solving measures showed a significant positive effect ranging from small to medium.

One paper measured internalising and externalising behaviours[5]. Despite no overall significant reduction, there was a significant reduction specifically in anxiety symptoms as well as problems at school, albeit of small effect size.

KONTAKT. Three papers reviewed the KONTAKT intervention involving 368 participants, with sample sizes ranging from 22 (for the qualitative paper) to 296. Participants were a mix of males and females, with the percentage of male participants ranging from 70- 73%. All participants had a diagnosis of ASD without ID, and the age range was 8- 17 years.

Two papers focused on social skills; however one used a qualitative methodology to review changes identified by parents/guardians and the CYP[27]. They noted commonalities of improved verbal and non-verbal communication regarding insight into self and emotions, alongside increased and improved social overtures and problem-solving skills. This translated in CYP appearing and feeling more confident and independent. The quantitative paper found an increase in skills for the treatment group both at post intervention and follow up time points (with large effect size reported)[16].

Two papers reviewed ASD symptomology, with both papers finding a significant positive effect (with medium- large effect sizes) for a greater reduction in ASD

symptomology for the treatment group compared with the control group. Both studies were of an RCT study design[16,28], using standardised measures with multiple respondents.

One paper focused on adaptive functioning, noting an improvement in skills post intervention with only small- medium effects[28].

SKILLS vs ENGAGE. Two papers reviewed these interventions, with a total participant of 210, with sample sizes ranging from 62- 148. Participants were a mix of male and females, with the percentage of male participants ranging from 74- 87%. All targeted participants had a diagnosis of ASD without ID, and the age range was 6- 15 years. Both papers used RCT study design. As the intervention focus is on comparing clinic-based vs peer mediated interventions, the primary focus for evaluation was on social engagement.

Both papers looked at social engagement and showed significant positive effect (with small effect sizes) for both groups post intervention, however there was a greater improvement noted for the SKILLS group in Joint Engage and Solitary Play in comparison to the ENGAGE group.

Social competence and internalising and externalising behaviours were measure in one paper[6] and reported a significantly increase in problem behaviours within the SKILLS group at follow up only (small effect size), however interpersonal relationships were showed to have great significant improvement within the ENGAGE group (small effect size). This paper also found that despite this, the SKILLS group had greater levels of social stress and emotional symptoms following the intervention.

Emotion- Based Social Skills Training [EBSST]. EBSST was reviewed in two papers, with a total of 302 participants, with sample sizes ranging from 85- 217. Participants were a mix of male and females, with the percentage of male participants ranging from 88- 90%. One paper the participants had a diagnosis of ASD with no ID, and one had a diagnosis of ASD with

mild ID. The mean age was 9.35 years. The two papers measured social competence, emotional competence and psychopathology using a non-randomised controlled study design.

One paper reported a significant improvement in emotional competence, with a large effect size for the intervention group both post and follow up time points in comparison to the control group[30]. There were no significant findings for either social competence or psychopathology on either of the papers.

Individual interventions

The outcomes are grouped by the constructs they measured. These categories were created based on previous work in the field looking at social and emotional competence (CASEL, 2020; Denham, 2015; Durlak et al., 2011; Wigelsworth et al., 2016) alongside some adaptations to fit with the obtained literature. It is important to note the overlap between categories, for example social and emotional competence, as well as some programmes have results crossing over multiple different constructs.

There are seven papers that are SSTs, five are emotional competence focused groups and ten are psychotherapy papers two of which are focused on different yoga-based therapy and two on different play-based therapy.

Overall, the individuals programmes had a total of 862 participants, with a sample size range between 3- 120. The age range for participants was 5- 18 years old. There were 13 papers focusing on populations with ASD diagnoses, five focused on populations with ID, two focused on ADHD, one on 22q11 deletion syndrome and one had a mixed population of neurodevelopmental conditions.

Predominantly they focused on mixed populations of males and females (n= 17), with the percentage range of males to females from 41- 98%. Three papers focused on exclusively male populations, and two papers on exclusively females.

Social Skills and Competence[7]. Overall, 16 programmes measured social competencies skills (SST *n*= 7; emotional competence *n*=4; Psychotherapy *n*= 5), focusing on; specific social skills taught, communication skills, relationship skills and interactions, social behaviours and social cognitions. 15 reported significant positive effects, which included all social skills programmes. However, there was a nuance in the results because some effects were only with some informants, and some showed effects in particular sub-scales rather than full scale. Of these, five programmes used an RCT design with only two papers showing large effects on social reciprocity[15] and behaviours[35]. Both focused on ASD without ID populations, with one using a SST[35] and one using a social-emotional virtual reality (VR) programme[15].

Three papers using non-randomised controlled design showed large effects for increase in social competence. One showed increase in relationships for a play therapy programme for individuals with an ID diagnoses[25], one specifically social cognitive ability for those with a diagnosis of 22q11 deletion syndrome[33] following a specific social cognitive training intervention, and the third showed increase in overall social competence for a mixed population of participants following process orientated psychotherapy[34]. Both the single subject design programmes showed large effects on social interactions and skills[26,39], one for individuals with a diagnosis of ID following an SST and one for those with an ASD diagnosis following a social-emotional learning programme. Finally, five within-subject design studies showed a range of results again. The large effects were shown for increase in social relationships for an all-female population with a diagnosis of ADHD[3] and overall competence for ASD without ID population[12], both following an SST programme.

[7] *Linked to CASEL skills of Social Awareness and Relationship Skills*

Emotional Competence[8]. Eight programmes measured the impact the interventions had on participants emotional competence (SST *n*= 2; emotional competence focused *n*= 2; Psychotherapy *n*= 4), such as emotional recognition and regulation, empathy, expression and overall competence. Seven programmes found significant positive effect on emotional competence; however, these showed some variation in results because some effects were only with some informants, and some showed effects in particular sub-scales rather than full scale.

Three of these used an RCT design: one showed a large effect for a CBT based programme support by a social robot in increasing emotional understanding[24]; one showing a medium effect for expression and regulation following a Virtual Reality [VR] supported intervention[15] and one showing a medium effect for expression and understanding following a yoga-based therapy programme[36], all for individuals with an ASD diagnosis without ID. Of the others, two used a within-subjects design showing medium- large effects for regulation and empathy in a population with a diagnosis of ASD without ID, one following a SST[12] and one following a CBT based resilience programme[13]. One programme used a qualitative paradigm for a yoga-based therapy for individuals with a diagnosis of ASD without ID and noted increase in self-control, regulation and emotional awareness[21]. One used a non-randomised controlled design showing positive change within an ID population following an emotional competence programme, however, did not report effect size.

Specific Symptomology[9]. It was notable that some programmes reviewed specific symptomology linked to diagnoses (i.e. ADHD or ASD symptoms). These are summarised here.

Seven programmes measured the impact the interventions had on specific symptomology (SST *n*= 4; Psychotherapy *n*= 3). Six programmes showed overall large effect

[8] *Linked to CASEL skills of Self- Awareness, Self-Management & Responsible Decision Making*
[9] *Including executive functioning, ASD or ADHD symptoms.*

in reduction of specific symptomology reduction, with only one using an RCT design for an SST programme for individuals with ASD without ID[35]. Four used within-subjects design, two of these were SST's, using a within-subject design one for individuals with ADHD[3] and one for individuals with ASD without ID[12], two were psychotherapeutic programmes for individuals with ASD without ID[9,13]. One single study also showed a large effect for individuals with ID[26].

Quality of life[10]. Overall, six programmes focused on various constructs linked to quality of life (Social skills *n*= 2, emotional competence *n*= 2, psychotherapy *n*= 2).

Three papers focused on adaptive functioning, two within an emotional competence programme framework[1,15] and one classed as a psychotherapy intervention[33]. They used a mix of designs, two RCT[1,15], one mixed non-randomised controlled trial and qualitative. Both the RCT studies showed significant positive effects for the intervention group post group, with small to medium effects sizes.

Two SST's looked at loneliness, with neither programme found a significant effect on loneliness. One paper[9] explored the impact of their intervention on overall quality of life following a mindfulness group for individuals with ASD without ID. This study used a within-subjects design, however found no significant effects.

Internalising/externalising behaviours[11]. Six programmes measured the impact on internalising and externalising behaviour (SST *n*= 1; Psychotherapy *n*= 5). Five programmes found significant positive effect. One RCT showed a large effect with individuals with an ID diagnosis who participated in an implicit play therapy programme[29].

[10] Included general Quality of Life, Adaptive Functioning and Loneliness

[11] *Including anxiety, depression, withdrawal, aggression, overall mood and psychopathology*

Predominantly the programmes used a within- subject design, two programmes showed medium effects on specific internalising and externalising behaviours (i.e. aggression, depression) within an ASD without ID population; one was a mindfulness group[9] and the other a CBT based resilience intervention[13]. The other programme focused on females with ADHD diagnoses was an SST within two different age groups[3]. Within the pre-adolescent group a reduction in symptoms linked to difficulties such as depression, borderline personality disorder or oppositional defiant disorder was found at post and follow up with small- medium effects. However, in the adolescent group, only a reduction in anxiety symptoms was found with a large effect. A music therapy group only indicated a small effect on mood rating for the participants with ASD diagnoses[37].

Table 1.4

Outcome table: Social Skills Training Interventions[12]

Intervention	Paper ID	Population (*n*, age and NDD diagnosis)	Study Design	Comparator	Constructs measured (no. of questionnaires used for each)	Results[13]
PEERS	14	ASD (no ID) *n*= 5 Age range= 13-15	Within subjects Pre-post trial	Within group 2-time points; Pre-post= 14 weeks	Social Skills (2- Parent, Child)	Overall not significant. Significant improvement in social engagement subscale (*p*<0.05, *d*= 0.77), cognition (*p*<0.05, *d*= ,99), communication (*p*<0.01, *d*= 1.41) and (*p*<0.05, *d*= .82) motivation. Knowledge of social skills increased (*p*<0.05, *d*= 1.92)
					Internalising/externalising behaviours (2- Parent)	Overall not significant, however significant improvement in internalising symptoms (*p*<0.05, *d*= 0.85)
					ASD symptomology (1- Parent)	Significant reduction in symptomology (*p*<0.01, *d*= 1.12)

[12] N.B: All results for each category are identified using the following symbols = parent; = child; = Teacher; = researcher

[13] No p values for non- significant results.

				Quality of play (2- Parent, Child)	Not significant
18	ASD (no ID) *n*= 33 Age range= 13-17	RCT	Between group (treatment vs delayed treatment) 2 time points Pre- Post= 12 weeks	Social Skills (3- Parent, Teacher, Child)	Treatment group significantly improved on social functioning ($p<0.05$, $d=0.89$), but the delayed treatment group did not. Treatment group knowledge of social skills significantly improved ($p<0.001$, $d=3.21$), but the delayed treatment group did not.
				Internalising/externalising behaviours (2- Parent, Teacher)	Not significant.
				Friendship quality (3- Parent, Child)	Treatment group significantly increased number of social gatherings ($p<0.01$) but the delayed treatment group did not. Treatment group did not show significantly increased friendship quality. The delayed treatment group showed a significant decline in friendship quality ($p<0.05$)
19	ASD (no ID) *n*= 28 Age range= 12- 17	Non-randomised controlled	Between and within group (Treatment vs delayed treatment) 3 time points Pre- Post= 14 weeks	Social skills (3- Parent, Teacher, Child)	Treatment group reported greater improvement social skills post ($p<0.01$), however the delayed treatment group still showed a significant improvement. Treatment

	Post- Follow up= 14 weeks (only for treatment group)		still showed the improvements at follow up ($p<0.01$; $p<0.03$) Treatment group showed greater improvement in knowledge of social skills significantly improved post ($p<0.001$) compared to the delayed treatment group. Treatment still showed the improvements follow up ($p<0.01$)
		Internalising/Externalising behaviours (2- Parent, Teacher)	Treatment group significantly reduced problem behaviours only at follow up ($p<0.04$)
		ASD symptomology (2- Parent, Teacher)	Treatment group showed greater reduction in symptoms post ($p<0.02$) compared to the delayed treatment group. Treatment still showed the improvements follow up ($p<0.01$)
		Friendship quality (2- Parent, Child)	Treatment group significantly greater increase number of social gatherings post ($p<0.001$; $p<0.015$) compared to the delayed treatment group. Treatment still showed the improvements follow up ($p<0.01$; $p<0.05$)

	20	ASD (no ID) Total *n*= 73 Age range= 12-14	RCT	Between group (Treatment vs Control group) 2 time points Pre-Post= 14 weeks	Social skills (3- Parent, Teacher, Child)	Treatment group showed greater improvement in knowledge of social skills (*p*<0.001, *d*= 1.88) compared to control group.
					Internalising/Externalising behaviours (3- Parent, Teacher, Child)	Not significant.
					ASD symptomology (2- Parent, Teacher)	Treatment group significantly reduced symptoms (*p*<0.01, *d*= -0.63) compared to the control group.
					Friendship quality (3- Paren, Child)	Treatment group greater improvements in number of social gatherings (*p*<0.01, *d*= 0.82) compared to control group.
					Self-esteem (1- Child)	No significant findings.
	22	ASD (No ID) Total *n*= 16 Age range= 12-17	Within subjects Pre-post trial	Within group 2 time points Pre-post = 14 weeks	Emotion recognition (1- researcher)	No significant findings.
					Emotion regulation (1- child)	No significant findings.
					Mood rating (2- Parent, Child)	No significant findings.
					ASD symptomology (1- parent)	No overall significant findings, however significant improvements

					post on emotional responsiveness subscale ($p<0.05$)
				Internalising/externalising (1- parent)	No overall significant findings, however significant changes post on aggression ($p<0.05$), anxiety ($p<0.01$), withdrawal ($p<0.05$), adaptability ($p<0.005$), leadership ($p<0.05$), activities of daily living ($p= 0.053$) subscales.
32	ASD (no ID) *N*= 58 Age range= 11-16	RCT	Between group (treatment vs waitlist) 2 time points Pre- post= 14 weeks	Social skills (3- parent, teacher, child)	Overall significant improvement in knowledge of social skills post intervention for intervention group post ($p<.001$, $n^2= 0.72$), the wait-list did not.
				Social Interaction Quality (3- parent and child)	Overall significant improvement in social interaction post intervention for intervention group ($p<.005$, $n^2= 0.15$), the wait-list did not.
				ASD symptomology (2- parent and teacher)	Significant decrease in problem behaviours post intervention for intervention group ($p<.05$, $n^2= .06$), the wait-list did not.
				Social Anxiety (1-child)	Overall significant improvement in social anxiety post intervention for intervention group post ($p< 0.01$, $n^2= 0.12$), the waitlist did not.

	38	ASD (no ID) *n*= 28 Age range= 11-15	Non-randomised controlled	Mixed Between/within group (treatment vs delayed treatment) 3 time points Pre- Post= 14 weeks (between) Post- Follow up= 14 weeks (within)	Social Skills (1- child)	Overall significant improvement in knowledge of social skills post intervention for intervention group post (*p*= 0.002, n^2= 0.32) when compared to delayed treatment. Within group statistics showed both groups showed improvement at follow up (*p*<.001, n^2= .61)
					ASD Symptomology (2- parent)	Treatment group significantly reduced symptoms post (*p*<0.05) but not in the delayed treatment group when they were compared. Within group statistics showed both groups showed improvement at follow up (*p*<.001, n^2= .38)
					Friendship quality (2- parent and child)	Significant improvement for both groups post intervention (*p*= 0.36; *p*= 0.46), not for follow up.
					Internalising/externalising behaviours (2- parent and child)	No significant outcomes for post intervention. However, within statistics at follow up showed significant improvement (*p*<.002, n^2= .32)
					Adaptive functioning (1- parent)	Overall significant improvement for treatment group post when compared to DG (*p*= 0.005, n^2= 0.27), however both groups showed improvement in communication and interpersonal relationships (TG *p*<.001; DG *p*<.01)

						Within group statistics showed both groups showed improvement at follow up (p<.001, n^2= .86)
Secret Agent Society	4	ASD (no ID) *n*= 49 Mean age= 9.64	RCT	Mixed Between-within group (Intervention vs Wait list) 4 time points Pre- post= 7 weeks Post- follow up= 6 weeks Follow up= 5 months	Social Skills (2- parent and teacher)	Significant improvement for treatment group from pre- post (p<0.001, n^2= .54), but not for waitlist group (p > .28, n^2 = .02) Significant improvement for both groups (treatment and delayed treatment) from post- follow up (ps < .001, $n^2 \geq .45$)
					Emotion Regulation (2- parent and teacher)	Significant improvement for treatment group from pre- post (p < .001, n^2 = .57) but not for waitlist group. Significant improvement for both groups (treatment and delayed treatment) from post- follow up (ps < .02, n^2 > .11)
					Emotion recognition (2- Child)	Significant improvement for both treatment and waitlist groups pre-post on Facial Expression Recognition (p < .001, n^2 = .29) and body Posture Recognition (p < .02, n^2= .11) Significant improvement for both groups (treatment and delayed treatment) from post- follow up (ps < .02, n^2s > .11)

				Social problem solving (2- child)	Significant improvement for treatment group from pre- post (*p* < .001, n^2 = .35) but not for waitlist group. Significant improvement for both groups (treatment and delayed treatment) from post- follow up (*ps* < .02, n^2> .11)
5	Mixed: ASD & PDD-NOS (no ID) *n*= 69 Age range= 7-12	Non-randomised controlled /Qualitative: Thematic analysis	Mixed between-within group (structured intervention vs unstructured intervention) 3 time points Pre- post= 10 weeks Post- follow up= 6 weeks	Social skills (2- parent and teacher)	Within groups showed significant increase post for both (*p*< 0.001, n^2= .20; *p*<0.001, n^2= 0.23)
				Emotion Regulation (2- parent and teacher)	Structured intervention showed significant improvement in emotion regulation skills post for the structured group (*p*< 0.001, n^2= .34) group not the unstructured group.
				Internalising/externalising behaviours (3- parent and teacher)	No overall significant findings, however significant reduction for structured intervention group in anxiety symptoms post (*p*<0.001, n^2= .19) and behavioural difficulties in school (*p*<0.001, n^2= 0.29) but not unstructured group.
				Social problem solving (2- child)	Structured intervention significantly outperformed those in the unstructured group post (*p*=0.25 & *p*= 0.006, n^2= .12)

						Any effects show maintained after 6 weeks (no data)
				Thematic analysis on social skills improvements from parent and teacher feedback:  Social Gains; happier to go to school, greater self-esteem, included and participating more in activities, improved emotional awareness and regulation		
	10	ASD *n*= 84 Mean age= 10.7	Non-randomised controlled	Between group (Treatment vs Delayed treatment) 3 time points Pre-post= 9 weeks Post- follow up= 20 weeks	Social skills (2- parent and teacher)	Treatment group showed greater improved social skills post ( $p<0.001$) compared to delayed treatment. Continued into follow up ( $p<0.001$) Teacher report only showed improvement at follow up ($p<0.001$)
					Emotional regulation (2- parent and teacher)	Treatment group showed greater improved skills post ($p<0.001$) compared to delayed treatment. Continued into follow up ($p<0.001$; $p<0.001$)
					Social Problem Solving (2- child)	Treatment group significantly improved post and follow up ( $p<0.001$) compared to delayed treatment.
KONTAKT	16	ASD (no ID) *n*= 50 Age range= 8-17	RCT	Between group (Intervention vs TAU) 2 time points	Social Skills (2- parent and teacher)	Treatment group showed greater improved post ($p<0.001$, *ES*=0.76) and follow up ($p<0.000$, *ES*= 0.82) scores compared to TAU.

				Pre- Post= 24 weeks	ASD Symptomology (2- researcher)	Treatment group showed greater improved post ($p<0.05$, *ES*= 0.83) but not follow up compared to TAU.
					Adaptive functioning (2- parent and teacher)	No significant findings.
					Stress (2- parent and child)	No significant findings.
	28	ASD (No ID) *n*= 296 Age range= 8- 17	RCT	Between group (Intervention vs TAU) 3 time point Pre- post= 12 weeks Post- follow up= 12 weeks	ASD symptomology (3- parent, researcher and teacher)	No significant findings for child group. Adolescent treatment group significantly improved post (p= 0.12, *ES*= 0.32; $p<0.001$, *ES*= 0.41) and follow up (p= 0.15, *ES*= 0.33 p= 0.002, *ES*= 0.38) compared to TAU.
					Adaptive functioning (3- parent, teacher and researcher)	Treatment group significantly improved post (p= 0.01, *ES*= 0.40, p= 0.004, *ES*= 0.34) and follow up (p= 0.02, *ES*= 0.36; $p<0.001$, *ES*= 0.45) compared to TAU

					Stress (2- parent and child)	Treatment group significantly reduced parental stress at follow up only ($p<0.001$, $ES= 0.50$)
	27	ASD (no ID) and parents *n*= 22 Age range= 9-17 2 time points Pre- post= 12 weeks	Qualitative: Thematic and frequencies analysis	Thematic analysis and Frequencies analysis on changes post intervention: Positive changes: Verbal communication: self-description, affective report, social overtures. Non-verbal: understanding social signals, emotion recognition, emotion expression. Managing conflict: alternative thought and behaviours. Confidence, independence and awareness. Negative changes: increased phobia and missed school		
SKILLS vs ENGAGE	6	ASD (no ID) *n*= 62 Mean age= 14.72	RCT	Between group (SKILLS vs ENGAGE) 3 time points Pre- post= 8 weeks Post- follow up= 4-6 weeks	Social Engagement (1- researcher)	Overall significant average improvement in Joint Engage subscale and solitary play both groups showed improvement at follow up ($p= 0.03$, $f^2= 0.08$)
					Social Skills (2- teacher and child)	SKILLS group significantly increased at follow up ($p= 0.03$, $f^2= 0.09$) compared to ENGAGE group.
					Interpersonal relationships (1- child)	ENGAGE group significantly improved at post only ($p=0.01$, $f^2= 0.07$) compared to SKILLS
					Internalising/externalising behaviours (1- child)	SKILLS group significantly increased emotional symptoms and problem

						behaviours at follow up (p= 0.03, f^2= 0.11)
					Social Stress (1- child)	SKILLS group significantly greater social stress post only (p= 0.03, f^2= 0.04) compared to ENGAGE group.
	17	ASD no ID *n*= 148 Age range= 6-11	RCT	Between group (SKILLS vs ENGAGE) 3 time points Pre-post= 8 weeks Post- follow up= 6-8 weeks	Social network salience (1- child)	No significant findings
					Social engagement (1- researcher)	Both groups increased at post (p= .003), however SKILLS group significantly greater than ENGAGE (p= 0.40) in joint engagement (p= 0.04) and social isolation (p=0.002)
Superheroes	26	ID *N*= 4 Age range= 15-16	Single subject Pre-Post	Within group 4 time points Pre- post= 3 weeks Post- maintenance= 3 weeks Maintenance- follow up= 5- 6weeks	Social Skills/Symptoms (1- researcher)	Ron: increase in skill accuracy in training setting for expressing wants, conversation and turn taking (pre-post range = 10%- 100%, *es*= 1) Generalisability setting of all three skills increased to 100% (*es*= 1) at all time points. Tom: increase in skill accuracy in training setting for expressing wants, conversation and turn taking (pre-post range = 12.5%- 100%, *es*=1)

						Generalisability setting showed increase between 92- 100% (*ES*= 1*)* at all time points. Ben: increase in skill accuracy in training setting for expressing wants, conversation and turn taking (pre-post range = 7.5- 100%, *es*= 1). Generalisability setting showed increase between 84- 100% (*es*= 1) at all time points. Chris: increase in skill accuracy in training setting for expressing wants, conversation and turn taking increase in skill accuracy (pre- post range= 7.5%- 100%, *es*= 1. Generalisability setting showed increase between 92- 1005 (*es*= 1) at all time points.
					Social functioning (1- teacher)	 Increase across all participants (only totals used) Ron = 24; Tom= 39; Ben= 51; Chris= 31
SS.GRIN.HFA	8	ASD (no ID) *N*= 55 Age range= 8-12	RCT	Between group (SS.GRIN.HFA vs Control) 2 time points Pre-post= 15 weeks	Social skills (2- parent)	Treatment group significantly improved ( *p*<0.05) compared to control group. Parets in control group reported a decline in the skills.
					Loneliness (1- child)	No significant outcomes
					Social self-efficacy (2- parent and child)	No significant outcomes
NETT	35	ASD (no ID) *N*=69	RCT	Mixed Between-within group	Social behaviour/ Symptoms (2- parent)	Intervention group significantly improved post only (*p*=0.04, *d*=

		Age range= 8-11		(intervention vs waitlist) 3 time points Pre- post= 12 weeks Post- follow up= 12 weeks		0.88) compared with the control group.
					Emotional competence (4- researcher, parent and child)	No significant findings.
Generic SST	2	ADHD *N*= 120 Age range= 8- 12	RCT	Between group (intervention vs waitlist/heterogeneous vs homogeneous/ ADHD-I vs ADHD-C) 3 time points Pre- post= 8 weeks Post- follow up= 12 weeks	Social functioning/Psychopathology (2- parent and child)	No overall significant findings, however, the intervention group showed significant improvements in the assertion subscale post ( $p<0.001$, $n^2= 0.13$; $p<0.001$, $n^2= 0.15$) and follow up ( $p<0.001$, $n^2= 0.11$; $p<0.001$, $n^2= 0.12$) compared to control group. Diagnostically heterogeneous groups significant improvement post for cooperation subscale post ( $p<.001$, $n^2= 0.08$) and follow up ( $p<.001$, $n^2= 0.08$), assertion subscale post ( $p<.001$, $n^2= 0.07$) and follow up ( $p<.001$, $n^2= 0.06$), and empathy post ($p<.001$, $n^2= 0.11$) and follow up ($p<.001$, $n^2= 0.08$) compared to the homogenous group. Homogenous group showed greater improvement in externalising behaviours post ( $p<.001$, $n^2= 0.06$),

					however there was no different between groups at follow up. ADHD- Inattention group improved greater in assertiveness subscale only post (👨‍👩‍👧‍👦 $p<0.001$, $n^2= 0.11$; 🧍 $p<.001$, $n^2= 0.12$) and follow up (👨‍👩‍👧‍👦 $p<0.001$, $n^2= 0.06$; 🧍 $p<.001$, $n^2= 0.06$) compared to ADHD- Combined
3	ADHD females (no ID) *N*= 55 (Pre-adolescent trial *n*= 33, Adolescence trial *n*= 22) Pre-adolescent age range= 7-11 Adolescence age range= 12-16	Within subjects Pre-Post	Within group 3 time points Pre-post= 8 weeks Post- follow up= 8 weeks	Social Functioning (3-parent and child)	Pre-adolescence trial: Significant improvement in social skills post (👨‍👩‍👧‍👦 $p=0.023$, $d= 2.88$) and follow up (👨‍👩‍👧‍👦 $p= 0.023$, $d= 1.08$) No overall significant change reported in self-perception, however significant improvement in physical appearance subscale post (🧍 $p=0.012$, $d= 1.71$) and follow up (🧍 $p= 0.012$, $d= 1.69$) No overall significance in social impairment, however significant improvement in self-esteem subscale post (🧍 $p=0.024$, $d= 3.13$) and follow up (🧍 $p= 0.024$, $d= 0.34$)

		Adolescent trial No overall significant change reported in self-perception, however significant improvement in romantic appeal subscale post (p=0.034, d= 1.0) and follow up (p= 0.034, d= 2.71) No overall significance in social impairment, however significant improvement in social impairment within peer relationships post (p= 0.006, d=4.68) and follow up (p=0.006, d= 0.38) and family relationships post (p= 0.002, d=2.98) and follow up (p= 0.002, d= 0.89)
	Symptomology/ Psychopathology (3- parent and child (combined)	Pre-adolescence trial combined Significant reduction in ADHD symptoms post (p=0.001, d=3.33) and follow up (p=0.001, d= 0.81). ODD symptoms post (p=0.021, d=0.20) and follow up (p= 0.021, d= 2.26). Depression symptoms post (p=0.007, d= 3.49) and follow up (p=0.007, d= 0.94).

					Borderline Personality Disorder post (p=0.04, d=1.53) and follow up (p= 0.04, d= 0.55) No significant change for Anxiety symptoms (p= 0.195)
					Adolescent trial combined Significant reduction in ADHD symptoms post (p=0.001, d=3.33) and follow up (p=0.001, d= 0.48). Anxiety symptoms post (p=0.006, d=1.62) and follow up (p= 0.006, d= 0.04) No significant outcomes for ODD severity (p=0.95), Depression (p= 0.507) or Borderline Personality features (p= 0.449)
7	ASD (no ID) N= 52 Age range= 8-12	Non-randomised controlled	Mixed between-within group (intervention vs waitlist) 3 time points Pre- post= 12 weeks Post- follow up= 12 weeks	Social skills (2- parent and teacher)	Intervention group significantly improved post (p<0.05, r= 0.34; p<0.01, r=0.46) and follow up ( p<0.001;  p= 0.004) compared to the control group.
				Loneliness (1- child	No significant findings.
12	ASD (no ID) N= 6 Age range= 9-11	Within subjects Pre-post	Within group 2 time points Pre-post= 22 weeks	Social skills (1- researcher)	Significant improvement in social skills group ( p= 0.026, ES= -0.91) and general adaptation ( p=0.028, ES= -0.90)

					ASD symptomology (1- researcher)	Significant reduction in symptoms (p= 0.031, *ES*= -0.90)
					Emotional empathy (1- parent)	Significant increase in emotional empathy (p= 0.027, *ES*= -0.90)

Table 1.5

Outcome Table: Emotional Competence Focused Interventions

Intervention	**Paper ID**	**Population (*n*, age and NDD diagnosis)**	**Study Design**	**Comparator**	**Constructs measured (no. of questionnaires used for each)**	**Results**
EBSST	30	ASD (no ID) *N*= 217 Mean age= 9.4	Non-randomised controlled	Mixed Between-within group (intervention vs waitlist) 3 time points Pre- post= 16 weeks Post- follow up= 24 weeks	Social skills (2- parent and teacher)	No significant findings.
					Emotional competence (2- parent and teacher)	Intervention group significantly improved post (p<0.001) and follow up (p= 0.012) compared to control group.
					Psychopathology (2- parent and teacher)	No significant findings.
	31	ASD with mild ID *N*= 85 Mean age= 9.3	Non-randomised controlled	Mixed Between-within group (intervention vs waitlist) 2 time points	Social skills (2- parent and teacher)	No significant findings.
					Emotional competence (2- parent and teacher)	No significant findings.

				Pre- post= 16 weeks	Psychopathology (2-parent and teacher)	No significant findings.
Generic SEL	1	Mild ID Females *N*= 32 Age range= 14-18	RCT	Mixed Between-within group 3 time points Pre- post= 22 sessions Post- follow up = 6 weeks	Communication skills (1-parent)	Significant improvement for intervention group post group only (*p*<.001, *es*= .29). Control group did not show significant improvement.
					Socialisation skills (1-parent)	Significant improvement for intervention group post group only (*p*<.001, *es*= .47). Control group did not show significant improvement.
					Daily living skills (1-parent)	No significant findings.
					General adaptive skills (1-parent)	Significant improvement for intervention group post group only (*p*<.001, *es*= .48). Control group did not show significant improvement.
	11	Mild ID *N*= 50 Age Range= 8-15	Non-randomised controlled	Within group 2 time points Pre-Post= 8 weeks	Emotion Understanding	Significant improvement in emotional comprehension for the intervention group (*p*<.001). Control group showed no significant change.
	15	ASD (no ID) *N*= 72 Age range= 7-10	RCT	Between group (training vs control) 2 time points Pre-post= 14 weeks	Emotion Recognition (1- child)	No significant findings.
					Emotion expression and regulation (1-child)	Training group significantly improved (*p*= 0.025, partial n^2= 0.069) compared to control group.

				Social Interaction (1-child)	Training group significantly improved on social reciprocity (p=0.007, partial n^2= 0.100) compared to control group.
				Adaptive functioning (1-parent)	Community use skills improved in the control group (p=0.01, n^2= 0.09)
23	ASD *N*= 46 Age range= 6-11	Within-subjects Pre-Post/ Qualitative: no specific method	Within group 2 time points Pre-post= 16 weeks Mixed Between-within group (intervention vs waitlist) 2 time points Pre- post= 16 weeks	Social Skills (3- parent and child)	Significant improvement (p<0.001, d=0.51; p<0.01, d=0.34)
				Social competence (2- parent and child)	Significant improvement (p<0.01, d= 0.68; p<0.01, d=0.56)
			No specific method used, however noted theme from parental interviews post intervention: - Reduction in inappropriate behaviour - Awareness of or listening to and acknowledging views of others - Improved conversational skills - Increased social participation - Reciprocating interest in others		
39	ASD *N*= 6 Age range= 7.9- 9.9	Single subject pre-post	Single case design 2 time points Pre-post= 13 weeks	Social behaviours (1-teacher)	**All four in intervention group showed significantly increased frequencies of social behaviours.**

						Jane: R^2= .662, *F* (1, 5) = 57.720, *p*= <0.001, (*ES*=.16) **Jack:** R^2= .227, *F* (1, 5) = 9.267, *p*= <0.001, (*ES*=.02) **Debbie:** R^2= .191, *F* (1, 5) = 7.188, *p*= 0.002, (*ES*=.09) **David:** R^2= .450, *F* (1, 5) = 21. 658, *p*= <0.001, (*ES*=.21)

Table 1.6

Outcomes Table: Psychotherapy Based Interventions

Intervention	Paper ID	Population (*n*, age and NDD diagnosis)	Study Design	Comparator	Constructs measured (no. of questionnaires used for each)	Results
Tübinger training	9	ASD (no ID) *N*= 25 Age range= 7-12	Within- subject Pre-Post	Within group 2 time points Pre-post= 12 weeks	ASD symptomology (2- Parent)	Overall, no significant findings, however significant improvement in motivation (*p*= 0.023, *δ*= 0.49) and emotional symptoms (*p*=0.002, *δ*= 0.77*)*
					Quality of Life (1- parent)	No significant findings.
					Internalising/externalising behaviour (2- parent)	Significant improvement in externalising behaviours only (*p*= 0.003, *δ*= 0.72)
Drums Alive Drumtastic	37	ASD *N*= 14	Within subject Pre-Post	Within group 2 time points	Mood rating (2- parent and child)	Significant improvement (*p*=0.047, *d*= -.25)

		Age range= 5-14		Pre-post= 4 weeks		No other significant outcomes.
					Social behaviours (1- researcher)	No significant findings.
Learn to Play	25	Mix ID *N= 35* Age range= 5- 7.6	Non-randomised controlled	Between group Pre- post= 6 months	Social relationships (1- teacher)	only Significant improvement in social interactions for intervention group (p<.005, d= .61), social disruption (p= .002, d= -1.12) and social disconnection (p= .004, d=-0.95)
Play therapy	29	ID *N*= 24 Age range= 10-12	RCT/ Qualitative: not specific method	Between group (intervention vs control) 2 time points Pre-post= 12 weeks	Internalising/externalising behaviours (2- parent)	Intervention group significantly improved on one measure (p= 0.05, d=.91) compared to control group.
					Observation data: Reporting from researcher, parents and teachers identified specific examples described internalising behaviour reductions such as in anxiety and increase in engagement with peers. Increase in confidence and control with impulsivity. Also identified reduction in externalising behaviours such as more patient, focused, turn taking.	
Yoga based therapy	21	ASD (with ID) Males *N*= 3 Age range= 15-18	Qualitative: Hermeneutic phenomenlogical epistemology Pre-post= 5 weeks		**Hermeneutic phenomenlogical epistemology facilitating feedback from participants:** Themes that emerged;	

			Repeated exposure to breathing exercises triggered prompt/cue for tension release, building a connection to calmness and increasing their sense of self-control. Deep stretches created bodily awareness, helping with a sense of freedom and a way of managing extreme tactile sensitivity. Built ways of managing different emotions. Communication of feels from the participants; relaxed, nice, good and calm.		
36	ASD (no ID) *N*= 64 Age range= 8-12	RCT	Between group (intervention vs waitlist) 3 time points Pre-post= 6 weeks Post- follow up= 6 weeks	Executive functioning (1-parent)	Intervention group significantly improved post (*p*= 0.047, *d*= -0.39) and follow up (*p*= 0.017, *d* = -0.59) compared to control group.
				Sleep habits (1- parent)	Intervention group significantly improved post only (*p*= 0.015, *d*= -0.36) compared to control group.
				Psychopathology (2- parent and child)	No significant findings.
				Emotional competence (1-chid)	Overall, no significant findings, however intervention group showed significant improvements in verbal sharing of emotions post (*p*= 0.005, *d*= 0.59) and follow up (*p*= 0.016, *d*= -0.52) and willingness to understand one's emotions post only (*p*= 0.047, *d*=

						0.53) compared to control group.
RBP	13	ASD (no ID) *N*= 39 Mean age= 10	Within subjects Pre- Post	Within group 2 time points Pre-post= 12 weeks	Internalising/externalising behaviours (1- parent)	Overall, no significant findings, however significant improvement in aggressive behaviours (👫 *p*= 0.01, *d*= 0.57)
					ASD symptomology (2- parent)	Significant improvement (👫 *p*= 0.022, *d*= 1.04)
					Emotion regulation (1- child)	Overall, no significant findings, however, significantly improved on emotional control subscale (👫 *p*= 0.047, *d*= 0.65)
CBT	24	ASD (no ID) *N*= 14 Mean age= 6.1	RCT	Mixed Between and within group (robot group vs control group) 2 time points Pre-post= 12 weeks	Emotional understanding (2- researcher)	Robot group significantly improved greater (*p*= 0.001, n^2= .67), with control group not showing a significant improvement.
Social Cognitive Training	33	22q11 deletion syndrome *N*= 22 Age range 12-17	Non-randomised controlled/ Qualitative: Constant comparative method	Between group 2 time points Pre- post= 26 weeks	Social cognition (2- researcher)	significant improvement for the intervention group (*p*<0.05, *d*= .77)
					Social functioning (2- researcher)	No significant findings.
					Adaptive functioning (1- researcher	No significant findings.
				Themes gathered:		

				(1) changes observed in participants carry over into activities of daily life; (2) observations of the group processes; (3) negatives/barriers to group participation; (4) recommendations to improve the programme.		
Process orientated psychotherapy	34	Mix population (ID, ADHD and ADD) *N*= 87 Age range: 14- 16	Non-randomised controlled / Qualitative: Frequencies analysis	Between group (intervention vs waitlist) 2 time points Pre-post= 15 weeks	Social competence (1-child)	Intervention group significantly improved ($p<.001$, $n^2= 0.15$) compared to control group.
					Relationship quality (1-child)	No significant findings.
					Friendship intimacy (1-child)	No significant findings.
				Themes gathered through interviews with the counsellors regarding change and mechanisms to change through Frequencies analysis: Most progress within self-growth (26), social (26) and academic areas (21). Therapeutic factors to support gains; group cohesion (24), catharsis (19), interpersonal learning (14), socialising skills (12) and altruism (7).		

1.5 Discussion

Overall, most papers across the three categories measured social skills, aiming at exploring specific targeted skills alongside constructs such as relationship quality, motivation and social cognition. The most robust evidence for improvements on social skills came from CBT informed, explicit programmes across all three categories (i.e. The Programme for the Education and Enrichment of Relational Skills [PEERS], Cognitive Enhancement Therapy, Resilience Building Programme, NETT). However, the majority came from SST programmes which were often teaching a set of specific 'appropriate' social skills. This is unsurprising given SST programmes are cited as evidence-based practice for individuals with ASD and as the most appropriate interventions for other NDCs (Hassani & Schwab, 2020; Hagarty & Morgan, 2020; Hume et al., 2021). However, despite this, it is important to note that the evidence was varied regarding study design, measures and effect sizes reported. For example, the PEERS intervention showed a range of evidence for social skill improvement, however the strongest and most consistent evidence came from knowledge of the specific skills taught using an author derived measure. Similarly, the second largest focus of measurement was on diagnostic symptom reduction (i.e. ASD/ADHD symptoms), which again was most robustly evidenced within SST programmes despite the variation in effect sizes reported.

Whilst there have been longstanding discussions surrounding the importance of moving away from interventions shaped by the deficit model of neurodiversity, this review reflects how little meaningful change has taken place (Chapman & Bortha, 2021; Shuck et al., 2022). The papers identified rarely evidenced programmes that took a more strengths-based approach, indicating that this important component is not prioritised above the continued focus on changing behaviour to 'normative behaviour' (Leadbitter et al., 2021). The problem with this approach can be explained by the double-empathy problem. When

people with very different experiences of the world interact with one another, they will struggle to empathise with each other. Therefore, those with similar experiences are more likely to form connections and a level of understanding, more so than with others they do not share those experiences with (Milton, 2012). This is not unique to NDCs but highlights the different ways of communicating in a neurodiverse world. However, those with NDCs are still diagnosed with 'deficits' regarding their social skills when measured against skills identified as 'appropriate'. In this respect, attempts to reduce symptomology through these desired skills will not increase wellbeing but can result in masking an individual's true identity and needs, in an attempt to integrate with others. This is viewed as attempt to enforce compliance to the 'norm' instead of supporting inclusion for all (Shuck et al., 2022).

Interestingly, one paper explored homogenous groups vs heterogenous groups, with ASD only compared with a group of ASD and neurotypical peers (Dean et al., 2020; Kasari et al., 2015). Whilst the homogenous group showed increase in social skills and social engagement, only the heterogenous group showed improved interpersonal relationships. Alongside this, the homogenous group indicated worsening emotional symptoms. This appears in contradiction with the double empathy problem, indicating the peer mediated groups may give the opportunity to create a more inclusive environment that supports better understanding across populations (Shuck et al., 2021).

In contrast to the other SSTs, one did not rely heavily on teaching of specific skills, but instead supported exploration and development of internal resources such as emotion recognition and management. Thus, stepping away from the 'traditional' structure of SST programmes, which have long been deemed as showing a lack of focus on emotions or emotional competence (Gaffney et al., 2021). Emotional competence is important in supporting basic psychological needs to thrive (Collie, 2019; Leadbitter et al., 2021). Utilising a computer-based game to support a strengths-based focus promoting

neuroaffirming skills (Secret Agent Society [SAS]; Beaumont et al., 2008: 2015; Einfield et al., 2019), SAS showed positive effects on both social and emotional competence, as well as reducing in anxiety symptoms. It focused on emotional regulatory techniques that matched the child's different needs (i.e. using sensory experiences to regulate their emotions), exploring how communication skills are unique to everyone (i.e. "different brains") whilst building self-advocacy skills to voice their wants and needs.

Alongside this, there was tentative evidence for implicit groups as impacting on the development of social skills, emotional competence as well as impacting on internalising and externalising behaviours. For example, there was positive change on social and emotional competence, as well as internalising behaviours such as anxiety within an implicit play therapy groups for individuals with ID, as well as a process-oriented psychotherapy group for CYP with a mix of diagnoses. Similarly, an implicit SST programme sought to building on assertiveness skills, as well as empathy and insight into self and others through cooperative games guided by CYP with ASD without ID (Guivarch et al., 2017). They found that the implicit modality increased both empathy and social skills, whilst ASD symptoms decreased. Alongside this, yoga-based interventions focusing on enhance the interoceptive awareness showed positive effects in increasing emotional competence. However, difficulty with implicit learning has long been described for those within a NDC, supported by research that states explicit interventions are required for these individuals (Klin et al., 2003).

One reason why certain interventions showed impact might be their focus on supporting the development of self-determination through different intervention structures. Self-determination is about skills designed to increase self-advocacy, competency and management (Burke et al., 2020). It is a key component to wellbeing and positively related to quality of life, with the NDC population frequently being described as 'less self-determined' (Thompson- Hodgetts et al., 2023). SEL programmes are created to help develop skills that

support self-determination in all CYP, supporting confidence, empowerment, identity and coping, focusing on strengths of an individual. The SEL literature for the neurotypical population focuses on preventative strategies or to support the further development of skills identified as crucial to 'thriving' in life. In contrast, most of the NDC literature focuses on 'changing' individuals behaviours, not focusing on developing important attributes such as self-determination and identity which is arguably more important for CYP who frequently experience stigma and lack of opportunities (Burke et al., 2020; Cherewick & Matergia, 2023; Thompson-Hodgetts et al., 2023).

It is worth noting that some programmes across the different categories used a variety of assistive technology (i.e. multi-media, computer games) to support the learning of skills. For example, one used VR technology (Ip et al., 205) to enhance learning of SEL skills to positive effect, and another focused on supporting development of social skills via multi-media support (Jonsson et al., 2019; Olsson et al., 2016:2017). The literature indicates the usefulness of technology to enhance interventions. Using technology to support learning has also been identified as a "safer" environment for individuals, increasing engagement, motivation and learning (Tan et al., 2022). Nonetheless, there is a debate regarding the use of technology, with concerns regarding assistive technology as trying to "normalise" individuals with neurodevelopmental conditions, reflecting the overall sense that most programmes still aim to enforce compliance (Dahlstrom- Hakki et al., 2024; Shuck et al., 2022). As both the programmes used CBT and behavioural models to shape their intervention this may indicate the positive effects linked to greater masking rather than positive impact on the individuals quality of life. Therefore, whilst promising is an area that requires further investigation to see if this support person centred goals based on strengths, versus what is deemed 'appropriate'.

Another point of interest to note was the lack of neurodiversity specific measures beyond those measuring symptomology. For example, despite the recognition of how

important emotional competence is for individuals to thrive, measurement of emotional competence was not widely used, even amongst those programmes focus on developing skills in emotion recognition and regulation. This lack is reflected in the literature (i.e. Hagarty & Morgan, 2020; Leadbitter et al., 2021) either because of difficulty in measuring the subjective nature of emotional experience or due to the historical lack of attention paid to the emotions of those diagnosed with an NDC (Hagarty & Morgan, 2020). Similarly, despite quality of life viewed as an important indicator of the impact of interventions, it was rarely used. Again, this may be reflective of the difficulty in measuring a concept that is very individual, and it is noted that *what* this looks like is still being debated within the NDC population (Thompson-Hodgetts et al., 2023). However, as self-determination is noted to be crucially linked to quality of life, it raises the importance of measures, goals and targets to be created actively with the neurodiverse communities to increase the populations voice and validity of said measures. Subsequently, in exploring further how co-construction can support personalised outcomes for individuals with NDC, this can lend itself to further supporting the voice of participants in co-production of interventions that can meet those goals, helping assess the effectiveness and further development of impactful interventions (Leadbitter et al., 2021; Shuck et al., 2022).

Clinical implications

It is important to note that social skills programmes still show a predominance within the field, focusing on changing behaviour so it aligns with desired social skills rather than taking the strengths- based approach seen within the neurotypical population (Chapman & Bortha, 2021; Shuck et al., 2022). However, this scoping review also highlighted the limitations of a field that predominantly focuses on changing behaviour aligned to normative desired social skills. By placing the “problem” within the individual we run the risk that the interventions are not helping as they are aiming at doing but create the need to mask their true

identity and impact on their wellbeing (Shuck et al., 2022). This can increase vulnerability in the development of difficulties such as anxiety or depression, both of which are seen as having high morbidity rates in the NDC population (i.e. Hagarty & Morgan, 2020; Ratcliffe et al., 2019).

This scoping review showed indications that programmes are shifting their focus to incorporate strengths-based elements and approaches, therefore creating an opportunity to explore greater inclusivity for all. For example, Beaumont and colleagues found that using a neuroaffirming programme showed positive impact on social and emotional skills, therefore stepping away from the traditional stance of placing the "problems" in the individual. Similarly, it highlighted tentative positive outcomes for implicit group interventions for individuals with a range of diagnoses. The implicit, naturalistic settings appear to lend itself to greater generalisability of skills and indicates a contradiction of the view that implicit learning is a difficulty for individuals with an NDC (Klin et al., 2003). Importantly, these types of interventions focused more on skilling up of individuals using strengths-based approaches, whilst appreciating the nuances of sensory and emotional experiences, indicated positive impact on both social and emotional outcomes. This scoping review indicates that programmes that can balance the evidence-based elements of CBT informed interventions alongside the inclusive, naturalistic elements of implicit groups could be a way of shifting the focus of SEL interventions away from the traditional views of neurodiversity being seen as something to change (Foti et al., 2014; Klin et al., 2003; Shuck et al., 2022). Alongside this, quality of life can be greatly impacted on for those with an NDC. Therefore, as self-determination is positively to quality of life, focusing on interventions aimed at impacting this seems an important direction to move towards (Burke et al., 2020; Cherewick & Matergia, 2023; Collie, 2020).

Importantly there is scope for prioritising and increasing how co-construction can lend itself to further supporting the voice of participants in co-production of interventions alongside supporting personalised outcomes for individuals with NDC helping assess the effectiveness and further development of impactful interventions (Leadbitter et al., 2021; Shuck et al., 2022). Participatory exploratory methodology is important at all stages of developing interventions, especially during the early stages, aiding in creating meaningful change (Foulkes & Stapley, 2022; Sellars et al., 2021). For example, Armitt and colleagues (2023) used a play-based approach to co-production to develop an intervention with CYP with ADHD diagnosis. When reflecting on the process, they noted that whilst models of co-production was helpful, the most effective ways to co-engage stakeholders in an equitable way was using their clinical skills of engagement and flexibility, creating the opportunity to engage with children with variation of strengths and needs, whilst encouraging the CYP to engage with the workshop in whatever way felt most comfortable. Approaches such as this could not only help with developing interventions, but increasing the development of meaningful participant led goals and targets which helps increase participant motivation.

Strengths & Limitations

The use of four electronic databases, reviewing the reference list of 24 different articles and using this to re-shape search term, using screening and data extraction forms with different reviewers to evidence consistency in approach and reviewing, helped ensure a rigorous and transparent approach to the review, remaining true to the recommended guidelines (Triccio et al., 2018) as illustrated in Appendix B. Despite this, this review may not have identified all relevant interventions and programmes, however we attempted to be as comprehensive as possible regarding the search terms used and choosing databases that went beyond health and science (i.e. Education Resources Information Centre [ERIC]). Searching other databases may have yielded additional publications.

Also, the terminology around SEL programmes is wide and varied, with many different terms being used to potentially describe the same thing (Wigelsworth et al., 2016). We used CASELs framework to guide this, focusing on programmes that had at least one element to their conceptualisation of SEL. Most papers we found had more than one. The use of this helped with keeping consistency when determining if a group programme was SEL based and therefore included in the review. The exclusion and inclusion criteria were used by each reviewer to determine if it met the criteria, and discussions were held if the reviewers disagreed. However, the lack of consistency regarding study design, constructs and measures in the general literature does continue to raise difficulties with conceptualisation and comparison of the programmes which has been similarly noted in other reviews (i.e. Wigelsworth et al., 2023).

The quality of the evidence was not assessed, which is in line with the current methodological guidance for scoping reviews (i.e. Peters et al., 2020; Tricco et al., 2018). Whilst quality appraisals provide a greater insight to the methodological rigour of the studies, and therefore can provide greater confidence in conclusions drawn, the decision to not complete a quality assessment was made due to the extent of information provided both within the descriptive text of the results section as well as the tables. It was felt that by completing a quality of appraisal this would add an additional layer of complexity that is not necessary within a scoping review. Within the table's information on study design, population, comparators were noted to provide as much information as possible for readers to draw their conclusions surrounding specific interventions. Furthermore, the use of Cohen's (1992) criteria to guide interpretation of results was to create further insight into the outcomes extracted for the interventions. However, it is important to note that the conclusions drawn within this scoping review on effectiveness are tentative as it cannot provide quality ratings for each study. This review, including a wide range of search terms for neurodevelopmental

conditions which is a strength. However, the papers identified were limited regarding scope of different conditions and therefore is unable to provide an overview of interventions for the wider neurodevelopmental condition population. This reflects the limitation of the literature that appears to exist, with the primary focus of research being with individuals with a diagnosis of ASD without ID. As the prevalence of co-occurring conditions is high within the wider neurodevelopmental population, this is further a reflection on the limitations surround the literature reviewed.

Conclusion

Whilst it is important to note the tentative nature of the outcomes, this scoping review described and examined the outcomes for different SEL interventions available for CYP with neurodevelopmental conditions. Despite the advancement made in social- emotional learning literature, this does not appear to translate into the neurodevelopmental condition population with limited robust research focused on interventions beyond social skills training programmes. The review raises the relative lack of evidence of non- disorder led thinking, and the available opportunities to explore and develop strength-based approaches for CYP with neurodevelopmental conditions which importantly include their voice in the creation of such programmes. However, there are indications that programmes are shifting their focus to incorporate strengths-based elements and approaches to support CYP, more in line with the neurotypical research.

References

Adibseresnki, N., Shaydaei. M., & Movallali, G. (2016). The Effectiveness Of Emotional Intelligence Training On The Adaptive Behaviors Of Students With Intellectual Disability. *International Journal of Developmental Disabilities, 62*(4), 245-252.

Ajzen, I., & Fishbein, M. (1980). *Understanding Attitudes and Predicting Social Behaviour*. Prentice- Hall.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders (5th ed)*. https://doi.org/10.1176/appi.books.9780890425596

Antshel, K. M., & Remer, R. (2003). Social Skills Training in Children With Attention Deficit Hyperactivity Disorder: A Randomized- Controlled Clinical Trial. *Journal of Clinical Child and Adolescent Psychology, 31*(1), 153-165.

Arksey, H., & O'Malley, L. (2005). Scoping Studies: Towards A Methodological Framework. *International Journal of Social Research Methodology, 8*, 19-32.

Astle, D.E., Holmes, J., Kievit, R., & Gathercole, S.E. (2022). Annual Research Review: The Transdiagnostic Revolution in Neurodevelopmental Disorders. *The Journal of Child Psychology and Psychiatry, 63*(4), 397- 417.

Babinski, D.E., Huffnagle, S.M., Bansal, P.S., Breaux, R.P., & Waschbusch, D.A. (2020). Behavioral Treatment for the Social-Emotional Difficulties of Preadolescent and Adolescent Girls with ADHD. *Evidence-Based Practice in Child and Adolescent Mental Health, 5*(2), 173-188.

Bandura, A., & McClelland, D.C. (1977). *Social Learning Theory* (Vol 1). Prentice Hall.

Barry, M.M., Clark, A.M., Dowling, K. (2017). Promoting Social and Emotional Well-Being in Schools. *Health Education, 117*(5), 434- 451.

Beaumont, R., Rotolone, C., & Sofronoff, K. (2015). The Secret Agent Society Social Skills Program For Children With High-Functioning Autism Spectrum Disorders: A Comparison Of Two School Variants. *Psychology in the Schools, 52*(4), 390- 402.

Beaumont, R., & Sofronoff, K. (2008). A Multi-Component Social Skills Intervention For Children With Asperger Syndrome: The Junior Detective Training Program. *The Journal of Child Psychology and Psychiatry, 49*(7), 743-753.

Beck, A.T. (1979). *Cognitive Therapy for Depression.* Guildford Press.

Bond, C., Evans, V., & Humphrey, N. (2023). Implementing Targeted Social and Emotional Learning Interventions in Schools- Are More Specific Models Needed? *Journal of Research in Special Educational Needs,* https://doi.org/10.1111/1471-3802.12655

Burke, K.M., Raley, S.K., Shogren, K.A., Hagiwara, M., Mumbardó- Adam, C., Uyanik, H., & Behrens, S. (2020). A Meta-Analysis of Interventions to Promote Self-Determination for Students with Disabilities. *Remedial and Special Education, 41*(3), 176- 188.

CASEL (2020). *"What Is SEL?"*. CASEL. https://casel.org/what-is-sel/.

Chapman, R., & Bortha, M. (2021). Neurodivergence- Informed Therapy. *Developmental Medicine & Child Neurology, 65*, 310- 317.

Cherewick, M., & Matergia, M. (2023). Neurodiversity in Practice: a Conceptual Model of Autistic Strengths and Potential Mechanisms of Change to Support Positive Mental Health and Wellbeing in Autistic Children and Adolescents. *Advance in Neurodevelopmental Disorders,* https://doi.org/10.1007/s41252-023-00348-z

Cohen, J. (1992). A Power Primer. *Psychological Bulletin, 1123*(1), 155-159.

Collie, R.J. (2020). The Development of Social and Emotional Competence at School: An Integrated Model. *International Journal of Behavioural Development, 44*(1), 76-87.

Corcoran, R.P., Cheung, A.C.K., Kim, E., & Xie, C. (2018). Effective Universal School-Based Social And Emotional Learning Programs For Improving Academic Achievement: A Systematic Review And Meta-Analysis Of 50 Years Of Research. *Educational Research Review, 25*, 56-72.

Clarke, A.C., Sorgenfrei, M., Mulcahy, J., Davie, P., Friedrich, C., & McBride, T. (2021). *Adolescent Mental Health: A Systematic Review on the Effectiveness of School-Based interventions.* Early Intervention Foundation.

Colquhoun, H.L., Levac, D., O'Brien, K.K., Straus, S., Tricco, A.C., Perrier, L., Kastner, M., & Moher, D. (2014). Scoping Reviews: Time For Clarity In Definition, Methods And Reporting. *Journal of Clinical Epidemiology, 67*(12), 1291- 1294.

Dean, M., Williams, J., Orlich, F., & Kasari, C. (2020). Adolescents With Autism Spectrum Disorder And Social Skills Groups At School: A Randomized Trial Comparing Intervention Environment And Peer Composition. *School Psych Rev, 49*(1), 60-73.

Deckers, A., Muris, P., Roelofs, J., & Arntz, A. (2016). A Group-Administered social Skills Training for 8- to 12- Year-Old, high-Functioning Children With Autism Spectrum Disorders: An Evaluation of its Effectiveness in a Naturalistic Outpatient Treatment Setting. *Journal of Developmental Disorders, 46,* 3493- 3504.

DeRosier, M.E., Swick, D.C., Ornstein Davis, N., McMillen Sturtz, J., & Matthew, R. (2011). The Efficacy of a Social Skills Group Intervention for Improving Social Behaviors in Children with High Functioning Autism Spectrum Disorders. *Journal of Autism and Developmental Disorders, 41,* 1033-1043.

Domitrovich, C.E., Durlak, J.A., Staley, K.C., & Weissberg, R.P. (2017). Social-Emotional Competence: An Essential Factor for Promoting Positive Adjustment and Reducing Risk in School Children. *Child Development, 88*(2), 408- 416.

Drüsedau, L., Schoba, A., Conzelmann, A., Sokolov, A., Hautzinger, M., Renner, T.J., & Barth, G.M. (2022). A Structured Group Intervention (Tütass) With Focus On Self-Perception And Mindfulness For Children With Autism Spectrum Disorder, ASD. A Pilot Study. *European Archives of Psychiatry and Clinical Neuroscience, 272,* 177-185.

Durlak, J.A., Weissberg, R.P., Dymnicki, A.B., Taylor, R.B., & Schellinger, K.B. (2011). The Impact Of Enhancing Students Social And Emotional Learning: A Meta-Analysis Of School- Based Universal Interventions. *Child Development, 82*(1), 405-432.

Einfeld, S.L., Beaumont, R., Clakr, T., Clarke, K.S., Costley, D., Gray, K.M., Horstead, S.K., Redoblado Hodge, A., Roberts, J., Sofronoff, K., Taffe, J.R., & Howlin, P. (2018). School-Based Social Skills Training For Young People With Autism Spectrum Disorders. *Journal of Intellectual & Developmental Disability, 43*(1), 29-39.

Elias, M.J., Zins, J.E., Weissberg, R.P., Frey, K.S., Greenberg, M.T., Haynes, N.M., Kessler, R., Schwab-Stone, M.E., & Shriver, T.P. (1997). *Promotion Social and Emotional Learning: Guidelines for Educators.* Association for Supervision and Curriculum Development.

Faria, S.M.M., Esgalhado, G., & Pereira, C.M.G. (2019). Efficacy Of A Socioemotional Learning Programme In A Sample Of Children With Intellectual Disability, *Journal of Applied Research in Intellectual Disabilities, 32*(2), 457-470.

Fleming, M., Salim, E.E., Mackay, D.F., Henderson, A., Kinnear, D., Clark, D., King, A., McLay, J.S., Cooper, S.A., & Pell, J.P. 2020. Neurodevelopmental Multimorbidity

And Educational Outcomes Of Scottish Schoolchildren: A Population-Based Record Linkage Cohort Study. *PLoS Med*, *17*(10), 1-24.

Fotheringham, F., Cebula, K., Fletcher- Watson, S., Foley, S., & Crompton, C.J. (2023). Co-Designing a Neurodivergent Programme for Neurodivergent Young People in Mainstream High School. *Neurodiversity, 1,* 1-13.

Foti, F., De Crescenzo, F., Vivanti, G., Menghani, D., & Vicari, S. Implicit Learning in Individuals with Autism Spectrum Disorder: A Meta-Analysis. *Psychological Medicine, 45*(5), 897-910.

Francés, L., Quintero, J., Fernández, A., Ruiz, A., Caules, J., Fillon, G., Hervás, A., & Soler, C.V. (2022). Current State Of Knowledge On The Prevalence Of Neurodevelopmental Disorders In Childhood According To The DSM-5: A Systematic Review In Accordance With The PRISMA Criteria. *Child and Adolescent Psychiatry and Mental Health, 16*, 1-15.

Gaffney, H., Farrington, D.P., & White, H. (2021). *Social Skills Training: Toolkit Technical report.* Youth Endowment fund.

Gedikoglu, M. (2021). *Social and Emotional Learning: An Evidence review and Synthesis of Key Issues,* Education Policy Institute. United Kingdom. Retrieved from: https://policycommons.net/artifacts/3786457/social-and-emotional-learning-an-evidence-review-and-synthesis/4592219/

Goleman, D. (1995). *Emotional intelligence: why it can matter more than IQ*. New York; Bantam Books.

Guivarch, J., Murdymootoo, V., Elissalde, S-N., Xavier Salle- Collemiche, X., Tardieu,S., Jouve, E., & Poinso, F. (2017). Impact Of An Implicit Social Skills Training Group In Children With Autism Spectrum Disorder Without Intellectual Disability: A Before-And-After Study. *PLoS ONE, 12*(7), https://doi.org/ 10.1371/journal.pone.0181159

Habayeb, S., Rich, B., Alvord, M.K. (2017). Targeting Heterogeneity and Comorbidity in Children with Autism Spectrum Disorder Through the Resilience Builder Group Therapy Program, *46,* 539- 557.

Hagarty, I., & Morgan, G. (2020). Social- Emotional Learning for Children with Learning Disabilities: A Systematic Review. *Educational Psychology in Practice: Theory, Research and Practice in Educational Psychology, 36*(2), 208-222.

Hassani, S., & Schwab, S. (2020). Social-Emotional Learning Interventions for Students With Special Educational Needs: A Systematic Literature Review. *Frontier in Education, 6*.

Hassani, S., Jakob, K., Schwab, S., Hellmich, F., Loeper, M., & Goerel, G. (2023). Fostering Students' Peer Relationships through the Classroom-Based Intervention FRIEND-SHIP.

Hawkins, J. D., & Weis, J. G. (1985). The social development model: An integrated approach to delinquency prevention. The Journal of Primary Prevention, 6(2), 73-97.

Hill, T.L., Gray, S.A.O., Baker, C.N., Boggs, K., Carey, E., Johnson, C., Kamps, J.L., & Varela, R.E. (2017). A Pilot Study Examining the Effectiveness of the PEERS Program on Social Skills and Anxiety in Adolescents with Autism Spectrum Disorder, *Journal of Developmental and Physical Disabilities, 29*(5), 797- 808.

Hume, K., Steinbrenner, J.R., Odom, S.L, Morin, K.L., Nowell, S.W., Tomaszewski, B., Szendrey, S., McIntyre, N.S., Yücesoy-Özkan, S., & Savage, M.N. (2021). Evidence-Based Practices for Children, Youth, and Young Adults with Autism: Third Generation Review. *Journal of Autism Developmental Disorders, 51,* 4013–4032. https://doi.org/10.1007/s10803-020-04844-2

Ip, H.H.S., Wong, S.W.L., Chan, D.F.Y., Byrne, J., Li, C., Yuan, V.S.N., Lau, K.S.Y., & Wong, J.Y.W. (2018). Enhance Emotional And Social Adaptation Skills For Children With Autism Spectrum Disorder: A Virtual Reality Enabled Approach. *Computers & Education, 117,* 1-15.

Jones, S.M & Doolittle, E.J. (2017). Social and Emotional Learning: Introducing the Issue. *The Future of Children, 27*(1), 3-11.

Jonsson, U., Olsson, N.C., Coco, C., Görling, A., Flygare, O., Råde, A., Chen, Q., Berggren, S., Tammimies, K., & Bölte, S. (2019). Long-Term Social Skills Group Training For Children And Adolescents With Autism Spectrum Disorder: A Randomized Controlled Trial. *European Child & Adolescent Psychiatry, 28*, 189-201.

Kasari, C., Dean, M., Kretzmann, M., Shih, W., Orlich, F., Whitney, R., Landa, R., Lord, C., & King, B. (2016). Children With Autism Spectrum Disorder And Social Skills Groups At School: A Randomized Trial Comparing Intervention Approach And Peer Composition. *Journal of Child Psychology and Psychiatry, 57*(2), 171-179.

Klin, A., Jones, W., & Schultz, R.T. (2003). The Inactive Mind, Or From Actions To Cognition: Lessons From Autism. *Philosophical Transactions of the Royal Society of London, 358*, 345–360.

Kwan, C., Gitimoghaddam, M., & Collet, J.P. (2020). Effects of Social Isolation and Loneliness in Children with Neurodevelopmental Disabilities: A Scoping Review. *Brain Sciences, 10,* 786- 817.

Laugeson, E.A., Frankel, F., Mogil, C., & Dillon, A.R. (2009). Parent-Assisted Social Skills Training to Improve Friendships in Teens with Autism Spectrum Disorders. *Journal of Autism and Developmental Disorders, 39*, 596- 606.

Laugeson, E.A., Frankel, F., Gantman, A., Dillon, A.R & Mogil, C. (2012). Evidence-Based Social Skills Training for Adolescents with Autism Spectrum Disorders: The UCLA PEERS Program. *Journal of Autism and Developmental Disorders, 42,* 1025- 1036.

Laugeson, E.A., Gantman, A., Kapp, S.K., Orenski, K., & Ellingsen, R. (2015). A Randomized Controlled Trial to Improve Social Skills in Young Adults with Autism Spectrum Disorder: The UCLA PEERS Program. *Journal of Autism and Developmental Disorders, 45,* 3978-3989.

Laxman, K. (2022). Socio-Emotional Well-Being Benefits Of Yoga For Atypically Developing Children. *Journal of Research in Special Education Needs, 22*(2), 158-166.

Leadbitter, K., Leneh Buckle, K., Ellis C., & Dekker, M. (2021). Autistic Self Advocacy and the Neurodiversity Movement: Implications for Autism Early Intervention Research and Practice. *Frontiers in Psychology, 12*: doi: 10.3389/fpsyg.2021.635690

Levac, D., Colquhoun, H., O'Brien, K.K. (2010). Scoping Studies: Advancing The Methodology. *Implementation Science, 5,* 1-9.

Lordo, D.N., Bertolin, M., Sudikoff, E.L., Keith, C., Braddock, B., & Kaufman, D.A.S. (2016). Parents Perceive Improvements in Socio-emotional Functioning in Adolescents with ASD Following Social Skills Treatment. *Journal of Autism and Developmental Disorders, 47*(1), 203-214.

Löytömäki, J., Laakso, M-J., & Huttunen, K. (2022). Social-Emotional and Behavioural Difficulties in Children with Neurodevelopmental Disorders: Emotion Perception in Daily Life and in a Formal Assessment Context. *Journal of Autism and Developmental Disorders.* https://doi.org/10.1007/s10803-022-05768-9

MacKay, T., Knott, F., & Dunlop, A.W. (2007). Developing Social Interaction And Understanding In Individuals With Autism Spectrum Disorder: A Groupwork Intervention. *Journal of Intellectual and Developmental Disability, 32*(4), 279- 290.

Mahoney, J.L., Durlak, J.A., & Weissberg, R.P. (2018). An Update on Social and Emotional Learning Outcome Research. *Phi Delta Kappan, 100*(4), 18-23.

Marino, F., Chilà, P., Sfrazzetto, S.T., Carrozza, C., Crimi, I., Failla, C., Busà, M, Bernava, G., Tartarisco, G., Vagni, D, Ruta, L., & Pioggia, G. (2020). Outcomes of a Robot-Assisted Social-Emotional Understanding Intervention for Young Children with Autism Spectrum Disorders. *Journal of Autism and Developmental Disorders, 50,* 1973- 1987.

McKown, C., Gumbiner, L.M., Russo, N.M. (2009). Social- Emotional Learning Skill, Self-Regulation, and Social Competence in Typically Developing and Clinic- Referred Children. *Journal of Clinical Child & Adolescent Psychology, 38*(6), 858- 871.

Milton, D. (2012). On the Ontological Status of Autism: the 'Double Empathy Problem'. *Disability and Society, 27*(6), 883-887.

Munn, Z., Peters, M.D.J., Stern, C., Tufanaru, C., McArthur, C., & Aromataris, E. (2018). Systematic Review Or Scoping Review? Guidance For Authors When Choosing Between A Systematic Or Scoping Review Approach. *BMC Medical Research Methodology, 18*, 143-149.

National Institute for Health and Care Excellence [NICE]. (2019). Attention Deficit Hyperactivity Disorder: Diagnosis and Management [NICE guideline no. 87]. https://www.nice.org.uk/guidance/ng87

O'Connor, C., & Stagnitti, K. (2011). Play, Behaviour, Language And Social Skills: The Comparison Of A Play And A Non-Play Intervention Within A Specialist School Setting. *Research in Development Disabilities, 32,* 1205- 1211.

O'Handley, R.D., Ford, W.B., Radley, K.C., Helbig, K.A., & Wimberly, J.K. (2016). Social Skills Training for Adolescents With Intellectual Disabilities: A School-Based Evaluation. *Behaviour Modification, 40*(4), 541- 567.

OECD. (2015). *Skills for social progress: the power of social and emotional skills*. OECD Skills Studies. OECD Publishing. Paris.

Olsson, N.C., Rautio, D., Asztalos, J., Stoetzer, U., & Bölte, S. (2016). *Autism, 20*(8), 995-1010.

Olsson, N.C., Flygare, O., Coco, C., Görling, A., Råde, A., Chen, Q., Lindstedt, K., Berggren, S., Serlachius, E., Jonsson, U., Tammimies, K., Kjellen, L., & Bölte, S. (2017). Social Skills Training for Children and Adolescents With Autism Spectrum Disorder: A Randomized Controlled Trial. *Journal of The American Academy of Child & Adolescent Psychiatry, 56*(7), 585-592.

Packman, J., & Bratton, S.C. (2003). A School-Based Group Play/Activity Therapy Intervention With Learning Disabled Preadolescents Exhibiting Behavior Problems. *International Journal of Play Therapy, 12*(2), 7-29.

Payton, J.W., Wardlaw, D.M., Graczyk, P.A., Bloodworth, M.R., Tompsett, C.J., & Weissberg, R.P. (2000). Social and Emotional Learning: A Framework Promoting Mental Health and Reducing Risk Behaviour in Children and Youth. *Journal of School Health, 70*(5), 179- 185.

Peters, M.D.J., Godfrey, C. M., Khalil, H., McInerney, P., Parker, D., & Soares, C.B. (2015). Guidance For Conducting Systematic Scoping Reviews. *International Journal of Evidence Based Healthcare, 13*, 141-146.

Peters, M.D.J., Godfrey, C., McInerney, P., Munn, Z., Tricco, A.C., & Khalil, H. (2020). Chapter 11: Scoping Reviews. In E. Aromataris & Z. Munn (Eds.), *JBI Manual for Evidence Synthesis*. JBI. https://doi.org/10.46658/JBIMES-20-12

Pham, M. T., Rajic, A., Greig, J.D., Sargeant, J.M., Papadopoulos, A., & McEwen, S. A. (2014). A Scoping Review Of Scoping Reviews: Advancing The Approach And Enhancing The Consistency. *Research Synthesis Methods, 5*, 371- 385.

Pollack, Isa., Mitic, M., Birchwood, J., Dörfler, S., Krammer, I., Rogers, J.C., Schek, E.J., Schrank, B., Stiehl, K.A.M., & Woodcock, K.A. (2022). *Relationships Among Children and Adolescents: Methods and Targets Used in Effective Programs* [Unpublished Doctoral Dissertation]. University of Birmingham.

Ratcliffe, B., Wong, M., Dossetor, D., & Hayes, S. (2014). Teaching Social–Emotional Skills To School-Aged Children With Autism Spectrum Disorder: A Treatment Versus Control Trial In 41 Mainstream Schools. *Research in Autism Spectrum Disorders, 8,* 1722- 1733.

Ratcliffe, B., Wong, M., Dossetor, D., & Hayes, S. (2019). Improving Emotional Competence in Children with Autism Spectrum Disorder and Mild Intellectual

Disability in Schools: A Preliminary Treatment Versus Waitlist Study. *Behaviour Change, 36*, 216- 232.

Salovey, P., & Mayer, J. D. (1990). Emotional intelligence. *Imagination, Cognition and Personality, 9*(3), 185-211.

Shechtman, Z., & Katz, E. (2007). Therapeutic Bonding in Group as an Explanatory Variable of Progress in the Social Competence of Students With Learning Disabilities. *Group Dynamics: Theory, Research and Practice, 11*(2), 117-128.

Schohl, K.A., Van Hecke, A.V., Meyer Carson, A., Dolan, B., Karst, J., & Stevens, S. (2014). A Replication and Extension of the PEERS Intervention: Examining Effects on Social Skills and Social Anxiety in Adolescents with Autism Spectrum Disorders. *Journal of Autism and Developmental Disorders, 44,* 532- 545.

Shashi, V., Harrell, W., Eack, S., Sanders, C., McConkie-Rosell, A., Keshavan, M.S., Bonner, M.J., Schoch, K., & Hooper, S.R. (2015). Social Cognitive Training In Adolescents With Chromosome 22q11.2 Deletion Syndrome: Feasibility And Preliminary Effects Of The Intervention. *Journal of Intellectual Disabilities Research, 59*(10), 902- 913.

Soorya, L.V., Weinger, P.M., Beck, T., Soffes, S., Halpern, D., Gorenstein, M., Kolevzon, A., Buxbaum, J., & Wang, A.T. (2015). Randomized Comparative Trial of a Social Cognitive Skills Group for Children With Autism Spectrum Disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 54*(3), 208-2016.

Tan, M.C.C., Chye, S.Y.L., & Teng, K.S.M. (2022). "In the shoes of another": Immersive Technology for Social and Emotional Learning. *Education and Information Technologies, 27*, 8165- 8188.

Tanksale, R., Sofronoff, K., Sheffield, J., & Gilmour, J. (2021). Evaluating The Effects Of A Yoga-Based Program Integrated With Third-Wave Cognitive Behavioral Therapy Components On Self-Regulation In Children On The Autism Spectrum: A Pilot Randomized Controlled Trial. *Autism, 25*(4), 995- 1008.

Taylor, R.D., Oberle, E., Durlak, J. A., & Weissberg, R.P. (2017). Promoting Positive youth Development Through School- Based Social and Emotional Learning Interventions: A Meta- Analysis of Follow Up Effects. *Child Development, 88*(4), 1156- 1171.

Thompson- Hodgetts, S., Ryan, J., Coombs, E., Brown, H.M., Xavier, A., Devlin, C., Lee, A., Kedmy, A., & Borden, A. (2023). Toward Understanding And Enhancing Self-

Determination: A Qualitative Exploration With Autistic Adults Without Co-Occurring Intellectual Disability. *Frontiers in Psychology*, DOI**:** 10.3389/fpsyt.2023.1250391

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., Moher, D., Peters, M.D.J., Horsley, T., Week., L., Hempel, S., Akl, E.A., Chang., C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M.G., Garritty, C.,…Straus, S.E. (2018). PRISMA Extension For Scoping Reviews (PRISMA-SCR): Checklist And Explanation. *Annual of Internal Medicine, 169,* 467- 473. https://doi:10.7326/M18-0850

Weissberg, R.P., Durlak, J.A., Domitrovich, C.E., & Gullotta, T.P. (2015). Social And Emotional Learning: Past, Present, And Future. In J.A. Durlak, C.E. Domitrovich, R.P. Weissberg, & T.P. Gullotta (Eds.), *Handbook of social and emotional learning: Research and practice* (pp. 3-19). New York, NY: Guilford Press.

Wigelsworth, M., Lendrum, A., Oldfield, J., Scott, A., ten Bokkel. I., Tate, K., & Emery, C. (2016). The Impact of Trial Stage, Developer Involvement and International Transferability on Universal Social and Emotional Learning Programme Outcome: A Meta- Analysis. *Cambridge Journal of Education, 46*(3), 347- 376.

Wigelsworth, M., Verity, L., Mason, C., Qualter, P., & Humphrey, N. (2022). Social and Emotional Learning in Primary Schools: A Review of the Current State of Evidence. *British Journal of Educational Psychology, 92,* 898- 924.

Willemin, T., Litchke, L.G., Liu, T., & Ekins, C. (2018). Social Emotional Effects of Drumtastic®: A Dyadic Within-Group Drumming Pilot Program for Children with Autism Spectrum Disorder. *International Journal of Special Education, 33*(1), 94-103.

Woodcock, K., & Blackwell, S. (2020). Psychological Treatment Strategies For Challenging Behaviours In Neurodevelopmental Disorders: What Lies Beyond A Purely Behavioural Approach? *Current Opinion Psychiatry, 33* (2), 92-109. doi: 10.1097/YCO.0000000000000571. PMID: 31743125.

Yamada, T., Miura, Y., Oi, M., Akatsuka, N., Tanaka, K., Tsukidate, N., Yamamoto, T., Okuno, H., Nakanishi, M., Taniike, M., Mohri, I., & Laugeson, E.A. (2020). Examining the Treatment Efficacy of PEERS in Japan: Improving Social Skills Among Adolescents with Autism Spectrum Disorder. *Journal of Autism and Developmental Disorders, 50*, 976- 997.

Yang, N.K., Schaller, J.L., Huang, T-A., Wang, M.H., & Tsai, S-F. (2003). Enhancing Appropriate Social Behaviors for Children with Autism in General Education Classrooms: An Analysis of Six Cases. *Education and Training in Developmental Disabilities, 38*(4), 405- 416.

Chapter 2. Empirical Paper

HOW MENTAL HEALTH AND RESILIENCE SESSIONS SUPPORT TRANSITION FROM PRIMARY TO SECONDARY SCHOOL: EXPLORING YOUNG PEOPLE'S EXPERIENCES TO INFORM FURTHER DEVELOPMENT AND RESEARCH

2.1 Abstract

Rationale

Moving from primary-secondary school is a common occurrence, and whilst for many this transition happens without concern, this time of life is also recognised as a vulnerable time for young people's mental health and wellbeing. Although these topics are being discussed more openly, there is still widespread misinformation which leads to confusion, fear and stigma. Building insight and understanding into mental health and wellbeing could help young people develop coping strategies to help them "thrive" during times of stress or change.

Aim

This qualitative study aimed to gain insight into young people's experiences of mental health and resilience sessions, and how the sessions might support their move from primary-secondary school. Alongside this, the insights were to help inform future rigorous trials of the sessions.

Methodology

Semi-structured interviews were conducted with eight young people aged between 10- 15 years old following attendance at the two sessions. Interviews were audio recorded and then transcribed, before being analysed using Reflexive Thematic Analysis (RTA).

Results

Three overarching themes were generated through the analysis**:** *"We're all in the same boat": The Normality of Change; Safety in numbers: How social connection creates a sense of safety and wellbeing; Moving from "them" to "us": changing understanding of mental health and wellbeing.* Two sub-themes were also generated.

Discussion

Noticeably this study found a greater sense of readiness for the move rather than concern, which appeared to be supported through shared experiences and space to discuss worries with peers. It also highlighted how the sessions changed their view of what mental health is, creating a sense of universality and ultimately impacting on stigma and fear surrounding it. Furthermore, it highlighted possible concepts to measure when developing the sessions and research further.

2.2 Introduction

Transitions are viewed as a normal, unavoidable part of life, with moving from primary to secondary school being a common occurrence around the world (Mumford & Birchwood, 2021). In the United Kingdom (UK), children and young people (CYP) experience multiple educational transitions, such as starting primary school, right through to leaving school for higher education (Bagnall et al., 2020; Mumford & Birchwood, 2021). As of 2007, the primary-secondary school transition became a mandatory area for inspection by UK Ofsted, reflecting the growing interest in this time of a young person's life and indeed increased research attention in recent years. However, despite this there is currently no legal requirement in the UK for schools to provide support for CYP moving to secondary school (Department of Education, [DoE] 2022), leading to inconsistent and disjointed support.

Transitions are often seen as a time of growth, development and learning (Hopwood et al., 2016; Topping, 2011) that can be empowering and exciting (British Psychological Society, 2020). The transition to secondary school is something some CYP look forward to, adjusting without any major difficulties, with most concerns and worries abating within the first year (Evangelou et al., 2008; White, 2020). However, the transition is also highlighted as a particularly vulnerable and stressful time for some CYP (Donaldson, 2022; Evans et al., 2018; Hopwood et al., 2016; Zeedyk et al., 2003).

Transitions have a disruptive nature to them, and the primary-secondary school transition happens during a crucial developmental stage in adolescence, involving an "emotional roller coaster" of physical, cognitive, psychosocial and emotional change, set within the context of puberty (Hanewald, 2013; Jindal- Snape et al., 2018; Strand, 2019; Topping, 2011). Therefore, the process of adapting to the psychological, social and educational changes and increasing expectations has been described as incompatible to the developmental needs of adolescents (Beatson et al., 2023). The Multiple and Multi-

dimensional Transitions Theory (Jindal- Snape, 2018) conceptualises this change as a set of multiple transitions happening across multiple domains at the same time. It recognises how these transitions happen as a group process, with one individuals experience being impact on by another, as well as vice versa, all within an ever-changing environment. The literature reflects this, highlighting CYP concerns regarding academic, environmental and social aspects, as well as emphasising the impact 'poor' transitions can have on CYP overall mental health and wellbeing in the short and long term (Beatson et al., 2023; Bagnall et al., 2020; Evans et al., 2018; Gray et al., 2021; Spernes, 2020). Therefore, transition from primary-secondary school has been highlighted as a promising point for intervention given the impact this can have on both the individual and the ecosystem surrounding them.

Furthermore, the last 20 years has created a greater awareness around the prevalence of CYP experiencing significant, long term mental health difficulties (Gedikoglu, 2021; WHO, 2021). An NHS report estimated one in six school aged children in the UK have a mental health difficulty, an increase from one in nine in 2017 (NHS Digital, 2020). Even for those not receiving a diagnosis of a mental health condition, there is a high prevalence of CYP, particularly adolescents, experiencing anxiety or depression symptoms (Choi, 2018; Evans et al., 2019). As the move from primary-secondary school occurs during this vulnerable time, it highlights the importance of supporting CYP mental health and wellbeing.

Predominantly discussions and learning surrounding mental health focus on mental ill-health and its symptoms. However, in recent years the narrative has shifted towards recognising that mental health is not only the absence of symptoms such as depression, but the ability to "thrive" through developing and utilising coping strategies, such as self-esteem, mastery, emotion regulation and social support, particularly during times of stress or change (Choi, 2018; Donaldson, 2022; Glazzard, 2019; The World Health Organisation [WHO], 2016). Bagnall and colleagues (2021) suggested that the experiences of stress and anxiety

during transition are linked to limited emotional resources to manage emotions surrounding the move, such as self-control, emotional intelligence, self-advocacy and self-efficacy (Bagnall et al., 2021). Therefore, whilst most children will not experience mental illness during the transition, there is an importance to skill up CYP to recognise and be proactive in developing positive mental health. Focusing on creating skills to "thrive" may be particularly relevant to school-based support, to enhance better adjustment post transition as well as affecting their future wellbeing and coping abilities (Choi, 2018). Following on from the COVID- 19 pandemic a greater emphasis was placed on skilling CYP up to manage change and uncertainty, particularly through focusing on developing and maintaining resilience in a changing situation (British Psychological Society, 2020). One way of conceptualising resilience by Marsten (2011;2014) that proposes that resilience is the ability to "adapt successfully to disturbances that threaten functioning, viability or development". Particularly, the importance of psychosocial resources, adaptation skills such as self-regulation and self-efficacy. Marsten places resilience within multiple interacting systems and noted that there are "windows of opportunities" in which to embed interventions based on developmental timings. Marsten believed that interventions that focused on positive objectives alongside aiming to promote competence is important in the development of resilience. Furthermore, adaption to change is important within transition as perceived ability to cope can impact on how their level of stress is perceived (The Transactional Model of Stress and Coping; Lazarus & Folkman, 1984), therefore the development of coping strategies becomes a crucial element for CYP.

Mental health literacy was first defined by Jorm and colleagues (1997) and remains a definition that is often viewed as "gold standard". It defines mental health literacy as the knowledge and beliefs about mental health disorders to ultimately aide in the individuals recognition, management and prevention of mental health disorders. Whilst it is often

recognised as a key protective factor for CYP mental health, research shows that CYP predominantly have low mental health literacy (Campos et al., 2018; Donaldson et al., 2022). Furthermore, misinformation impacts on mental health literacy, and can lead to increased stigma, confusion and fear, which ultimately impacts on their ability to seek help if necessary (Donaldson et al., 2022). Therefore, as part of the skills to thrive, a vital component to CYP mental health and wellbeing is building their understanding and awareness of mental health and wellbeing, lessening the misinformation to challenge stigma and fear that surrounds this topic.

In response to the increased reported rates of mental health difficulties, coupled with acknowledging the key role mental health literacy as a protective factor, there has been a surge in school-based mental health interventions, designed to reduce or prevent mental health difficulties (Foulkes & Stapley, 2022). When exploring the effects of these interventions, Foulkes and Andrews (2023) proposed a hypothesis that found positive effects of mental health awareness leading to an increase in recognition of symptoms and difficulties. However, at the same time they noticed the risk of 'overinterpretation' where awareness has led to an over-pathologizing of 'normal' emotions and experiences. There are emerging intervention studies in support of this, finding indications of increased symptomology and distress in participants. For example, Bastounis and colleagues (2017) found in a meta-aggregation of CBT and Interpersonal therapy (IPT) that focusing on potential symptoms led to CYP reporting they felt worse following the intervention. Similarly, Andrews and colleagues (2023) found limited effectiveness of a universal school-based prevention programme and reported small but significant increase in internalising problems. Which leads to questioning the efficacy and potential harm of mental-health programmes.

Another focus for stakeholders for many years has been the role social and emotional learning [SEL] skills play in promoting positive mental and emotional wellbeing. SEL relates

to an umbrella term, which focuses on CYP abilities to learn about and manage their emotions and social interactions, with the belief that this affects positive outcomes across the life span (Wigelsworth et al., 2022). In section 1.2 there is further explanation of the key components and the large body of evidence surrounding the effectiveness of SEL programmes.

Although both mental health prevention programmes and SEL programmes can be seen under the same 'umbrella,' they can be seen as conceptually different. Durlak and colleagues (2011) described mental health programmes as being related to increased wellbeing and a lack of emotional distress, whilst SEL relating more to skill development. Others also note that predominantly, mental health programmes use a deficit focused framework rather than incorporating a competence enhancing model which SEL programmes are focused on (Clarke et al., 2020; Roberts et al., 2018). Furthermore, historically the majority of SEL research and programmes ignore mental health outcomes (Donaldson et al., 2022; Taylor et al., 2017). Therefore, there appears to be limited interventions that specifically address mental health awareness within a strength-based structure such as SEL (Clarke et al., 2020).

A recent review by Beatson and colleagues (2023) reviewed 26 SEL programmes specifically supporting the transition period either pre or post move. Within these, only eight were identified at focusing on mental health outcomes, all of which focused-on symptomology as an outcome, rather than change in mental health literacy or reduction in barriers to help seeking. Two papers reviewed interventions developed from the Penn Depression Prevention Programme called the 'Aussie Optimism Programme' (Quayle et al., 2001; Roberts et al., 2010), which include specific mental health elements. Both papers focused on the intervention being implemented before CYP moved to secondary school, aiming at promotion of positive mental health. It combines SEL skills with specific skills to

manage anxiety or depression symptoms through optimistic thinking styles. Quayle and colleagues found a significant reduction in depressive symptoms and an increase in self-esteem only, while Roberts and colleagues found no significant effects for any outcomes measured. Despite involving elements of mental health there were no clear indications of psychoeducation or supporting development of mental health literacy to support the embedding of SEL skills.

As noted in the literature, that whilst evidence on the effectiveness of both SEL and mental health interventions is growing, it does remain inconsistent. Furthermore, there is a noticeable lack of focus on the child's voice despite the invaluable impact this can have on shaping interventions (Barry et al., 2017; Foulkes & Stapley, 2022; van Rens et al., 2018). Using an exploratory participatory methodology is advised as a principal element of intervention development (Foulkes & Stapley, 2022; Sellars et al., 2021). Prioritising engagement at every stage is needed to maximise the development of interventions, increasing the likelihood of it promoting meaningful change and is recognised as particularly important at the preliminary stages (Skivington et al., 2022; Wight et al., 2015).

The present study follows the initial development of two psychoeducational sessions on mental health and resilience by Greenhill (2022), aimed at developing awareness and understanding of mental health whilst identifying the individual CYP strength and coping strategies within a context of group-based learning. Within this pilot study, Greenhill completed nine semi-structured interviews with CYP following attendance to the sessions to note refinements that would be useful. It found areas such as feelings of vulnerability impacting on being open within the group, the importance of group set- up and feelings of connectedness, whilst also recognising the valuable therapeutic space it provided. Please see Appendix H for post pilot study refinements that were agreed in collaboration with Greenhill, and other members of the researcher team. Following on from this, the present study aims to

explore CYP experiences following the refined session, using the CYP voice to carve out narratives to further drive refinements to the sessions, alongside building insight for future, more rigorous trials. Therefore, the aims of the research are:

1) Exploring CYP experiences of the mental health and resilience session and their views on how the sessions will aid a positive transition from primary to secondary school, to inform a rigorous trial focusing on their efficacy.
2) Gathering CYP ideas for further development of the sessions.

2.3 Method

A qualitative methodology felt most aligned with meeting the aims of this research. Most of the research surrounding CYP experiences of the support provided when moving from primary to secondary school uses quantitative paradigms that focus on one specific aspect, for example academic performance (Bagnall, 2019; Mumford & Birchwood, 2021). By using a qualitative methodology, it allowed the researcher to concentrate on individual views and experiences, enhancing the conceptual relevance and ecological validity by building insight into meaning and meaningfulness for the participants rather than "a single or 'correct' answer" (Bryne, 2021; MacLeod, 2013). Similarly, based on existing intervention development guidelines (i.e. Skivington et al., 2022; Wight et al., 2015) exploratory participatory involvement was used in the hope it would allow for in- depth exploration of how the intervention is experienced by CYP whilst actively engaging them in the future development.

Epistemological Statement

The author conducted this study from a critical realist ontology, therefore assuming that there is an accessible reality, however we cannot know another's reality with any certainty. What is reflected is the participants' multi-layered contextually situated "truths", with how we experience and know this being shaped by individual human processes (Braun & Clarke, 2021; 2022).

Participants

Recruitment

Originally this research project was due to take place within secondary school populations with recruitment due to start in the Autumn of 2020. However, the COVID-19 pandemic led to difficulties with recruitment, with many schools having to adjust to the new

and changing policies and procedures. This further led to an, understandable, impact on willingness to engage with the research. Therefore, it was agreed to extend to primary schools as well as youth hubs.

All participants following attendance at the two refined sessions, which were facilitated by the research team, were invited to participate in the research. These sessions took place at one primary school and one community youth hub, or "research sites", between April 2022 and July 2022. Overall, 29 attended the sessions at the primary school, and five at the community hub. The research sites are described in Table 2.1

Table 2.1

Research Sites

Site	Context	Description
1	Community	A youth and community hub that provides a safe space for young people to talk to professionals on a range of topics such as: mental health and self-esteem, sexual health, relationships or substance use. It also allows young people to access mentoring or counselling, signposts to specialist services, and provides support with education and employability, as well as provide a space for young people to do activities with other young people.
2	Educational	A mixed, single form entry primary school that is local authority maintained. Two thirds of the pupils are eligible for pupil premium funding, which is higher than the national average. Two in five are from minority ethnic backgrounds, and one in five speak English as a second language.

Sample

An opportunistic, heterogenous sample of eight children and young people [CYP] were recruited aged between 10-15 years old, with a research response rate of 24%. Participants were recruited on the basis that they attended the mental health and resilience sessions and took part in the research following parents informed consent alongside the participants own assent. Whilst there are not any strict guidelines on sample size within qualitative research, Braun & Clarke (2013) outlined recommendations based on the size of project. For a small size project, 6-10 interviews are deemed large enough to realistically find emerging patterns within the data, whilst remaining focused on the individual nature of what is being told (Byrne, 2021).

A breakdown of the participant demographics is outlined in Table 2.2. All participants' names have been changed to pseudonyms, which have been used throughout this study. The decision was made to keep the data from the single participants from research site 1, who was the only participant who had already experienced their transition to secondary school as well being a non-standard gender. It felt this was beneficial to support the transferability of the findings to a post-transition setting.

Table 2.2

Participant Demographics

Participant ID	Pseudonym	Gender identification	Age	Ethnicity	Research site
1	Harri	Non- binary	15	White British	1
2	Ali	Male	11	Pakistani British	2
3	Lily	Female	11	White British	2
4	Becky	Female	11	White British	2
5	Jim	Male	11	White British	2

6	Jade	Female	11	Black British	2
7	Ada	Female	10	Pakistani British	2
8	Sam	Male	11	Black British	2

Ethical Approval

Ethical approval was gained via an application to use an existing approved programme of work that includes the collaborative development of interventions to support CYP mental health and wellbeing (Appendix I). The author consulted with a research associate and interns who assisted in recruitment as well as facilitated workshops at the community youth hub and primary school, all of whom are part of the Kate Woodcock Research Group. To begin with, the study and its purpose was verbally explained to the education and community establishments. Following agreement to engage with the research, information sheets were sent to all CYP (Appendix J) as well as also provided to their parents or guardians (Appendix K). All CYP at both research sites could attend the sessions, even if they did not want to take part in the interviews. Verbal assent was collected for CYP and written informed parental consent was needed to take part in the interviews (Appendix L).

Materials & Procedures

The mental health and resilience sessions were developed through a pilot study by Greenhill (2022). Overall, Greenhill created the content of these sessions through a systematic review and exploratory meta-analysis identifying potential determinants of positive peer relationships (Mitic et al., 2021). In-line with this review, the decision was made to focus on mental health, affect and wellbeing/resilience as key components to the sessions.

As interventions for specific mental health difficulties (i.e. depression) are only recommended by national guidelines to be facilitated by training professionals (NICE, 2013; NICE 2019) the decision to focus on help seeking behaviour. This incorporated addressing

stigma and common mental health misconceptions; develop skills to help show support to those seeking help; increase children's knowledge of what support there is. The mental health component was largely underpinned by the Theory of Planned Behaviour (Fishbein & Azjen, 1975) as this has demonstrated effectiveness in explaining and predicting help-seeking behaviours (Damghanian & Alijanzadeh, 2018; Tomczyk et al., 2020).

The affect and wellbeing session focused on promoting global wellbeing, recognising that positive affect, perceived quality of life and satisfaction are potential determinants to positive peer relationships alongside low perceived threat (Mitic et al., 2021). Therefore, the sessions use the 5 Ways of Wellbeing Programme to structure this session. This programme summarises 5 dimensions in which individuals can make simple everyday changes to impact on their wellbeing (NEF, 2008). The research shows promising outcomes, which increase with every practice of these components (Mackay et al., 2019), as well as promising outcomes specifically shown for CYP struggling with their mental health (Ng et al., 2015). Furthermore, the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984) was used as the underpinning to the importance of coping strategies for CYP, given that an individual's evaluation of their coping strategies is a potential mediator to their perceived levels of stress (Greenhill, 2022). The coping strategies were based upon a revised version of an empirically constructed and theory-based model of coping, the Coping Strategies Checklist for Children (CCSC-RI; Ayers & Sandler, 1999). This focuses on 5 factors, based on cognitive-behavioural model [CBT]: problem-focused coping; positive cognitive restructuring; distraction strategies; avoidance strategies; support seeking strategies.

The delivery methods of the session were primarily influenced by a paper by Barry et al. (2017) which identified common elements of successful social- emotional interventions. As such, elements of group work, group discussion, role plays, worksheets and activities were embedded within the sessions.

Whilst the sessions weren't explicitly about transition, the concept was interweaved through the sessions. For example, when focused on worries they were prompted to think about this for themselves as well as others. Following the pilot study, the sessions were further refined following participants' and facilitators' feedback. This was completed in collaboration with Greenhill (2022) as well as other members of the research group. Key changes agreed post the initial pilot study can be found in Appendix H, as well as the two session manuals with all the details of the session aims, content, activities and individual activity aims in Appendix M Table 2.3 provides an overview of the session aims, content and activities.

The sessions for this study were facilitated for this study by research interns, a research assistant and a master's student involved with the research group. To support treatment fidelity the manual (Appendix M) details each individual activity aims as well as a narrative to use to explain the activity to the CYP and how to complete the activity itself. The manuals are created as such due to wanting the facilitation of these sessions to be led by members of the education staff rather than external facilitators in the future. Two practice sessions were also run for all facilitators prior to the session date. All facilitators were involved with the refining of the sessions and the manuals, therefore had oversight of the content before running the sessions. Each session lasted one hour on two separate days, 3 days a part, with the interviews being completed one week after the sessions.

Within the interviews, the worksheets from the sessions were used as visual aids to prompt conversation about the topics addressed and the utility of the activities the CYP engaged with. A cartoon child was also used, to aid the reflection and perspective taking with participants. All session materials can be found in Appendix M.

Table 2.3

Mental Health & Resilience Session Components

	Overall aims	Content	Activities
Mental Health	Increase mental health literacy; challenge stigma and negative attitudes; inform about worry; promote help seeking behaviours; identify social support; identify external barriers to seeking support; increase capability in seeking help; create a positive classroom culture towards help-seeking	1) Icebreaker; Build rapport between young people and facilitators to break the barriers to conversation 2) Introduction into mental health; Explore understanding and attitudes towards mental health, challenge misconceptions, mental health as a spectrum; Increase knowledge and awareness. 3) Introduction to feeling worried; recognising signs of feeling worried and situations that potential make children worry 4) Identifying resources and seeking help; identify sources of social support, support services, practice seeking help from a peer/practice supporting a peer	1) Human Web 2) Group discussion/sticky note exercise- Defining mental health; Mental Health Quiz 3) Worry Worksheet 4) Social support worksheet; Conversation Practice through role play; class discussion and reflection
Wellbeing and Resilience	Promote wellbeing, happiness and life satisfaction; identifying worry/stress and what this feels like; strategies for coping to increase perceived ability to cope	1) Resilience: exploring the concept of resilience, what they understand of it and shape it towards ability to adapt to change and the importance of looking after mental wellbeing. 2) Coping with worry; opportunity to explore their own internal/external resources to cope. Introducing new skills to manage worry 3) Wellbeing and Happiness; introduce and discuss 5 ways to wellbeing.	1) Class and small group discussion/ sticky note exercise 2) Class discussion; problem solving skills; balancing thoughts; social support; distraction techniques; worksheets. 3) 5 ways to wellbeing; group discussion/worksheets

Data collection

Semi-structured interview design was used to collect the data, which loosely followed a pre-defined interview schedule of open-ended questions aiming to ensure the overarching topics were addressed (Appendix N). The interview questions were designed to explore participants' experiences of the sessions themselves, whilst supporting reflection on how participants' feel or felt about moving to secondary school, and how the sessions may be beneficial for themselves and others when moving from primary to secondary school. They also aimed to gather feedback and suggestions for continual development of the sessions (see Table 2.4 for differences between pre and post transition interviews). The questions had been piloted with nine CYP during the pilot study (Greenhill, 2022) for the mental health and resilience sessions, aged 11-17. The pilot interviews allowed the researcher to check that the questions were appropriately worded alongside supporting feedback on the questions and the structure of the interview. Following this, the questions were reviewed with the research team to reflect the changes made and the focus of this research study. Interviews were recorded using a password protected Dictaphone owned by the University.

Table 2.4

Interview Schedule Summary

Pre- Transition	Post- Transition
Moving schools • The process of preparing to move schools. • Support received before the transition. • What were they looking forward to/ worried about	**Moving schools** • Experience of moving to secondary school- How they found it/how they have settled. • Support they received for the move and post move. • What were they looking forward to/ worried about Reflection on post move; best and more difficult aspects
Mental health pre & post sessions	**Mental health pre & post sessions**

• Experiences and knowledge of mental health before the sessions and relevance to them. • How has this change post sessions/what has helped with their learning? • Exploring worry and own mental wellbeing	• Experiences and knowledge of mental health before the sessions and relevance to them. • How has this change post sessions. • Impact the move had on their emotional wellbeing. • Mental wellbeing now
Resilience pre & post sessions • Experiences and knowledge of resilience before the sessions. • How has this change post sessions. • Reflection on what they/ others do to be proactive with their mental health and resilience.	**Resilience pre & post sessions** • Experiences and knowledge of resilience before the sessions. • How has this change post sessions. • Reflection on what they do/others do to be proactive with their mental health and resilience.
Benefits & Relevance of Sessions • Interest in the topics • Key learning post sessions • How & why this is beneficial. • Utility of these sessions before moving schools	**Benefits & Relevance of Sessions** • Interest in the topics • Key learning post sessions • How & why this is beneficial. • Utility of these sessions before/post moving schools
Evaluation of Sessions • Favourite & Least Favourite Elements of Sessions • What they would change, including suggestions for improvements • Types of facilitators • Any difficulties with the sessions we needed to be aware off (i.e. difficult emotions)	**Evaluation of Sessions** • Favourite & Least Favourite Elements of Sessions • What they would change, including suggestions for improvements • Types of facilitators • Any difficulties with the sessions we needed to be aware off (i.e. difficult emotions)

The interviews happened one week after attending the sessions. In each research site, a private space was identified for the interviews to lessen risk of interruptions and protect confidentiality. Before each interview, participants were reminded of the research rationale and verbal assent was checked with each participant. Following completion of the interview the CYP were given debrief sheets which included additional sources of support if needed (Appendix O). Interviews lasted between 41- 51 minutes. These were completed by different members of the research team, with majority of the interviews completed by the author (*n*= 5). All but one CYP from the primary school attended both sessions. Reflections were also

sought from the facilitators of the sessions, to aid any further content and delivery development.

Analysis

Once the interviews were audio recorded, they were transcribed verbatim by the researcher. A reflective diary to document any initial thoughts and observations, about both the data and the analytical process. The interviews were then listened to again, alongside the transcripts, to ensure accuracy and removal of any identifiable information. During this process, data that was related to improvements was separated and summarised separately. Once the remaining data had been checked and anonymised, Reflexive Thematic Analysis ([RTA] Braun & Clarke, 2019) was conducted, as it was the right method that matched the process of data collection and research question. The inductive nature means the analysis stays grounded in data, respecting the expressed subjectivity of the participants experiences, whilst also allowing and embracing the researcher's active role in interpretation of the data (Braun & Clarke, 2019; Bryne, 2021). It highlights how the researcher is part of the world they are trying to understand; they "cannot stand outside of the human and social reality they are observing" (Pilgrim, 2014). By using RTA, the researcher began with the data and the experiences spoken about by participants that eventually moves towards the theoretical level, allowing for flexibility in the interpretation. This flexibility also reflects in the capturing of data, allowing for both semantic (explicit or overt) and latent (implicit, interpretative) coding, developing patterns of shared meaning underpinned by a central organising concept (Braun & Clarke, 2020). It allowed for exploration of the participants' experiences of the sessions, alongside the utility of them for supporting the move from primary to secondary school.

Braun & Clarke (2006) developed the six-phase process to RTA for the analysis: 1) Data Familiarisation; 2) Generating Initial Codes; 3) Generating Initial Themes; 4) Reviewing Potential Themes; 5) Defining and Naming Themes; 6) Write- up. It is important

to note that Braun & Clarke emphasise that the phases are *guidelines* rather than rules of analysis; the importance of flexibility and engagement is prioritised over procedure (Braun & Clark, 2022). Table 2.5 for details on how the researcher moved through the steps, as well as initial coding examples in Figure 2.1. Appendix P for further details, Appendix R for examples of coding and theme development.

Table 2.5

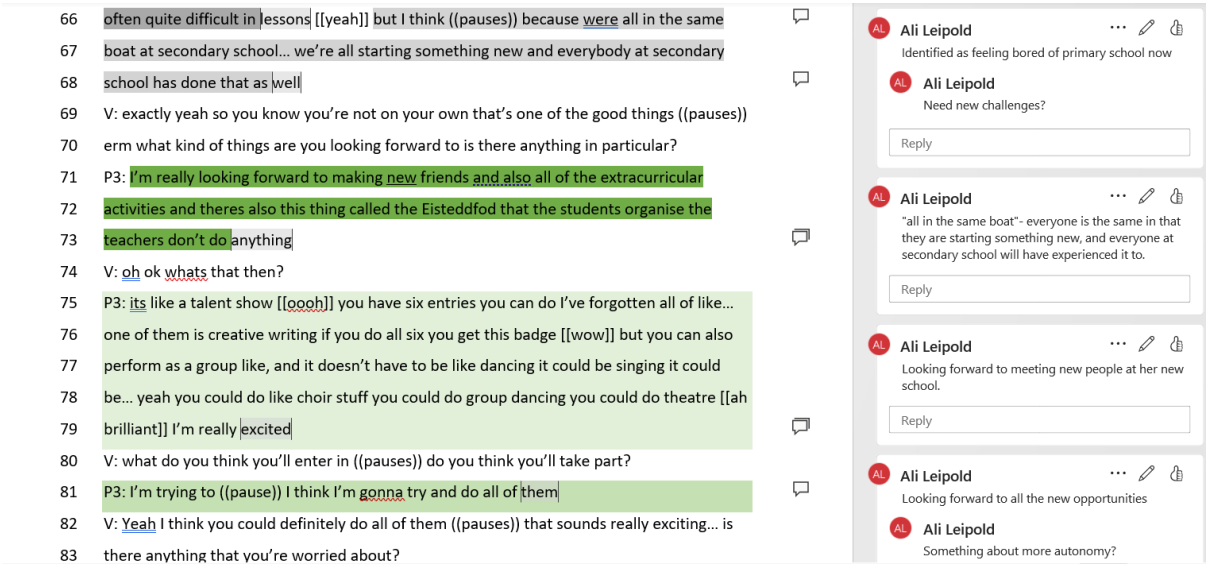
Reflexive Thematic Analysis (RTA) Steps

Step	Description	Example
1. Data familiarisation	Reading and re-reading the data. Noting down areas of initial interest	Conducting initial interviews, followed by making reflections on each interview of observations. Repeated listening to the recorded interviews, before transcribing. Transcribed interviews were then read repeatedly.
2. Generating initial codes	Systematic coding of the data for patterns of meaning across the data set. Summarising the data that might be relevant to the research questions	Repeated reading of the transcripts to complete line by line coding, generating semantic codes before moving to more latent codes in some areas. Noted any patterns that felt meaningful using colour coding and the comments feature on Microsoft Word to summarise what was highlighted. Researcher started to note potential ideas within the date using a mix of Microsoft Excel Spreadsheets and sketching diagrams.
3. Generating initial themes	Organising codes into potential themes, collating relevant evidence from the data.	Initially reviewing for repeated ideas or patterns of meaning. Merged similar codes together using Microsoft Excel Spreadsheet alongside the evidence to support the potential theme. Similar codes were developed into initial themes and subthemes. Initially this led

			to 6 provisional themes, with 5 sub-themes.
4.	Reviewing potential themes	Checking if the themes made sense in relation to the coded data extracts and the whole dataset.	Reviewed ability of potential themes to adequately represent the dataset, level of overlap between themes were reviewed and refined through repeated 'back and forth' process with the transcripts.
5.	Defining & naming themes	Continued analysis to refine each theme and the story being told.	Developing thematic maps (Appendix S) and continuing the iterative process with the transcripts to help find the story being told. Data extracts felt relevant to the theme and the research question were selected, whilst the research sense checked with her supervisor. This was further helped by recording voice notes about understanding and story of each theme, to explore any overlaps whilst noticing data that wasn't a good fit.
6.	Write-up	Selecting data examples to present in the final report. Final analysis of selected extracts linked to the research question and literature	The analysis was presented using data extracts to illustrate the researchers analytical narrative.

Figure 2.1

Initial Coding Process



Ensuring Quality and Reflexivity

RTA is not about reaching a consensus about coding but focused on the researcher's ability to engage in an active, thoughtful and reflective manner throughout the whole process (Braun & Clarke, 2019; Bryne, 2021). However, consultation was provided through individual meetings with the author and supervisor to help hold a space to sense-check the analysis and provide a reflective space to explore different interpretations as well as potential biases the researcher held towards the data.

Alongside this, to aid in awareness of any potential influences on the analysis the researcher kept a reflective diary throughout the whole research process (Ortlipp, 2008). This allowed the researcher to be aware of how their experiences were potentially influencing the analysis, such as the researcher's own poor experience of transition to a new primary school and then to a new sixth form following secondary education. The reflective diary also helped recognise when the research was, unintentionally, moving from a researcher to therapist positioning. This was noted to have benefits; helpful in building rapport and trust quickly, knowing how and when to ask questions to get a more in-depth answer. Appendix Q has an excerpt of the reflective diary.

2.4 Results

Three themes, for which two had subthemes were generated (see Table 2.6).

Table 2.6

Final Themes

Themes	Sub- themes	Participants Voicing Themes
"We're all in the same boat": The Normality of Change	Feeling Ready to Move	Sam, Lily, Ada, Jade, Jim, Becky & Ali
	Fleeting and in the moment worries	Sam, Lily, Jade, Jim, Becky & Harri
Safety in numbers: How social connection creates a sense of safety and wellbeing.	Group learning helped with developing insight into others	All
Moving from "them" to "us"; changing understanding of mental health and wellbeing	Building awareness is essential to managing change	Sam, Lily, Ada, Jade, Becky & Ali

"We're all in the same boat": The Normality of Change

Each participant reflected on how they felt about moving from primary to secondary school. The over-arching theme and sub-themes relate to how the participants appear to experience the upcoming move with a mixture of excitement and nerves, whilst acknowledging worries as being a 'normal' part of change.

Fleeting and in the moment worries

Despite a range of worries about moving, which are consistent with prior research, it seemed these didn't place much negative influence on participants' wellbeing because they perceived them as fleeting, normal and manageable. However, participants' appeared to have less efficacy about their ability to make new friends which was identified by all as most significant with the move (see also *'safety in numbers: how social connection creates a sense of safety and wellbeing'*).

Participants' named a feeling of isolation and vulnerability they feel when they don't have friends to turn to. Participants described it as being "weird" not having people to "hangout with", with Jim reflecting on his own previous experiences:

> [...] I was just worrying about um (.) because at that time my best friend had just left the school. So, I had to make new friends, so I was worried about making friends…I used to feel like I was all alone.

Participants voiced concerns about having to create new friendships, noting a sense of uncomfortableness, and for some this felt very scary to comprehend, even those with established friendships at their new school. For example, Sam felt "[…] nervous coz I was the only one in my class. I saw loads of other classes and I was a bit intimidated". Ada went further in describing the worry about how to become friends with people already in a group:

> Making new friends is scary because most people there when I went on my visit already seemed like they already had their own […] it's difficult to make friends when people are already in groups? […] because I get nervous talking to new people, and if they're in a group it's kinda harder. Just don't know what to say.

This was reflected in the sense of vulnerability about how participants would be viewed, both with peers but also teachers, particularly in the context of first impressions:

> Um it's a little bit scary kind of[…]Because it's like a first impression and I don't want to ruin it […] and if I (.) well like if I mess up then they probably won't like me and stuff like that (Ada).

Similarly, Ali noted "It's like […] I worry about what everyone else thinks […] like when meeting new teachers and students […] what are they going to say, you know?". This concern for participants' highlights the importance of feeling like you belong, that being part

of the group helps you feel safe, whilst also recognising how difficult it feels to try and 'fit' with an already formed group.

This sense of vulnerability was also reflected in the change in status from the oldest to the youngest in the school. For example, Becky described her concern as moving down the school hierarchy:

> Like (.) when you first go into like the lunch and like everyone's in front of you in the queue because I know my older brother was one of them people that would […] because it was year 7's he would just cut in front because he didn't care...coz like they're younger…so I suppose…easier? I was worried that would happen […] (Becky).

With this change in status, participants recognised feeling worried about the increase in independence and responsibility with "more homework…puts a lot of stress on you (Ada) or being late leading to greater consequences such as "detentions" (Jade). Further reflecting this sense of pressure building to fit in and cope.

There was an overall sense of participants' being present 'in the moment' with their concerns. Viewing them as fleeting and in the future, which helped with a sense of control over the worries. For example, both Lily and Jim noticed not worrying in advance, with Jim reflecting "I'll probably feel butterflies in my stomach, but I only feel that when I first go there".

Feeling ready to move

Overall, there was a sense of readiness for the change, linked to the excitement around the newness of this stage of life; be it for a "new start" as voiced by both Jim and Harri, or the increase in opportunities to try new things. Alongside this, readiness was created by a sense of unity, insight and understanding of the worries participants felt, which was partially

developed through their experiences in the sessions. Ultimately it reflected a positive outlook on this next stage in life.

There was a sense of "outgrowing" what is on offer at primary school, looking forward to the new opportunities and experiences. For example, Becky voiced excitement at being able to do more sports as something she enjoys, with Ada being excited to learn new things. Lily reflected:

> …I think it's definitely going to be really good because…I think in our class everyone's a bit bored of primary school and not really behaving very well so it's often quite difficult in lessons…I'm ready to try new things and make new friends.

Further supporting the development of readiness, participants found the sessions provided a space that allowed them to voice their shared experiences and worries allowing them to problem solve together, which in turn led to feeling more confident. Similarly to this, through holding a space for shared experiences it helped participants feel as they were all in the same boat, which in turn alleviate their stress of uncertainty. Lily commenting that:

> Lots of people are worried about lots of different aspects about going to secondary…we're all babies, the schools will have a massive campus[…] it might feel scary but I think ((pauses)) because we're all in the same boat at secondary school… we're all starting something new and everybody at secondary school has done that as well…so knowing we're not alone in how we feel…feels good?

Some participants had had an induction day at their new school, and this had furthered their confidence by reducing some uncertainty, either by having been able to start making new friends or having been shown round the campus.

Noticeable through building insight into self and others, a main learning was noticing the connection between how they think, and feel can impact on how they act and react to

situations. Previously, participants had not understood this connection. This helped with noticing more quickly when their emotions were changing, whilst also exploring and finding different ways of responding that were helpful. For example, following sessions participants' found it easier to describe how anxiety showed up in them with Sam noticing "I like tap my nails […] and like be really fidgety", and Becky recognised how her "thoughts can all rush around in [her] head […] and feel shaky and sweaty". This was further supported by activities such as the six pillars, helped them identify activities participants wanted to keep investing in to create 'buffers' during times of stress. For example, Jade recognised:

> […] I try and keep active...It just keeps my mood up because I'm doing something well it's hard to explain it keeps my mood up because[…] coz I'm doing something I love like football and if I do it then it just makes me happy […] So like if I distract myself from the problem, I get away from it.

The space allowed them to reflect on what participants already do, whilst building their knowledge to stop the worry getting too big. Sam reflected the usefulness of this when moving schools:

> It can help like wellbeing. Try doing stuff and maybe you'll have a better time? […] like understand how important connecting is...because I need to connect with other people, I need to be social with other people and not keep myself away...Coz that's the easiest way of making friends like just talking to them[..] and like when I play sports it clears my head[..] so (.) it can help if I have worries. When I'm new or whatever.

Safety in numbers: How social connection creates a sense of safety and wellbeing.

Social connections for participants were identified as being central to their overall wellbeing. Belonging created a greater sense of confidence in being able to manage worries

as well as the upcoming change, whilst also recognising how sharing worries can help lessen the impact.

This was noticeable when participants reflected on their social support during the sessions. Having social connections was voiced as a key factor to feeling ready to move, with those who already knew people voicing a sense of relief. For example, Jim said:

> It feels easier because if I don't make friends, I will still have a friend…like you have people to do things with and things don't feel as weird as it would if you like were alone […] you'll feel more welcome.

This also reflected how a sense of belonging led to feelings of safety that you have people to "stand up for you" or not having to worry about having no-one to "hang out with", which was reflected by Sam, Ada and Becky. Harri noticed the power of having friends and the impact that can have when you move schools:

> Middle school wasn't really a fun experience for me […] When I left middle school I had about 3 friends[…] And then now I'm in high school I've got a really big group[…] I've got more people to go to[…] gaining more friends helped me regain confidence…

One element from the sessions voiced by some of the participants as helpful was exploring their support system. While this didn't necessarily develop a new skill, it allowed them to recognise the impact reaching out to others can have, particularly those that were view as their "inner circle" (Sam). Becky reflected:

> […] I was like 'oh yeah' and like 'yeah that helps me, I would go to them'[…] it helped me (.) Coz like sometimes when you feel worried it can feel really big. And um (.) can feel like you don't have anyone.

Following the sessions there appeared to be a shared narrative around how connection can help with normalising worry as well as a way of managing worries before they got too big. For example, Becky spoke how by sharing worries with other it is "just like the pressures gone…coz like they can help sort it or it will make the pressure go or something. So, it doesn't get too big". Sam echoed similar sentiments:

> When you fight a worry or don't talk about it, it just grows and grows. But when you try to let the worry go and talk about it, it just helps, and you feel more relieved. It's not totally gone…but you don't think about it as much.

Group learning helped with developing insight into others.

Participants noticed how group learning played a key role in creating more supportive relationships with peers, through developing a greater understanding and insight into others. This in turn led to self-reflection, noting the differences between themselves and peers, increasing empathy as well as confidence in how they can support others.

Initially, participants voiced surprise that their peers held different views or understanding of mental health and wellbeing, which became known during a 'sticky note' exercise on what participants' thought mental health was. However, this was also reflected as being a key element to building their knowledge and understanding through different perspectives:

> Even though as much as I thought I knew [[about my friends]], I didn't know their views on mental health. All different […] Yeah so like before (.) we all had different experiences? So, like we viewed it differently. So that was interesting as um (.) I hadn't thought we would see it differently. Just found it helpful I suppose. For my learning. (Sam)

Similarly, reflecting the differences between themselves created an opportunity to further develop supportive relationships through greater understanding of one another. Another example was illustrated by the quiz activity, with Ada noting her surprise at the famous people with mental health difficulties:

> It was surprising they all had it coz I didn't think they would have it […]Because we view them as like happy people with perfect lives but we don't really think about their past that much[…] So that people can have bad mental health but just like hide it and like we'll never notice…so it's important to learn about it[…] to notice it in others so you might be able to help them

This greater understanding mirrored the increase in confidence to "help you understand like your friends and stuff and what they're going through […] and like ways to help them" (Harri). There was a sense of increased empathy, which in turn was acknowledged as important for creating reciprocal relationships, creating a sense of hope if they ever needed support:

> […] so if somebody has I don't know a down period… you can't judge them for that because you might have […] so I'm still obviously quite sympathetic but I'm also like they're not alone, and that's kind of made me more hopeful I guess…if I'm ever struggling (Lily).

It is important to note that despite this, some participants voiced a concern about initially speaking only about worries they had. Ali felt:

> Erm they just, they erm, they just said raise your hand if you are worried about this but like nobody raised their hand or anything…they were worried about what everyone else would think.

However, an element that participants' felt helpful was the use of a 'character' (Appendix M3) which allowed them to voice worries the 'character' had, helping them build confidence in sharing worries. This was further boosted by others sharing what they were concerned about, again creating that sense of shared experience. It creates a safe space to build their confidence in recognising and owning their own worries, with Ali, Becky and Sam all noticing that it was easier to think about others worries about school at first.

Similarly, participants' found the group element helpful for building their problem-solving skills, which in turn helped them feel able to manage worries when they came up. For example, Lily said that by voicing worries together they were able to come up with solutions "to pretty much all of them".

Moving from "them" to us": changing young peoples' understanding of emotional wellbeing

Overall, there was a movement away from a negative perspective of mental health, which appeared to be influenced by the lack of exposure to the topic, towards a more accepting, empathetic and universal view. This shift created a greater confidence in participants to open up, whilst building their recognition of the resources they already have to support positive wellbeing.

Prior to the sessions most participants described a reluctance to attend the sessions as it felt like it "[…] wasn't important for me…or like to do with me" (Ali). Similarly, Sam reflected this, however linked this to their negative exposure to the topic previously:

> When I first- well I didn't really want to do it because I had that really bad picture[…] I just thought if you had mental health- the picture I got was if you have mental health then you're not okay […] um well I heard people saying the joke like "oh you're mentally ill" or like "mental hospital" and that sort of stuff so like really bad […] and um it was only to do with other people coz of like the bad images. (Sam)

Following the sessions this fear seemed to have lessened with most participants noticing a shift towards appreciating the universal nature of mental health and wellbeing. Sam illustrated this through noticing:

> Mental health is in every human being and like you can't just say I don't want it…like. There are times when things are harder but like it can change […] we can bounce between feeling like things are okay to um then not […] Like my mental health isn't poor, so I'm not worried but it's knowing what I do that keeps me feeling well (.) that's important.

Lily noticed similarly the reality of experiencing emotions on a spectrum as well as noticing that mental health goes beyond just this:

> lots of people said you're just always happy but that's not actually very good mental health…it's things like you need to recognise being upset or worried or angry to have good mental health […] like (.) the emotions are okay but its um noticing? So, if they've gotten bigger or whatever is important. And like good mental health you can cope with a lot of things...you can cope with change and those emotions.

This felt like it lessened the stigma not only to mental health in general, but towards their own emotions. By recognising how emotions can change due to different situations (i.e. moving schools) it can help with normalising of emotions. In turn, this felt like it increased their acknowledgement of individual psychological responsibility to recognise, engage and alleviate difficult emotions such as worry, not to ignore or push away.

Similarly to the "*Group learning helped with developing insight into others" sub-theme,* building insight and knowledge through group learning helped them be receptive to others needs, it also helped them not feel as "alone" if they themselves were struggling. This

felt intricately linked to creating hope in the knowledge that participants would be supported, alongside the confidence in how they can support other.

This was also reflected in exploring different ways of looking after their wellbeing, with Becky reflecting the importance of recognising and respecting others individual needs:

> […] I want to be active and it helps me when I'm um like worried about things but then she [[cousin]] um she needs a bath to help instead so like it's different but doesn't mean it's better we just all different[…] so like having a bath and things I think like all of it would rush into my head like I'm sitting there in peace and not doing anything to take my mind of it would just all come at me all at once and then it would make me more anxious. But for her [cousin] (.) it helps her. Switch off.

Collectively it felt the increase in understanding reduced stigma attached to these discussions, alongside develop empathy and a sense of connectedness, which ultimately acts as a protective factor to participants' wellbeing.

Building awareness is essential to managing change

Similarly, there was a narrative shift when focusing on resilience away from "never giving up" towards recognising that resilience helps as a 'buffer' to times of stress or change to enhance their abilities to cope. It indicated that by building this insight, reducing the stigma that surrounded these topics, it increased their confidence in how they cope with changes both now and in the future. Although most participants reflected their emotional wellbeing was positive, the sessions developed understanding in how to strengthen resilience and the link to the impact on how their emotions. This ultimately led to increased confidence, which many participants identified as an important component to feeling they can cope. For example:

> I knew about good mental health, poor mental health and resilience but I never really connected all three…and knowing that you can use resilience in a kind of mental way and you can work through and it is possible… that's kind of… that's helped me a lot …you can go no no I've learned about this I need to try and edge myself back into good mental health so learning about it raises an awareness […] which in turn makes you kind of want to do that things that help […] so like the things that are <u>important</u> to you. (Lily).

Participants also appeared to notice this importance of this knowledge and insight for beyond childhood. For example, Jade commented:

> I feel like when you get older you have to get used to dealing with your own problems coz say you're like 20 and you don't have a teacher at all you'll have no one to solve your problems but your mum and basically nobody would want that. So…I kinda wanna deal with it myself then get help if I need it. And like […] [[the sessions]] It gave me more understanding? Like wellbeing. So, like what I do can actually help me feel good and (.) stay feeling good...Yeah coz I didn't think things I did could change how I feel.

This was echoed by Lily, whilst noticing the impact stigma can have:

> I think because lots of people could feel uncomfortable[..] not even just poor mental health just mental health and mental wellbeing but it's something that people need to be aware of because in the real world when they've grown up […] they will need that to make sure they are the best they can be and others are as well.

However, for a minority of participants discussing mental health raised the potential for confusion around the topic due to their previous exposure. For example, Ali stated:

> Like (.) erm (.) my parents said like different things to me and then they are like saying different things as well; about how we all have mental health? I hadn't heard that...For a while it was confusing then I found out it was like useful.

Becky, having had previous experience of mental health difficulties through a family member reflected more on how for others without experience, the sessions could cause confusion:

> […] they said other than what your family said, coz they didn't want to worry you about it, it might worry them more...Yeah so like (.) if your family had said something and then um it was different to what you heard. Then that like can be confusing? And then (.) um that might make you feel more worried. Coz like you don't know what's real.

Becky and Ali also voiced that they still felt the sessions weren't applicable for them or displayed a lack of understanding of why these topics were being discussed. Both felt that the sessions would be helpful for "others" moving school but didn't feel they needed help.

Further Development of the Programme

Alongside the themes developed, an overview of feedback was collated describing changes the participants suggested, and facilitators identified would be useful for further development of the programme (Table 2.7).

Table 2.7

Programme Development Feedback

Observations from Participants & Facilitators	Relevance to Development	Recommendations
The favourite sessions and deemed the most helpful were: • **Quiz focused on myths and facts about mental health.** • **The "Worry" exercise where participants drew out their thoughts, feelings and behaviours when worried.** • **6 Pillars & Mindfulness activities. These focused on building proactive ways of looking after their wellbeing.** • **Exploring their support network. This was exploring the different areas of support (i.e. friends, family, community)**	The quiz, worry exercise and 6 pillars all involved group learning, building insight into self and others. 6 pillars, worry and social support networks focused on developing specific insight as well as new skills to manage own wellbeing. Identified as the ones providing the most "knowledge". Indicated as the most "fun" as it involved working together as well as competitiveness.	• Continue to embed activities that involve group learning, insight into self and others. • Focus more time on activities such as the "6 pillars" to enhance the positive aspect of mental health that feels most relevant to young people. • Involve young people in running of sessions. • Keep the activities and ice breaker as a way of maintaining engagement as well as a sense of connection with their peers.
Participants and facilitators felt there were too many worksheets and time spent writing information down.	Too time-consuming, meaning that at times discussions or activities were cut short to complete worksheets.	• Create a workbook ahead of time, rather than individual sheets for each section. • Use the workbook for outside of the sessions.
Group discussion was highly valued by young people; however, this was impacted on due to time constraints (i.e. too big a group, too many worksheets to complete)	Important to maximise and prioritise group discussions, creating space for shared experience and knowledge development through learning from others, building insight	• Discussions in session using specific character (Appendix M3) to further embed safety, then the session

	into self and others, developing knowledge of skills participants could use for themselves. Continue to explore ways of creating a space where young people feel able to engage in these discussions.	homework for them to complete the worksheet at home. • Smaller group sizes to help with the learning element as well as the sense of safety to explore these topics.
Most young people felt it was important to have these sessions before participants moved schools, so they felt confident in having skills to cope with the move.	Explore further when to facilitate sessions (i.e. pre or post transition). Preferred before moving. Initial evaluation by Greenhill (2022) were completed with those post- transition.	• Further facilitation within primary school, whilst embedding a longitudinal design to follow up post transition.
Majority of young people felt that external facilitators are more helpful than their teachers.	Identified that "different ways of learning/perspectives helpful for their understanding" and "feeling more comfortable with people they don't know".	• Co-facilitate with teachers.
Other Changes young people and facilitators voiced would be helpful: • **Discussing common mental health difficulties, to remove the stigma attached to them.**	Despite moving away from deep discussions of mental health as we were cautious about over-identification, young people and facilitators identified more of a focus on these would be helpful. Have more time felt necessary for the proper exploration of the topics in the sessions.	• Adding to the mental health session more of an exploration of the common mental health difficulties noted in the quiz.

2.5 Discussion

The present study aimed to explore children and young peoples' [CYP] experience of two sessions focused on building insight and understanding of mental health and resilience sessions, and how this could support the transition from primary-secondary school. Alongside this, the findings were to help inform a rigorous trial to assess the efficacy of the programme.

The findings indicated positives through taking part in the sessions, related to feelings of connectedness through shared experiences, improving insight into themselves and others, whilst developing ways participants could be proactive with wellbeing. There was also a notable shift in how participants viewed mental health, moving away from viewing it as something negative to something important to understand as well as the power they have to influence it. RTA led to the interpretation of three over-arching themes, comprised of three additional sub-themes (Table 2.6): *"We're all in the same boat": The Normality of Change*; *Safety in numbers: How social connection creates a sense of safety and wellbeing; Moving from "them" to "us"; changing understanding of mental health and wellbeing*. Furthermore, the findings indicated measuring concept such as self-efficacy in the skills, peer relationships and mental health literacy would be a useful way to explore efficacy of these sessions. There is also a need to explore further whether these are most helpful before or following transition, as well as who best to facilitate the sessions.

We're all in the same boat": The Normality of Change

Most worries voiced by participants were like those described in previously reviewed literature (i.e. Evans et al., 2018; Jindal- Snape et al., 2018; Mumford & Birchwood, 2021), with relationships being their biggest preoccupation. However, worries were described by these participants as fleeting with a greater sense of being ready, indicating a 'present moment' focus for pre-adolescent in this group (Chen et al., 2016). This focus could be

beneficial for their transition, as more positive expectations and lower levels of worries about the transition are more likely to experience positive transitions (Donaldson, 2022). This appears reflective of the Multiple and Multi-dimensional transitions theory by Jindal-Snape (2016) which acknowledge the importance of considering transitions as simultaneously worrying and exciting, rather than focusing on purely the negatives of change. However, the biological and social changes adolescents go through impacts on how CYP experience their emotions (Bailen et al., 2019; McLaughlin et al., 2015), showing that this study may be biased towards younger, pre-adolescent populations and not fully reflect experiences of those who have experienced transition.

Overall, readiness was partially supported by the group learning elements of the intervention. This was framed as being important for promoting learning from others, building a greater sense of understanding and insight into themselves and others. It also supported the fleeting nature of worries through sharing, recognising the normality of them, the changeable nature of emotions as well as recognising their own capabilities to manage.

As the literature has shown, self-efficacy and confidence in ones' own abilities to cope is an important factor in aiding positive transitions as well as being a protective factor from developing mental health difficulties (i.e. Bailey & Barnes, 2012; Donaldson, 2022; White, 2020). Therefore, future rigorous trials of these sessions could focus on measuring CYP self-efficacy and confidence in using the skills.

Safety in numbers: How social connection creates a sense of safety and wellbeing.

Overall, participants focused on the importance of social relationships both regarding their experience of transition but also within the sessions. Following the sessions, CYP reflected a sense of more supportive relationships. They related this to an enhanced learning experience through learning with others, but also due to the increased knowledge of mental

health developed in the sessions, ultimately helping create greater insight and empathy. This further supports the previous research that there is a potential link between increasing mental health literacy through the sessions and creating more positive peer relations and social skills during the transitional periods (Greenhill, 2022; Mitic et al., 2021).

One of the main concerns that came up was relationships with others, whether participants had already established friendships at the new school or not, highlighting a sense of vulnerability in the change of relationships statuses. Literature reflects that peer relationships at the time of transition can feel 'unstable' creating a sense of uncertainty even when CYP already have friendship groups (i.e. Ng- Knight et al., 2019; Pratt & George, 2005). Participants related connection with others as a key element to feeling safe and confident, reflecting previous research on the importance of developing peer relationships especially during the transition time to influence feelings of self-worth and buffer against life stressors (Bagnall et al., 2020; Evans et al., 2018). As belonging is recognised as being extremely important for CYP, it would be important to measure peer connectedness, to assist in the implementation of the intervention as well as exploring the impact of strength- based mental health sessions on supportive relationship development.

To a lesser degree, some participants voiced a fear of being judged by their peers if they voiced their concerns, reflected in current literature (i.e. Bagnall et al., 2020). However, this was somewhat reduced due to initially focusing on worries the character had (Appendix M3) rather than their own. This helped by providing someone else who could "voice" their worry, reducing the fear around being judged. This helped them feel safer with exploring their worries and supported problem solving (Foulkes & Stapley, 2022), creating a more supportive relationship with their peers.

Moving from "them" to "us"; changing understanding of mental health and wellbeing

Prior to the sessions, exposure to misinformation led to an overall picture of mental health as something to fear and to do with others. This reflected recent research indicating that due to this kind of exposure, CYP often downplay or internalise worries for fear of being stigmatised (MIND, 2021; Nobre et al., 2021). However, following the sessions CYP reflected a sense of universality to mental health, shifting away from the dominant narrative of 'mental illness' into a more holistic view of mental health and wellbeing. Increasing mental health literacy has been identified as a protective factor for CYP, building both insight into mental health and emotional coping skills (i.e. Campos et al., 2018; Carvalho & da Luz Vale-Dias, 2021). This is reflected in post sessions, CYP feeling more confident to discuss these topics and particularly found it helpful to focus on the positive aspect of mental health to support their abilities (i.e. keeping well). Participants also reflected an increased empathy for others, which they framed as aiding in developing supportive relationships. This all indicates the increase in mental health literacy, evidencing in improving of attitudes towards mental health, increasing efficacy related to mental health and help-seeking alongside increased insight into self and others (Spiker & Hammer, 2018).

It would be important to explore the change in mental health literacy and stigma pre and post intervention, to explore further the potential link between mental health literacy and positive peer relationships as also noticed in Greenhill (2022).

Further Development of the Sessions

One of the most valued elements to the sessions was group interactions which were seen as key to enhancing and embedding their learning, alongside creating the sense of group membership. However, the facilitators for the current study found the large group size and multiple worksheets to be a barrier to this. Therefore, one suggestion is to focus in session on externalising discussions onto the 'characters' to facilitate group discussion in session. Then,

to help enhance individual learning as well as protect time for group learning, creating a workbook with all the activities in as homework for CYP to do outside of the sessions rather than whilst the sessions are happening. “Homework” is traditionally used in many evidence-based interventions as a way enhancing and embedding learning, allowing individuals to reflect on what they have taken away and develop their understanding (Kazantzis & Miller, 2022). It helps with enhancing insight and psychological responsibility, whilst also allowing for this to be done in a safer space.

Although the current content was considered interesting and met their needs, participants voiced wanting more information about specific mental health conditions. Participants reflected having heard about specific mental health difficulties in TV programmes such as Eastenders and wanted further information on what this meant. This appears to reflect the MIND (2021) research, that CYP want to build their knowledge, however it is important to discuss this in a containing and structured way, to lessen the risk of over-identification or over-medicalising of ‘normal’ emotions (Foulkes & Andrews, 2022). The group exercises (i.e. sticky note and quiz) felt like a good place to embed further information and discussion around common mental health difficulties.

The current study indicated potential for the sessions to be run pre-transition. However, it is important to note the first evaluation study (Greenhill, 2022) focused on a mix of CYP with some due to experience the transition imminently and some having experienced it years ago. In Greenhills’ study participants indicated a difficulty with translating into how they may have been helpful with the transition. In this current study, the author wondered if the participants felt easier discussing these topics in an environment, they knew with peers relationships that were already established. Group cohesion and familiarity has been identified as one of the most crucial elements to any group-based therapy or intervention

(Christensen et al., 2021). It helps create a sense of safety, normalising, motivation and understanding, which was mirrored in what our participants said.

Universal SEL programmes are traditionally aimed at being implemented by teachers, to aid with embedding into school culture alongside sustainability (i.e. reducing costs). A review by Mohammadi and colleagues (2020) found that mental health literacy interventions played a significant role in promoting students' knowledge and attitudes towards mental health, especially when it is integrated into the curriculum and facilitated by their teachers. However, in our study most of the participants preferred having external facilitators rather than their teachers. Participants related this to facilitators having a more in-depth knowledge of the topics, diverse ways of learning and finding the lack of previous relationship as helpful. In another review around facilitators and barriers to school-based programmes (Mackenzie & Williams, 2018) there was no noticeable difference between outcomes in teacher-led versus external facilitator led, however CYP voiced a preference to have both involved, and highlighted the relationship as a key factor. Therefore, it felt important that in further iterations of these sessions there is joint facilitation and a review of the CYP experiences post intervention.

Clinical Implications

Currently, these sessions are in the early stages of production. However, this study has identified areas of importance to highlight as well as to explore further.

The findings in this study contrast with current literature, where there are concerns about exposing CYP to universal mental health programmes can increase symptoms of mental health difficulties through increase in overidentification or labelling normal emotional responses (Andrews et al., 2022; Bastounis et al., 2017; Foulkes & Andrews, 2022). The sessions were developed using normalising language, steering away from exploring specific

mental health difficulties and it's symptoms, and rather focusing on recognising common emotions as normal within different contexts (i.e. worry when change is happening) (Andrews et al., 2022; Foulkes & Stapley, 2022). Similarly, the development of mental health literacy reflected an increase in confidence to cope with change not just in the here and now, but in the future as well. The ability to adapt to change is something highlighted within the literature as crucial for emotional wellbeing and resilience (i.e. Marsten, 2011; Rutter, 2000), therefore indicating that this is an important component of interventions.

By using delivery techniques designed for successful social and emotional interventions, it created safe spaces to connect with peers and share experiences, helps normalise worries and increase understanding and insight for CYP instead of creating an atmosphere of fear. The sessions combined strengths-based elements by focusing on CYP existing internal and external resources, whilst enhancing group belonging to explore topics initially viewed as something to be 'fearful' of. This enabled supportive conversations, alongside increasing confidence to identify difficulties in themselves and others, whilst reducing fear and stigma. This indicates important components for educators or facilitators of these programmes, to ensure the group learning element is focused on.

Similarly, the use of CYP narratives to shape and further develop sessions is highlighted as key to making programmes accessible and useful, which was evidenced in this study (Foulkes & Stapley, 2022). The next stage in the evaluation and production should also include the voice of the educational staff to ensure the useability and usefulness of the sessions.

Currently, this study is still in the early stages of production. One area that needs further clarification is the timing of the intervention. Within both this study and the pilot study by Greenhill (2022) data was gathered from both pre and post transition CYPs.

However, what would be helpful is to complete a pre and post study design, following up post transition to see the utility of the sessions. Group cohesion was identified as very important to group-based interventions, indicating that the 'safety' of the primary school setting might help embed the skills being discussed. However, it is important to explore the generalisability of the information and skills to the next environment, as that is what we are aiming for. This would also provide an indication of the 'dosage' of the sessions, as currently they have been run as a one session programme. This information would help guide the practical aspects of the intervention, which inevitably would like to be embedded within the school curricula.

Despite the further development and research needed, the results have provided indications for outcomes within a rigorous future trial. Both mental health literacy and peer connectedness are potentially linked given the results from this study and the original pilot study (Greenhill, 2022) therefore would be important to have as outcome variables to measure improvements within these constructs. Similarly, mental health literacy is linked to self-efficacy (i.e. Spiker and Hammer, 2018) therefore this would be important to measure due to the protective mechanism confidence has for CYPs (i.e. Donaldson, 2022).

Strengths & Limitations

Through using the participants' voices, we gained insight into their individual experiences that can help enhance the usefulness of sessions going forward, alongside what future more rigorous trials could focus on for the evaluation. This study was held in line with standards described by the American Psychological Association's (APA, 2018) Journal Article Reporting Standards for Qualitative Research (JARS- Qual). For example, using a reflective diary to ensure transparency about potential author related influences on the data. To also evidence participants voice alongside the adherence to the guidelines, direct

meaningful quotes were used to show the clear steps taken to ensure analysis and outcomes were grounded in the data.

The use of a convenience sample could impact on the generalisability of the findings, as well as potentially missing participants who had more unique or poorer experiences due to not wanted to volunteer. Despite this, both this study and the previous pilot study completed by Greenhill (2022) used diverse populations. For example, in the current study the sample included individuals with lived experience of mental health difficulties and previous difficulties at school, so reflected difference in their schooling experiences. It also contained reflections from one individual who had already moved schools. Similarly, in this study there were individuals from a range of ethnicities, with four CYPs from a white British background, two black British and two Pakistani British. Co-production using exploratory participatory methodology is a way of integrating divers opinions at the crucial preliminary stages of intervention development (Foulkes & Stapley, 2022; Sellars et al., 2021; Skivington et al., 2022). Therefore, as this is only the second stage in intervention development, this mix of diversities in term of experiences and backgrounds can be seen as a strength, creating the opportunity to explore and accommodate potential challenges that arise, increasing the likelihood of it promoting meaningful change (Wight et al., 2015).

Another limitation is the type of data collected, only predominantly collecting data pre-transition. For future development, it would be important to include a follow up post transition to explore the usefulness of the sessions as well as well as the implementation of the knowledge and skills.

Given the reflexive nature of RTA, it is important to note the authors role in the collection and analysis of the data. A reflection was made on the researchers' own lens and how this may affect the interpretation of participants narratives. For example, one participant

particularly resonated with the researcher regarding their worries about moving, as well as their stature and quietness. It felt reflective of the researchers' experiences of moving schools, which had been negative, and lead the researcher to note countertransference during this interview. Initially this led to placing a negative stance on the interpretation of data, focus on the worries and disregarding the real sense of normality. To counterbalance the potential biases, the author used a reflective diary to allow space to attend to said biases, take a step back from the data to continue checking the analysis remained centred on the data.

Conclusion

Whilst the findings reflect previous theory and research, particularly around the importance of understanding the transition needs of CYP, it also highlights a different 'lens' of viewing them. Amongst the findings, concerns were viewed as more 'fleeting', with a greater emphasis on CYP identifying feeling ready to move. These findings also highlighted the importance and the positive impact learning about mental health can have on CYP, and how by not providing these spaces we can end up increasing fear and stigma creating further barriers to accessing help if and when it is needed. The findings are also unique as it identifies a potential area for exploration; how learning about mental health and wellbeing aids peer relationships, which in turn supports positive transitions. Our findings can be used to further develop more rigours research, evaluating the concepts surrounding self-efficacy, mental health literacy and peer relationships, all key components to overall wellbeing for CYP.

References

American Psychological Association (APA). (2018). *Information recommended for inclusion in manuscripts that report primary qualitative research.* https://apastyle.apa.org/jars/qual-table-1.pdf

Andrews J. L., Birrell L., Chapman C., Teesson M., Newton N., Allsop S., McBride N., Hides L., Andrews G., Olsen N., Mewton L., & Slade, T. (2023). Evaluating the effectiveness of a universal eHealth school-based prevention programme for depression and anxiety, and the moderating role of friendship network characteristics. *Psychol Med, 53*(11), 5042-5051.

Bagnall, C.L., Skipper, Y., & Fox, C.L. (2020). You're in this world now: Students', teachers' and parents' experiences of school transition and how they feel it can be improved. *British Journal of Educational Psychology, 90*, 206- 226.

Bagnall, C.L., Fox, C.L., Skipper, Y., & Oldfield, J. (2021). Evaluating a universal emotional-centred intervention to improve children's emotional well-being over primary-secondary school transition. *Advances in Educational Research and Evaluation,* 2(1), 113-126.

Bailen, N.H., Green, L.M., & Thompson, R.J. (2019). Understanding Emotion in Adolescents: A Review of Emotional Frequency, Intensity, Instability and Clarity. *International Society for Research on Emotion, 11*(1), 63-73.

Bailey, S., & Baines, E. (2012). The impact of risk and resiliency factors on the adjustment of children after the transition from primary to secondary school. *Educational & Child Psychology, 29*(1), 47- 63.

Barry, M. M., Clarke, A. M., & Dowling, K. (2017). Promoting social and emotional well-being in schools. *Health Education, 117*(5), 434-451. https://doi.org/10.1108/HE-11-2016-0057

Barzeva, S.A., Richards, J.S., Meeus, W.H.J., & Oldehinkel, A.J. (2019). The Social Withdrawal and Social Anxiety Feedback Loop and the Role of Peer Victimisation and Acceptance in the Pathways. *Developmental and Psychopathology, 32,* 1402-1417.

Bastounis, A., Callaghan, P., Lykomitrou, F., Aubeeluck, A. & Michail, M. (2017) Exploring students' participation in universal, depression and anxiety, prevention programmes at

school: a meta-aggregation. *School Mental Health*, 9(4), 372–385. https://doi.org/10.1007/s12310-017-9230-7.

Beatson, R., Quach, J., Canterford, L., Farrow, P., Bagnall, C., Hockey, P., Phillips, E., Patton, G.C., Olsson, C.A., Ride, J., Brown, L.M., Roy, A., & Mundy, L.K. (2023). Improving Primary to Secondary School Transitions: A Systematic Review of School-Based Interventions to Prepare and Support Student Social- Emotional and Educational Outcomes. *Educational Research Review, 40*.

Braun, V., & Clarke, V. (2022). *Thematic Analysis: A Practical guide.* SAGE.

Braun, V., & Clarke, V. (2021). Conceptual and design thinking for thematic analysis. *Qualitative Psychology, 9* (1), 3-26. https://doi.org/10.1037/qup0000196

Braun, V., & Clark, V. (2020). Can I use TA? Should I use TA? Should I *not* use TA? Comparing reflexive thematic analysis and other pattern- based qualitative analytic approaches. *Counselling & Psychotherapy Research, 21*, 37-37. DOI: 10.1002/capr.12360

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2). 77-101. http://dx.doi.org/10.1191/1478088706qp063oa

British Psychological Society. (2020). *Compassionate transitions: reconnecting school communities post COVID-19 closures.* Retrieved from: https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20%20Files/Compassionate%20transitions%20-%20reconnecting%20school%20communities.pdf

Byrne, D. (2021). A worked example of Braun and Clarke's approach to reflexive thematic analysis. *Quality & Quantity, 56*, 1391-1412. https://doi.org/10.1007/s11135-021-01182-y

Campos, L., Dias, P., Duarte, A., Veiga, E., Dias, C. C., & Palha, F. (2018). Is it possible to "find space for mental health" in young people? Effectiveness of a school-based mental health literacy promotion program. *International Journal of Environmental Research and Public Health, 15*, 1426- 1438.

Chen, T., Liu, L., Cui, J., Chen, X., & Wang, Y. (2016). Developmental trajectory of time perspective: from children to older adults. PsyCh Journal, 5(4),245–255.

Choi, A. (2018). *Emotional well-being of children and adolescents: Recent trends and relevant factors* [No. 169]. OECD Publishing, Paris. http://dx.doi.org/10.1787/41576fb2-en

Christensen, A.B., Wahrén, S., Reinholt, N., Poulsen, S., Hvenegaard, M., Simonsen, E., & Arnfred, S. (2021). “Despite the Differences, We Were All the Same”. Group Cohesion in Diagnosis-Specific and Transdiagnostic CBT Groups for Anxiety and Depression: A Qualitative Study. *International Journal of Environmental Research and Public Health, 18*: https://doi.org/10.3390/ijerph18105324

Coffrey, A. (2013). Relationships: The Key to Successful Transition from Primary to Secondary School? *Improving Schools, 16*(3), 261-271.

Collaborative for Academic, Social and Emotional Learning. (2020). *"What Is SEL?"*. CASEL. https://casel.org/what-is-sel/.

Clarke, A.C., Sorgenfrei, M., Mulcahy, J., Davie, P., Friedrich, C., & McBride, T. (2021). *Adolescent Mental Health: A Systematic Review on the Effectiveness of School-Based interventions.* Early Intervention Foundation.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2019). *Developing and evaluating complex interventions*. Medical Reserach Council. www.mrc.ac.uk/complexinterventionsguidance

Curson, S., Wilson- Smith, K., & Holiman, A. (2019). Exploring the experience of students making the transition from primary to secondary school: An interpretative phenomenological analysis of the role of friendship and family support. *Psychology Teaching Review, 25* (1), 30-41.

De Carvalho, M.M., & da Luz Vale-Dias, M. (2021). Is Mental Health Literacy Related to Different Types of Coping? Comparing Adolescents, Young- Adults and Adult Correlates. *International Journal of Developmental and Educational Psychology, 2*(2), 281- 290.

Department of Health and Social Care and Department for Education. (2017). *Transforming children and young people’s mental health provision: A green paper*. London.

Department of Education. (2022).

Donaldson, C., Moore, G., & Hawkins, J. (2022). *A Systematic Review of School Transition Interventions to Improve Mental Health and Wellbeing Outcomes in Children and Young People. School Mental Health, 15*, 19-35.

Dowling, K., & Barry, M.M. (2020). The Effects of Implementation Quality of a School-Based Social and Emotional Well-Being Program on Students’ Outcomes. *European Journal of Investigation in Health, Psychology and Education, 10*, 595- 614.

Dray, J., Bowman, J., Campbell, E., Freund, M., Wolfenden, L., Hodder, R.K., McElwaine, K., Tremain, D., Bartlem, K., Bailey, J., Small, T., Palazzi, K., Oldmeadow, C., & Wiggers, J. (2017). Systematic Review Of Universal Resilience- Focused Interventions Targeting Child And Adolescent Mental Health In The School Setting. *Journal of the American Academy of Child and Adolescent Psychiatry, 56*(10), 813-824.

Durlak, J.A., Weissberg, R.P., Dymnicki, A., Taylor, R.D., & Schellinger, K.B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development, 82,* 405-432.

Evans, D., Borriello, G. A., & Field, A. P. (2018). A review of the academic and psychological impact of the transition to secondary education. *Frontiers in Psychology, 9* (1482), 1-18.

Evangelou, M., Taggart, B., Sylva, K., Melhuish, E., Sammons, P., & Siraj-Blatchford, I. (2008). *What Makes a Successful Transition from Primary to Secondary School*. Institute of Education, University of London.

Foulkes, L., & Andrews, J.L. (2023). Are Mental Health Awareness Efforts Contributing to the Rise in Reported Mental Health Problems? A Call to Test the Prevalence Inflation Hypothesis. *New Ideas in Psychology, 69,* 101010

Foulkes, L., & Stapley, E. (2022). Want to improve school mental health interventions? Ask young people what they actually think. *Journal of Philosophy of Education, 56*, 41-50.

Galton, M., Gray, J., and Ruddock, J. (1999). *The Impact of School Transitions and Transfers on Pupil Progress and Attainment.* London: Department of Education.

Gedikoglu, M. (2021). *Social and Emotional Learning: An Evidence review and Synthesis of Key Issues,* Education Policy Institute. United Kingdom. Retrieved from: https://policycommons.net/artifacts/3786457/social-and-emotional-learning-an-evidence-review-and-synthesis/4592219/

Glazzard, J. (2019). A Whole School Approach to Supporting Children and Young People's Mental Health. Journal of Public Mental Health. *Journal of Public Mental Health,* DOI: https://doi.org/10.1108/JPMH-10-2018-0074

Gray, S.L., Saville, K., Hargreaves, E., Jones, E., & Perryman, J. (2021). *Moving Up: Secondary School Transition Processes During the COVID-19 Pandemic for Schools.* Institute of Education, University College London.

Greenhill, J. (2022). *Developing Mental Health and Resilience Sessions to Support Primary-Secondary School Transition: Exploring the Experiences of Young People.* [unpublished masters thesis]. University of Birmingham.

Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental Illness Stigma, Help Seeking and Public Health Programs, *American Journal of Public Health, 103*(5), 777- 780.

Hopwood, B., Hay, I., & Dyment, J. (2016). The transition from primary to secondary school: Teachers perspectives. *The Australian Educational Researcher, 43*(3), 289- 307.

Humphrey, N., Lendrum, A., & Wigelsworth, M. (2010). Social and emotional aspects of learning (SEAL) programme in secondary schools: national evaluation.

Jindal- Snape, D., Hannah, E. F.S., Cantali, D., Barlow, W., MacGillivray, S. (2020). Systematic literature review of primary- secondary transitions: International research. *Review of Education, 8*(2), 526- 566.

Kazantzis, N., & Miller, A.R. (2022). A Comprehensive Model of Homework in Cognitive Behavior Therapy. *Cognitive Therapy and Research, 41*(1), 247-257.

Kuosmanen, T., Clarke, A.M., & Barry, M.M. (2019). Promoting Adolescents' Mental Health and Wellbeing: Evidence Synthesis. *Journal of Public Mental Health, 18*(1), 73- 83.

Lester, L., Waters, S., & Cross, D. (2013). The Relationship Between School Connectedness and Mental Health During the Transition to Secondary School: A Path Analysis. *Australian Journal of Guidance and Counselling,* 1-15.

Mackenzie, K., & Williams, C. (2018). Universal, School- Based Interventions to Promote Mental and Emotional Wellbeing: What is Being Done in the UK and Does it Work? A Systematic Review. *BMJ Open, 8:* doi: 10.1136/bmjopen-2018-022560. PMID: 30196267; PMCID: PMC6129100.

Mahoney, J.L., Durlak, J.A., & Weissberg, R.P. (2018). An Update on Social and Emotional Learning Outcome Research. *Phi Delta Kappan, 100* (4), 18-23.

McLaughlin, K.A., Garrad, M.C., & Somerville, L.H. (2015). What Develops During Emotional Development? A Component Process Approach to Identifying Sources of Psychopathology Risk in Adolescence. *Dialogues in Clinical Neuroscience, 17*(4), 403-410.

McLeod, S. A. (2019, October 24). *Social identity theory.* Simply Psychology. www.simplypsychology.org/social-identity-theory.html

MIND. (2021). *Supporting Young People- With a Focus on Trauma.*

Mitic, M., Woodcock, K. A., Amering, M., Krammer, I., Stiehl, K.A.M., Zehetmayer, S., & Schrank, B. (2021). Toward an Integrated Model of Supportive Peer Relationships in Early Adolescence: A Systematic Review and Exploratory Meta-Analysis. *Front Psychol, 25,* doi: 10.3389/fpsyg.2021.589403. PMID: 33716860; PMCID: PMC7947339.

Mohammadi, A.S., Panahi, S., Sayarifard, A., & Ashouri, A. (2020). Identifying the Prerequisites, Facilitators, and Barriers in Improving Adolescents' Mental Health Literacy Interventions: A Systematic Review. *Journal of Education and Health Promotion, 9*: doi: 10.4103/jehp.jehp_623_20. eCollection 2020.

Moore, G., Angel, L., Brown, R., van Godwin, J., Hallingberg, B., & Rice, F. (2021). Socio-economic status, mental health difficulties and feelings about transition to secondary school among 10–11 year olds in Wales: Multi-level analysis of a cross sectional survey. *Child Indicators Research, 14*(4), 1597–1615.

Mumford, J., & Birchwood, J. (2021). Transition: a systematic review of literature exploring experiences of pupils moving from primary to secondary school in the UK. *Pastoral Care in Education, 39* (4), 377- 400. https://doi.org/10.1080/02643944.2020.1855670

National Health Service [NHS] Digital. (2020). Mental Health of Children and Young People in England. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up

Ng-Knight, T., Shelton, K. H., Riglin, L., Frederickson, N., McManus, I. C., & Rice, F. (2019). 'Best friends forever'? Friendship stability across school transition and associations with mental health and educational attainment. *British Journal of Educational Psychology*, *89*(4), 585-599.

Nobre, J., Oliveira, A.P., Monterio, F., Sequeira, C., & Ferré- Grau, C. (2021). Promotion of Mental Health Literacy in Adolescents: A Scoping Review. *International Journal of Environmental Research and Public Health, 18*(18): https://doi.org/10.3390/ijerph18189500

Ofsted. (2015). *Key Stage 3: The wasted years?* www.gov.uk/government/publications/key-stage-3-the-wasted-years

O'Conner, C.A., Dyson, J., Cowdell, F., & Watson, R. (2017). Do Universal School-based Mental Health Promotion programmes improve the Mental Health and Emotional Well-being of young people? A literature review. *Journal of Clinical Nursing, 27,* 412- 426.

O'Reilly, M., Svirydzenka, N., Adams, S., & Dogra, N. (2018). Review of mental health promotion in schools. *Social Psychiatry and Psychiatric Epidemiology*, *53*(7), 647–662.

Ortlipp, M. (2008). Keeping and Using Reflective Journals in the Qualitative Research Process. *The Qualitative Research, 13*(4), 695- 705.

Pratt, S., & George, R. (2005). Transferring friendships: Girls' and boys' friendships in the transition from primary to secondary school. *Children and Society, 19*(1), 16-26.

Punukollu, M., Burns, C., & Marques, M. (2020). Effectiveness of a pilot school-based intervention on improving scottish students' mental health: a mixed methods evaluation. *International Journal of Adolescence and Youth, 25*(1), 505-518.

Quayle, D., Dziurawiec, S., Roberts, C., Kane, R., & Ebsworthy, G. (2001). The effect of an optimism and life skills program on depressive symptoms in preadolescence. *Behaviour Change, 18*(4), 194–203.

Roberts, C. M., Kane, R., Bishop, B., Cross, D., Fenton, J., & Hart, B. (2010). The prevention of anxiety and depression in children from disadvantaged schools. *Behaviour Research and Therapy, 48*(1), 68–73.

Roberts, C.M., Kane, R.T., Rooney, R.M., Pintabona, Y., Baughman, N., Hassan, S., Cross, D., Zubrick, S.R., & Silburn, S.R. (2018). Efficacy of the Aussie Optimism Program: Promoting Pro-Social Behaviour and Preventing Suicidality in Primary School Students. A Randomised- Controlled Trial. *Frontier Psychol, 8,* 1392.

Sellars, E., Pavarini, G., Michelson, D., Creswell, C., & Fazel, M. (2021). Young people's advisory groups in health research: Scoping review and mapping of practices. *Archives of Disease in Childhood, 106*(7), 698–704. https://doi.org/10.1136/archdischild-2020-320452

Schwager, S., Berger, U., Glaeser, A, Strauss, B., & Wick, K. (2019). Evaluation of "Healthy Learning. Together", an Easily Applicable Mental Health Promotion Tool for Students Aged 9 to 18 Years. *International Journal of Environmental Research and Public Health, 16*, 487- 502.

Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., Boyd, K. A., Craig, N., French, D. P., McIntosh, E., Petticrew, M., Rycroft-Malone, J., White, M., & Moore, L. (2021). A new framework for developing and evaluating complex interventions: Update of Medical Research Council guidance. *The BMJ, 374*. https://doi.org/10.1136/bmj.n2061

Spernes, K. (2022). The Transition Between Primary and Secondary School: A Thematic Review Emphasising Social and Emotional Issues. *Research Papers in Education,37*(3), 303-320.

Strand, G. M. (2019). "Experiencing the Transition to Lower Secondary School: Students' Voices. *International Journal of Educational Research*, *97*, 13–21. doi:10.1016/j.ijer.2019.06.009

Taylor, R.D., Oberle, E., Durlak, J.A., & Weissberg, R.P. (2017). Promoting Positive Youth Development Through School- Based Social and Emotional Learning Interventions: A Meta- Analysis of Follow- Up Effects. *Child Development, 88*(4), 1156-1171.

Topping, K. (2011). Primary- secondary transition: Differenced between teachers and children's perceptions. *Improving Schools, 14*(3), 268- 285.

van Rens, M., Haelermans, C., Groot, W., & van den Brink, H. M. (2018). Facilitating a successful transition to secondary school: (How) does it work? A systematic literature review. *Adolescent Research Review, 3*, 43-56. https://doi.org/10.1007/s40894-017-0063-2

van Rens, M., Haelermans, C., Groot, W., & van den Brink, H. M. (2019). Girls' and boys' perceptions of the transition from primary to secondary school. *Child Indicators Research, 12*(4), 1481-1506. https://doi.org/10.1007/s12187-018-9591-y

Vaz, S., Falkmer, M., Parsons, R., Passmore, A.E., Parkin, T., Falkmer, T. (2014). School Belongingness and Mental Health Functioning across the Primary-Secondary Transition in a Mainstream Sample: Multi-Group Cross-Lagged Analyses. *PLOS, 9*(6).

West, P., Sweeting, H., Young, R. (2010). Transition matters: pupils' experiences of the primary- secondary school transition in the West of Scotland and consequences for well-being and attainment. *Research Papers in Education, 25*(1), 21-50.

White, J. *Supporting children's mental health and wellbeing at transition from primary to secondary school: evidence review.* Edinburgh: NHS Health Scotland, 2020.

Wigelsworth, M., Verity, L., Mason, C., Qualter, P., & Humphrey, N. (2022). Social and Emotional Learning in Primary Schools: A Review of the Current State of Evidence. *British Journal of Educational Psychology, 92,* 898- 924.

Wight, D., Wimbush, E., Jepson, R., & Doi, L. (2015). Six steps in quality intervention development (6SQuID). *Journal of Epidemiology and Community Health, 70*(5), 520–525. https://doi.org/10.1136/jech-2015-205952

WHO (2016). *WHO Mental Health: Strengthening Our Response*. ww.who.int/mediacentre/factsheets/fs220/en/.

World Health Organization [WHO]. (2021). *WHO Adolescent Mental Health*. Available online: https://www.who.int/newsroom/fact-sheets/detail/adolescent-mental-healthm (accessed on 17 October 2020).

Zeedyk, M.S., Gallacher, J., Henderson, M., Hope, G., Husband, B., & Lindsay, K. (2003). Negotiating the transition from primary to secondary school: perceptions of pupils, parents and teachers. Sch. Psychol. Int. 24, 67–79. doi: 10.1177/0143034303024001010

Chapter 3. Press Release for the Literature Review

Group Social And Emotional Learning Interventions For Young People With Neurodevelopmental Conditions: A Scoping Review Of The Quantitative And Qualitative Evidence

The importance of social- emotional learning skills for young people have been increasingly focused on particularly in recognising the implications and impact they have on child development and beyond. These skills are made up of interpersonal and intrapersonal skills, identified as key to developing the "whole self" (Humphrey, 2013; Wigelsworth et al., 2022), including being key determinants to young people's mental health and wellbeing, supporting their ability to learn, thrive, and actively engage with the world around them (Clarke et al., 2021).

Young people with neurodevelopmental conditions represent up to 10% of children worldwide and is widely stated that these conditions have an impact on multiple areas of their lives such as personal, social, occupational or academic functioning. Alongside this, the risks to social-emotional skills are well documented, highlighting emotional recognition and regulation as particularly vulnerable in this population. Despite social- emotional learning being widely supported within the neurotypical population, particularly focusing on proactive and preventative interventions, there appears to be a scarcity of focus on programmes aimed at supporting these key life skills for those with a neurodevelopmental condition.

Lead researcher Ali Hosking, from the University of Birmingham, completed a scoping review to understand the social-emotional learning interventions available for young people with a neurodevelopmental condition, whilst exploring the available evidence on effectiveness. With the support of other researchers at the School of Psychology, all available research in the area from 1997 was gathered and systematically screened against a specific

inclusion criterion. 39 studies were identified, involving young people with diagnoses such as Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder and Intellectual Disabilities, from 12 different countries. Components of the interventions, constructs measured, and outcomes were reviewed and reported on to reflect the breadth of information available, alongside the utility of the interventions.

Within this review, three arbitrary categories of interventions were recognised to aid in the analysis and presentation of results. These were: Social Skills Training Programmes, Emotional Competence Focused Programmes and Psychotherapeutic programmes. Overall, the findings showed the advancement made in social- emotional learning literature, still does not appear to translate into the neurodevelopmental condition population with limited robust research focused on interventions beyond social skills training programmes. Social skills training places the focus on explicitly teaching "acceptable" social skills such as appropriate eye contact, working within a deficit focused model. Unlike the neurotypical literature, it reflects an emphasis on "fixing" something viewed as "wrong" rather than recognising and enhancing individuals strengths. This review raises the relative lack of evidence of non-disorder les thinking and opportunities for the neurodevelopmental condition population to engage with strengths-based interventions. Similarly, there was a lack young peoples' voices in the interventions, as well as measures, which indicates an area of further exploration to enhance and engage. Overall, there was a range of study designs used, constructs measured as well as effect sizes identified in the studies, creating a difficulty to confidently draw a conclusion on what type of intervention is helpful for this population.

However, there are some positive indications towards a more neurodivergent affirming stance. There is tentative evidence to support development of social competence through focusing on emotional intelligence and implicit interventions, demonstrating a different way of developing skills beyond the explicit interventions. This is also replicated in

the outcomes for interventions focused on enhancing emotional competence, with indications for interventions such as play- based or yoga-based interventions enhancing the interoceptive awareness as way of impacting on their social relationships.

Given the impact social-emotional learning skills can have on young people with a neurodevelopmental condition, this scoping review indicates the tentative evidence available for extending programmes to focus on more neuro-divergent affirming techniques, to continue the movement towards being proactive and empowering for *all* children. Furthermore, there is an opportunity within the research community to enhance engagement with young people at all stages of development, to support interventions that are meaningful and measure that reflect the true impact on the individuals needs and goals.

3.1 Further Reading

CASEL (2020). *"What Is SEL?"*. CASEL. https://casel.org/what-is-sel/.

Cherewick, M., & Matergia, M. (2023). Neurodiversity in Practice: a Conceptual Model of Autistic Strengths and Potential Mechanisms of Change to Support Positive Mental Health and Wellbeing in Autistic Children and Adolescents. *Advance in Neurodevelopmental Disorders,* https://doi.org/10.1007/s41252-023-00348-z

Hassani, S., & Schwab, S. (2020). Social-Emotional Learning Interventions for Students With Special Educational Needs: A Systematic Literature Review. *Frontier in Education, 6*.

Hagarty, I., & Morgan, G. (2020). Social- Emotional Learning for Children with Learning Disabilities: A Systematic Review. *Educational Psychology in Practice: Theory, Research and Practice in Educational Psychology, 36*(2), 208-222.

National Institute for Health and Care Excellence [NICE]. (2019). Attention Deficit Hyperactivity Disorder: Diagnosis and Management [NICE guideline no. 87]. https://www.nice.org.uk/guidance/ng87

Wigelsworth, M., Verity, L., Mason, C., Qualter, P., & Humphrey, N. (2022). Social and Emotional Learning in Primary Schools: A Review of the Current State of Evidence. *British Journal of Educational Psychology, 92,* 898- 924.

Chapter 4. Press Release for the Empirical Paper

How Mental Health And Resilience Sessions Support Transition From Primary To Secondary School: Exploring Young Peoples Experiences To Inform Further Development And Research

Transitions are viewed as a normal, unavoidable part of life, with moving from primary to secondary school being a common occurrence around the world. For many, the transition to secondary school is something children and young people look forward to, adjusting without any major difficulties, with most concerns and worries abating within the first year. However, the transition from primary school to secondary school is highlighted as a particularly vulnerable and stressful time for some young people.

Concerns have been well documented for young people during this time of change, but primarily focused on the impact that 'poor transitions' can have on a young persons mental health and wellbeing, long after the transition is completed. The rate of young people diagnosed with a mental health difficult has increased in recent years, however research also shows there is still a high level of confusion, fear and misunderstanding of what mental health entails.

Social- emotional learning programmes are widely recognised as important for young people, and there has been a recent increase in social-emotional learning programmes specific designed to focus on moving schools. However, these rarely address increasing understanding in young people about mental health. Similarly, there is a wide range of universal mental health problems available for young people, however these have recently raised concern regarding over-identification with symptoms of mental health difficulties in young people or the over- diagnosis of 'normal' emotions. With this in mind, this study aims to explore how

by combining elements of both programmes may be beneficial for young people about to move from primary- secondary school.

Lead researcher Ali Hosking, supported by colleagues at the University of Birmingham, explored the perspectives of eight young people, aged 10-15 years. Interviews were carried out to gain insight into participants experiences of mental health and resilience sessions designed to support the move from primary to secondary school, to identify shared patterns of meaning across their responses. The research highlighted their views regarding moving schools, how the sessions were experienced alongside seeking feedback to further refine these sessions.

Whilst findings reflect the current literature of 'normal worries' for the majority of young people, it also highlighted the propensity that young people's readiness to change far outweighed any nerves they might be experience supported by a sense of unity and space to normalise worries. One young person remarked: "…I'm ready to try new things and make new friends." Alongside finding it comforting that "we're all in the same boat at secondary school… we're all starting something new and everybody at secondary school has done that as well…so knowing we're not alone in how we feel…feels good?".

The young people praised the learning aspects of the programme for contributing further to their confidence not only for the move, but how to manage stresses and changes in life going forward. There was a sense that the insight it built helped young people build confidence in themselves, and also how they might support those around them.

Through educating young people, these sessions helped dispel myths and confusion they often felt due to the fragmented exposure. The group sessions appeared to create a shift from "them" to "us", a powerful change creating an inclusive conversation, normalising of emotions and built confident in recognising and management for themselves and others. This

felt powerful as recent research has highlighted that fear and misinformation can lead to young people trying to “push away” how they’re feeling, from fear of judgement or not knowing how to access support. Lead researcher Ali Hosking says that this space allows for a “…safe environment to explore their understanding and worries, whilst developing proactive skills to empower young people in taken charge of their mental wellbeing. To embed hope that if they are ever struggling, “they are not alone”. Furthermore, this study identified concepts important to focus on when developing a more rigours trial on the effectiveness of sessions, particular self-efficacy, peer relationships and mental health literacy.

4.1 Further Reading

Beatson, R., Quach, J., Canterford, L., Farrow, P., Bagnall, C., Hockey, P., Phillips, E., Patton, G.C., Olsson, C.A., Ride, J., Brown, L.M., Roy, A., & Mundy, L.K. (2023). Improving Primary to Secondary School Transitions: A Systematic Review of School-Based Interventions to Prepare and Support Student Social- Emotional and Educational Outcomes. *Educational Research Review, 40*.

Braun, V., & Clarke, V. (2022). *Thematic Analysis: A Practical guide.* SAGE.

Braun, V., & Clarke, V. (2021). Conceptual and design thinking for thematic analysis. *Qualitative Psychology, 9* (1), 3-26. https://doi.org/10.1037/qup0000196

Department of Health and Social Care and Department for Education. (2017). *Transforming children and young people's mental health provision: A green paper*. London.

Donaldson, C., Moore, G., & Hawkins, J. (2022). *A Systematic Review of School Transition Interventions to Improve Mental Health and Wellbeing Outcomes in Children and Young People. School Mental Health, 15*, 19-35.

Foulkes, L., & Andrews, J.L. (2023). Are Mental Health Awareness Efforts Contributing to the Rise in Reported Mental Health Problems? A Call to Test the Prevalence Inflation Hypothesis. *New Ideas in Psychology, 69,* 101010

Foulkes, L., & Stapley, E. (2022). Want to improve school mental health interventions? Ask young people what they actually think. *Journal of Philosophy of Education, 56*, 41-50.

Greenhill, J. (2022). *Developing Mental Health and Resilience Sessions to Support Primary-Secondary School Transition: Exploring the Experiences of Young People.* [unpublished masters thesis]. University of Birmingham.

Mitic, M., Woodcock, K. A., Amering, M., Krammer, I., Stiehl, K.A.M., Zehetmayer, S., & Schrank, B. (2021). Toward an Integrated Model of Supportive Peer Relationships in Early Adolescence: A Systematic Review and Exploratory Meta-Analysis. *Front Psychol, 25,* doi: 10.3389/fpsyg.2021.589403. PMID: 33716860; PMCID: PMC7947339.

Mumford, J., & Birchwood, J. (2021). Transition: a systematic review of literature exploring experiences of pupils moving from primary to secondary school in the UK. *Pastoral*

Appendix A

Table A1

Definition of Social-Emotional Learning Constructs and specific skills (Table from Wigelsworth et al., 2019)

Broad construct	Core competency (linked to CASEL framework)	Specific skills
Intra-personal skills	Self-awareness	Identifying emotions; Accurate self-perception; Recognizing strengths; Self-confidence; Self-efficacy
	Self- management	Impulse control; Stress management; Self-discipline; Self-motivation; Goal setting; Organizational skills
Inter-personal skills	Social awareness	Perspective taking; Empathy/sympathy; Appreciating diversity; Respect for others
	Relationship skills	Communication; Social engagement; Relationship building; Teamwork
Responsible decision making	Responsible decision making	Identifying problems; Analysing solutions; Solving problems; Evaluating; Reflecting; Ethical responsibility

Appendix B

Figure B1

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist (Tricco et al., 2018)

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	8
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	8
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	12
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	12, 14
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	13
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	15-17
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	17- 18
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	18-19
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	19-20
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	n/a
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	20

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1

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	21
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	22-67
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	n/a
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	22- 67
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	22-67
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	68- 73
Limitations	20	Discuss the limitations of the scoping review process.	73
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	75
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	n/a

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

Appendix C

Table C1

PCC Pneumonic

P	Population, patient or problem (e.g., age, gender, disorder/disease)	Children and young people, up to the age of 18 years old, with a neurodevelopmental disorder. A Neurodevelopmental Disorder is classified as a disorder that starts in the developmental period with deficits that impact on functioning included- but not limited to- intellectual disabilities, communication disorders, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, Neurodevelopmental Motor Disorders, specific learning disorders. Research that focused on NDD populations only. Mixed populations were excluded.
C	Concept (e.g. interventions, phenomena of interest, or outcomes).	Specifically research focused on interventions focused on developing Social and Emotional skill. Social and Emotional Learning is focused on developing skills in self-awareness, self-management, social awareness, responsible decision making and relationship skills (CASEL; Goleman, 1995/ SEAL community, 2005). Group interventions that had some direct with the young people Any outcomes/measures
C	Context	Open regarding geographical location and settings.
T	Types of Evidence	Qualitative or quantitative research, with or without a comparator group. Limited to intervention research articles in peer reviewed journals.

Appendix D

Figure D1

Screen Capture of Initial Title Level Screen

Paper Title	Include for Abstract screen? (Researcher) (Yes/No/Maybe)	Exclusion reason	Intern Inclusion	Exclusion	Screen abstract?	Agreement?
Prospective associations between ASD screening scores, parenting stress, and later socio-emotional-cognitive maturity in a community-based birth cohort	No	not intervention	no		no	yes
The behavioral phenotype of young boys with Duchenne muscular dystrophy	No	not intervention	no		no	yes
Comorbidities of early-onset temporal epilepsy: Cognitive, social, emotional, and morphologic dimensions	no	Developmental trajectory not intervention	maybe		yes	no
Social-emotional processing in nonverbal individuals with Angelman syndrome: evidence from brain responses to known and novel names	yes		yes		yes	yes
The emotionally connected classroom: Wellness and the learning experience	Yes		yes		yes	yes
Supporting social/sexual challenges at the workplace	No	wrong population	no		no	yes
Art Therapy With Puppet Making to Promote Emotional Empathy for an Adolescent With Autism	Yes		maybe		yes	yes
Improving Emotional Competence in Children With Autism Spectrum Disorder and Mild Intellectual Disability in Schools: A Preliminary Treatment Versus Waitlist Study	yes		maybe		yes	yes
Promoting a Collective Voice from Parents, Educators and Allied Health Professionals on the Educational Needs of Students on the Autism Spectrum	no	not evaluating SEL intervention	maybe		yes	no
Assessment of a neuro-developmental screening tool in children in Bhutan	no	assessment tool not intervention	maybe		yes	no

Note. 'Traffic light' system to indicate individual decisions to include a study (green), exclude (red) or seek further information (amber) via abstract or full text screen or further consultation with the group

Figure D2

Screenshot of abstract screening

Title	for full paper screen? (Researc	Exclusion reason	Intern Inclusion	Exclusion	Agreement?	For full screen?
Dance/Movement Therapy's Influence on Adolescents' Mathematics, Social-Emotional, and Dance Skills	maybe		no		no	yes
Earlier is better: A meta-analysis of 70 years of intervention improving cognitive development in institutionalized children	no	wrong intervention	maybe		no	yes
Socio-emotional intervention in attention deficit hyperactive disorder	yes		maybe		yes	yes
The connection between social-emotional learning and learning disabilities: Implications for intervention	maybe	not clear if interventions	maybe		yes	yes
Responding to Young Children's Social-Emotional Needs through Video Modeling	maybe	not clear on intervention	maybe		yes	yes
Designing affective video games to support the social-emotional development of teenagers with autism spectrum disorders	yes		maybe		yes	yes
Psycho-Cognitive Intervention for ASD from Cross-Species Behavioral Analyses of Infants, Chicks and Common Marmosets	no	comparison study not intervent	no		yes	no

Appendix E

Table E1

Table of Additional Search Terms Identified

String 1- neurodevelopmental disorders	String 2- social emotional wellbeing	Group 3- intervention	Group 4- young people
Autism & related disorder	Social	Situated learning	peers
ABA- applied behavioural analysis	Emotional skills	School-based intervention	relationships
Attention deficit disorder with hyperactivity	Social adaptation	Education	student
Special needs	Emotional competence	Teaching methods	children
	Mental health	rehabilitation	Regular education relationships
	psychology	Cognitive Behavioural Therapy	Gender differences
	prosocial	Psychotherapy	infants
	Quality of life	Middle school	Special education relationships
	Empathy quotient	Randomised trial	
	Behaviour problems	Play therapy	
	competence	Social skills training	
	Psychosocial factors	Cooperative/ collaborative learning	
	wellbeing	Game based learning	
	Social support	Interactive learning environment	
	Interpersonal competence	Program development	
	Behaviour	Early intervention	
		Teaching	
		Social emotional therapy	
		Cognitive training	

Note. Following discussion around additional terms, it was identified that the three highlighted would be re-run in the searches.

Appendix F

Table F1

Overview of Study Characteristics

ID	Author	Year	Country	Setting
1	Adibseresnki, N., et al.	2016	Iran	Special Needs School
2	Antshel, K. M., & Remer, R.	2003	USA	Research site (clinical setting)
3	Babinski, S. M., et al.	2020	USA	Research site (clinical setting)
4	Beaumont, R., & Sofronoff, K.	2008	Australia	Research site (University setting)
5	Beaumont, C., et al.	2015	Australia	Mainstream School
6	Dean, J., et al.	2020	USA	Mainstream School
7	Deckers, A., et al.	2016	Netherlands	Research site (clinical setting)
8	DeRosier, M.E., et al.	2011	USA	Research site (clinical setting)
9	Drüsedau, A., et al.	2021	Germany	Research site (clinical setting)
10	Einfeld, R., et al.	2019	Australia	Mainstream school
11	Faria, S.M.M., et al.	2018	Spain	Mainstream School
12	Guivarch, V., et al.	2017	France	Research site (clinical setting)
13	Habayeb, B., et al.	2017	USA	Research site (clinical setting)
14	Hill, T. L., et al.	2017	USA	Research site (community setting)
15	Ip; S. W. L., et al.	2018	China	Research site (clinical setting)/ Virtual Reality
16	Jonsson, U., et al.	2019	Sweden	Research site (clinical setting)
17	Kasari, C., et al.	2015	USA	Mainstream School
18	Laugeson, E.A., et al.	2009	USA	Research site (clinical setting)
19	Laugeson, E.A., et al.	2012	USA	Mainstream School
20	Laugeson, E.A., et al.	2015	USA	Research site (clinical setting)
21	Laxman, K.	2022	New Zealand	Special needs school
22	Lordo, M., et al.	2017	USA	Not stated

23	Mackay, T., et al.	2007	Scotland	Mainstream school
24	Marino, P., et al.	2020	Italy	Research site (clinical setting)
25	O'Connor, C., & Stagnitti, K.	2011	Australia	Special Needs School
26	O'Handley, R. D., et al.	2016	USA	Mainstream school
27	Olsson, N.C., et al.	2016	Sweden	Research site (clinical setting)
28	Olsson, N.C., et al.	2017	Sweden	Research site (clinical setting)
29	Packman, J & Bratton, S.C.	2003	USA	Special needs school
30	Ratcliffe, M., et al.	2014	Australia	Mainstream school
31	Ratcliffe, M., et al.	2019	Australia	Mainstream school
32	Schohl, K.A., et al.	2014	USA	Research site (clinical setting)
33	Shashi, V., et al.	2015	USA	Research site (university setting)
34	Shechtman, Z & Katz E.	2007	Israel	Mainstream school
35	Soorya, L.V., et al.	2015	USA	Research site (community setting)
36	Tanksale, R., et al.	2021	Australia	Research site (clinical setting)
37	Willemin, T., et al.	2018	Germany	Research site (community setting)
38	Yamada, Y., et al.	2020	Japan	Mainstream school
39	Yang; J. L., et al.	2003	Taiwan	Mainstream school

Appendix G

Table G1

Details of Informants and Measures Used in Each Paper

ID	Author	Constructs	Measures used/respondents	Measure type
1	Adibseresnki, N., et al.	Communication skills	Vineland Adaptive Behaviour Scale (parent)	Standardised
		Socialisation skills	Vineland Adaptive Behaviour Scale (parent)	Standardised
		Daily living skills	Vineland Adaptive Behaviour Scale (parent)	Standardised
		General adaptive skills	Vineland Adaptive Behaviour Scale (parent)	Standardised
2	Antshel, K. M., & Remer, R.	Social skills	Social Skills Responsiveness Scale (Parent and child)	Standardised
3	Babinski, S. M., et al.	Social functioning	Social Skills Responsiveness Scale (Parent)	Standardised
			Impairment scale for Children (Parent)	Standardised
			Self-perception profile for children/adolescence (child/adolescent)	Standardised
		Psychopathology	Screen for Child Anxiety Related Emotional Disorders (Parent and Child)	Standardised
			Short Mood and Feelings Questionnaire (Parent and Child)	Standardised
			Borderline Personality Scale for Children (Parent and Child)	Standardised
4	Beaumont & Sofronoff	Social Skills/ emotion regulation	Social Skills Questionnaire (Parent and Teacher)	Standardised
			Emotion Regulation and Social Skills Questionnaire (Parent and Teacher)	Author derived
		Emotion recognition	Assessment of Perception of Emotion from Facial Expression (Child)	Standardised
			Assessment of Perception of Emotion from Posture Cues (Child)	Standardised

		Social problem solving	James and the maths test and Dylan is being teased (child rated)	Standardised
5	Beaumont, C., et al.	Social Skills/ emotion regulation	Social Skills Questionnaire (Parent and Teacher) Emotion Regulation and Social Skills Questionnaire (Parent and Teacher) Qualitative Thematic Analysis	Standardised Author derived
		Internalising/externalising behaviours	The Spence's Anxiety Scale (Parent scale) Child Adjustment and Parent Efficacy Scale- Developmental Disability (Parent and Teacher)	Standardised Standardised (Teacher version derived for study)
		Social problem solving	James and the maths test and Dylan is being teased (child rated)	Standardised
6	Dean, J., et al.	Social engagement	Teen Observation of Peer Interaction (Researcher)	Standardised
		Social skills	Social Skills Improvement System (Teacher and Child)	Standardised
		Internalising/externalising behaviours	Behaviour Assessment for Children (Child)	Standardised
		Social Stress	Behaviour Assessment for Children (Child)	Standardised
		Interpersonal relationships	Behaviour Assessment for Children (Child)	Standardised
7	Deckers, A., et al.	Social Skills	Social Skills Observation (Parent and Teacher)	Standardised
		Loneliness	Loneliness and Aloneness Scale for Children and Adolescence (Child)	Standardised
8	DeRosier, M.E., et al.	Social Skills	Social Responsiveness Scale (Parent) Achieved Learning Questionnaire (Parent)	Standardised Author derived
		Social Self-Efficacy	Self-efficacy scale (parent and child)	Standardised
		Loneliness	Social Dissatisfaction Questionnaire (child)	Standardised
9	Drüsedau, A., et al.	ASD symptomology	Social Reactivity Scale (Parent)	Standardised Standardised

			Strengths and Difficulties Questionnaire (parent) Child Behaviour Checklist (Parent)	
		Quality of Life	Inventory for Assessment and Quality of Life for Children and Adolescence (Parent)	Standardised
		Internalising/externalising behaviours	Depression Inventory for Children and Adolescence (Parent)	Standardised Standardised
10	Einfeld, R., et al.	Social Skills	Social Skills Questionnaire (Parent and Teacher)	Standardised
		Emotion Regulation	Emotion Regulation and Social Skills Questionnaire (Parent and Teacher)	Standardised
		Social problem solving	James and the maths test and Dylan is being teased (child rated)	Standardised
11	Faria, S.M.M., et al	Emotion Understanding	Test of Emotional Comprehension (TEC) (therapist)	Standardised
12	Guivarch, V., et al.	Social Skills	Social- Emotional Profile (therapist)	Standardised
		ASD symptomology	Childhood Autism Rating Scale (Therapist)	Standardised
		Emotional empathy	Empathy Quotient (Parent)	Standardised
13	Habayeb, B., et al.	Internalising/externalising behaviours	Behaviour Assessment System for Children-2 (Parent)	Standardised
		Social skills	Social communication questionnaire (Parent)	Standardised
		ASD symptomology	Social responsiveness scale (impairments-(parent)	Standardised Standardised
		Emotion regulation	How I feel questionnaire (child)	Standardised
14	Hill, T. L., et al.	Social Skills	Social Skills Improvement System (Parent)	Standardised

			Test of Adolescent Social Skills knowledge (child)	Developed by original authors of Peers (Laugeson et al.,2009)
		Internalising/externalising behaviours	Screen for Child Anxiety Related Emotional Disorders (Child) Social Skills Improvement System (Parent)	Standardised Standardised
		ASD symptomology	Social Responsiveness Scale (Parent) Social Skills Improvement System (Parent)	Standardised Standardised
		Social Interaction quality	Quality of play questionnaire (parent and child)	Developed by original authors of Peers (Laugeson et al.,2009)
15	Ip; S. W. L., et al.	Emotion Recognition	Face and Eyes test (child)	Standardised
		Social Interaction/emotion expression and regulation	Psychoeducational Profile- Third Edition (child)	Standardised
		Adaptive functioning	Adaptive Behaviour Assessment System- II (parent)	Standardised
16	Jonsson, U., et al.	Social Skills	Social responsiveness scale (parent and teacher)	Standardised
		ASD symptomology	Autism Clinical Global Impression Scale (trainer) Developmental Disabilities -Children Global Assessment Scale (trainer)	Standardised Standardised
		Adaptive functioning	Adaptive Behaviour Assessment System- II (parent and teacher)	Standardised
		Stress	Stress in children (child) Perceived stress scale (parent)	Standardised Standardised
17	Kasari, C., et al.	Social network salience	The Friendship Survey (child)	Standardised
		Social engagement	Playground Observation of Peer Engagement (researcher)	Author derived
18	Laugeson, E.A., et al. 2009	Social functioning/social skills	Social Skills Rating System (parent and teacher)	Standardised Author derived

			Test of Adolescent Social Skills knowledge (child)	
		Internalising/externalising behaviours	Social Skills Rating System (parent and teacher)	Standardised
		Social Interaction quality	Quality of Play questionnaire (parent and child) Friendship quality scale (child)	Author derived Standardised
19	Laugeson, E.A., et al. 2012	Social skills	Social Skills Rating System (parent and teacher) Test of Adolescent Social Skills knowledge (child)	Standardised Developed by original authors of Peers (Laugeson et al.,2009)
		Internalising/externalising behaviours	Social Skills Rating System (parent and teacher)	Standardised
		ASD symptomology	Social Responsiveness Scale (parent and teacher)	Standardised
		Social Interaction quality	Quality of Play questionnaire (parent and child)	Developed by original authors of Peers (Laugeson et al.,2009)
20	Laugeson, E.A., et al.2014	Social skills	Social Skills Rating System (parent and teacher) Test of Adolescent Social Skills knowledge (child)	Standardised Developed by original authors of Peers (Laugeson et al.,2009)
		Internalising/externalising behaviour	Social Skills Rating System (parent and teacher) Social Anxiety Scale (child)	Standardised Standardised
		ASD symptomology	Social Responsiveness Scale (parent and teacher)	Standardised
		Social Interaction quality	Quality of Play questionnaire (parent and child) Friendship quality scale (child)	Author derived Standardised

		Self-esteem	Piers Harris Self Concept Scale 2nd Edition (child)	Standardised
21	Laxman, K.	Wellbeing	Qualitative- no measures used	Author derived
22	Lordo, M., et al.	Emotion recognition	NEPSY- II (affect recognition only- researcher)	Standardised
		Emotion regulation	Emotion regulation index for children and adolescence (child)	Standardised
		ASD symptomology	Gilliam Autism Rating Scale- third edition (parent) Adaptive Behavioural Assessment System-second edition (parent)	Standardised
		Internalising/externalising behaviours	Positive and Negative affect schedule for children (child and parent) Behaviour assessment system for children-second edition (parent)	Standardised Standardised
23	Mackay, T., et al.	Social skills	Spence Social Skills Questionnaire (Parent and child) The three things (parent)	Standardised Author derived
		Social Competence	Social Competence with peers (parent and child)	Standardised
24	Marino, P., et al.	Emotional understanding	Test of emotional comprehension (researcher) Emotional Lexicon Test (researcher)	Standardised Standardised
25	O'Connor & Stagnitti.	Social interactions	Penn interactive peer play scale (teacher)	Standardised
26	O'Handley, R. D., et al.	Social functioning	The Autism Social Skills Profile (teacher rated)	Standardised
		Social Skills	Researcher recorded- no measures	Author derived
27	Olsson, N.C., et al. 2016	Social skills	Qualitative- no measures used	Author derived interview
28	Olsson, N.C., et al. 2017	Social skills	Social responsiveness scale (parent and teacher)	Standardised
		ASD symptomology	Autism Clinical Global Impression Scale (trainer)	Standardised Standardised

			Social responsiveness scale (parent and teacher)	
		Adaptive functioning	Adaptive Behaviour Assessment System- II (parent and teacher) Developmental Disabilities -Children Global Assessment Scale (trainer)	Standardised Standardised
		Stress	Stress in children (child) Perceived stress scale (parent)	Standardised Standardised
29	Packman, J & Bratton, S.C.	Internalising/externalising behaviours	Behaviour assessment system for children-second edition (parent) Child Behaviour Checklist (Parent) Qualitative feedback	Standardised Standardised Author derived questions
30	Ratcliffe, M., et al. 2014	Social Skills	Social Skills Improvement System (parent and teacher)	Standardised
		Emotional competence	Emotions development questionnaire parent and teacher)	Developed by original authors of EBSST (Wong et al., 2010)
		Psychopathology	Strengths and difficulties questionnaire (parent and teacher)	Standardised
31	Ratcliffe, M., et al. 2019	Social Skills	Social Skills Improvement System (parent and teacher)	Standardised
		Emotional competence	Emotions development questionnaire (parent and teacher)	Developed by original authors of EBSST (Wong et al., 2010)
		Psychopathology	Developmental behaviour checklist (parent and teacher)	Standardised
32	Schohl, K.A., et al. 2014	Social skills	Social Skills Rating System (parent and teacher) Test of Adolescent Social Skills knowledge (child)	Standardised Developed by original authors of Peers (Laugeson et al.,2009)

		Social Interaction Quality	Quality of Socialisation Questionnaire (parent and child) Friendship quality scale (child)	Author derived Standardised
		ASD symptomology	Social Responsiveness Scale (parent and teacher)	Standardised
		Social Anxiety	Social Interaction Anxiety Scale (child)	Standardised
33	Shashi, V., et al. 2015	Social cognition	Mayer- salovey- caruso emotional intelligence test youth (MSCEIT-YV) (researcher) Diagnostic analysis of nonverbal accuracy (DANVA) (researcher)	Standardised Standardised
		Social functioning	Global functioning- social (researcher) Social Skills Responsiveness Scale (researcher)	Standardised Standardised
		Adaptative functioning	Adaptive Behaviour Assessment System- II (researcher)	Standardised
34	Shechtman, Z & Katz E.	Social Competence	Adolescent Interpersonal Competence Questionnaire (child) Qualitative Interview	Standardised Author derived
		Friendship intimacy	Intimacy in friendship scale (child)	Standardised
		Relationship quality	Working alliance inventory (child) Qualitative Interview	Standardised Author derived
35	Soorya, L.V., et al.	Social behaviour	Social Responsiveness Scale (parent) Children's Communication Checklist (Parent)	Standardised Standardised Standardised
		Emotion competence	Diagnostic analysis of non-verbal accuracy-2 (researcher) Griffith Empathy Measure (parent) Strange Stories test (child) The Eyes Test (child)	Standardised Standardised Standardised
36	Tanksale, R., et al.	Executive functioning (regulation)	Behavior Rating Inventory of Executive Function–Second Edition (parent)	Standardised

		Sleep habits	Children's sleep habit questionnaire (parent)	Standardised
		Psychopathology	Anxiety Scale for Children- ASD parent version (parent and child)	Standardised
		Emotional competence	Emotion awareness questionnaire (child)	Standardised
37	Willemin, T., et al.	Mood rating	Positive and Negative affect schedule for children (parent) The Fun Toolkit; Smiley/Fun o meter (children)	Standardised Standardised
		Pro-social behaviours	Social and Personal relationship scale (observations- researcher)	Author derived
38	Yamada, Y., et al.	Social Skills	Test of Adolescent Social Skills knowledge (child)	Author derived
		ASD symptomology	Social Responsiveness Scale (Parent) Social Communication Questionnaire (parent)	Standardised Standardised
		Social Interaction Quality	Quality of play questionnaire (parent and child)	Standardised
		Adaptive Functioning	Vineland Adaptive Behaviour Scale (parent)	Standardised
		Internalising/externalising behaviour	Child Behaviour Checklist (Parent) Depression self rating scale for children (child)	Standardised Standardised
39	Yang; J. L., et al.	Social skills	Behaviour record form (Teacher)	Author derived

Appendix H

Table H1

Changes identified following the pilot study and the adaptations made following discussion with the research group

Changes identified	Adaptations made
Continue to create a safe space for young people to aid self-disclosure	Agreed to add an icebreaker at the beginning to create a sense of unity (i.e. human web task) Use 'objects' to help externalise worries (i.e. using a character to explore worries rather than identifying them as their worries). Sticky notes for any discussions that are collected and read out by facilitator-handwriting not identifiable
Discussing mental health as a spectrum was found to be helpful for young people	Kept this description and activities
Focusing on specific mental health disorders can lead to overidentification	Removed anxiety and depression topics, and shifted to generalisable knowledge of mental health. Discussed worry rather than anxiety. We are not focusing on students who potentially have depression/anxiety therefore it is important to keep the sessions general about building mental health literacy/insight/awareness and building skills of wellbeing, rather than specifics.
Use of language	Change from thinking positively to challenging thoughts
Steps to wellbeing was particular helpful	Added link to discuss around worry and how it may help
Overall flow of sessions didn't work	Adapted it to mental health first session, wellbeing second and linking it back to what had been learnt during the initial session.

Appendix I

Figure I1

Screenshot of Approval for Application to Use

[redacted] [redacted]

Application for Ethical Review ERN_19-1520AP14

Samantha Waldron (Research Support Services)

Fri 06/08/2021 11:24

To: Kate Woodcock (Psychology) [redacted]

Cc: Sally Reynard (PhD Psychology Lab FT) [redacted] Pedro Rodrigues [redacted]

Dear Dr Kate Woodcock & Dr João Dias,

Re: "Evaluation of Social and Emotional Wellbeing Interventions"
Application for Ethical Review ERN_19-1520AP14

Thank you for the above application to use Programme of Work ERN_19-1520P. This has now been considered by the Science, Technology, Engineering and Mathematics Ethical Review Committee.

On behalf of the Committee, I can confirm a favourable ethical opinion for this application.

I would like to remind you that any substantive changes to the nature of the study as described in the Application for Ethical Review, and/or any adverse events occurring during the study should be promptly brought to the Committee's attention by the Principal Investigator and may necessitate further ethical review.

Please be aware that whilst Health and Safety (H&S) issues may be considered during the ethical review process, you are still required to follow the University's guidance on H&S and to ensure that H&S risk assessments have been carried out as appropriate. For further information about this, please contact your School H&S representative or the University's H&S Unit at healthandsafety@contacts.bham.ac.uk.

If you require a hard copy of this correspondence, please let me know.

Kind regards

Ms Sam Waldron (she/her)

[redacted]

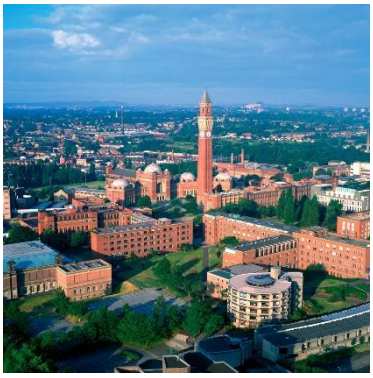
Please remember to submit a new Self-Assessment Form for each new project. Click Ethical Review Process for further details regarding the University's Ethical Review process.

Click Research Governance for further details regarding the University's Research Governance and Clinical Trials Insurance processes, or email researchgovernance@contacts.bham.ac.uk with any queries

Appendix J

Information Sheet for Evaluation of Social and Emotional Wellbeing Interventions Study

We are researchers from the School of Psychology, University of Birmingham.



Alexandra Hosking (Ali) is leading the study.

They are completing their research in the Kate Woodcock Research Group at the university. Kate Woodcock is the Director of the Research Group. She works at the university doing research and teaching students.

The aim of our study is to work with lots of different people such as young people, teachers and professionals to help us to create new ways of testing and helping to improve different thinking and emotional skills in young people.

We want you to engage with a lesson that teaches children and teenagers about social skills, mental health and wellbeing, and controlling emotions. After this we want to find out what you thought about them and how you felt.

What happens if you decide to take part?

Your participation is entirely your choice. If you choose to take part, we will ask you to participate in three sessions; one discussing your thoughts on moving to secondary school, and then two focusing on mental health and wellbeing. Then we will ask you to do an **Individual interviews**. We will talk to you about thoughts/feelings/experiences, either face-to-face, by telephone or by Zoom. This will not take longer than 45 minutes.

Important information:

- It is up to you whether you want to take part or not.
- If you take part, you will be helping us to help other young people in future.
- The activities you take part might help you to think and learn about ways that you can cope with difficult thoughts and feelings.
- Some of the issues discussed may cause you to experience some uneasiness or negativity. Sessions may ask you to think about topics such as mental health, friendships, and difficult scenarios. It is important that you only take part in the activities that you are happy to do so.
- If you decide you want to take part but then change your mind, that's OK! Just tell us or your parents/caregivers.
- If you change your mind, you can tell us to throw away the information you have given us. You can only ask us to throw away the information up to 1 week after you do take part in the study. But if you took part in a group, we cannot throw away that information because we can't separate it from the information we got from other people in the group.
- If you take part, only us and the people you tell will know that you have taken part.
- We will use the information from the results of the study to write reports for other people, but your name will not be in the reports.

- Some research activities may be recorded. This recording may be temporarily saved outside the European Union. Once we have finished our activity, we will download the recording immediately and save it to our server at the University of Birmingham, where it is safe and secure. We will then delete the sound from where it is saved online.

- We can keep most things confidential; this means that we will not share things with other people unnecessarily. The only exception to this is if we hear about something that suggests that a child is at risk. If this happens, we have a duty to inform someone.

- It's important to remember that although most of the information you give us is confidential, we cannot guarantee in a group discussion that your contribution is kept private, please make sure that you only discuss issues you feel comfortable with other people knowing about.

If you have any questions, just telephone or email us [redacted] (Ali) or [redacted].

Keeping in touch

If you would like us to let you know about other studies we do in the future, you can tell us you are happy for us to keep your name, address, email and phone number. But if you change your mind at any time, you can ask us to throw these away.

If you want to take part, please complete the consent form or email us, or ask your parent or guardian to help you with this.

Appendix K

Parent/Caregiver/Guardian Information Sheet for Evaluation of Social and Emotional Wellbeing Interventions Study

We would like to invite your child to participate in the Evaluation of Social and Emotional Wellbeing Interventions Study, affiliated with the University of Birmingham, School of Psychology. The research is led by Alexandra Hosking (Ali: Trainee Clinical Psychologist) and Dr Kate Woodcock, senior lecturer at the university's Psychology department.

Should you have any questions or require further information, please contact the Kate Woodcock Research Group on [redacted] or Ali Hosking directly on [redacted].

Aims

All of the work at KWRG aims to better understand some of the problems faced by young people and their caregivers. We aim to create and test strategies and tools designed to reduce these problems. To make the strategies and tools as useful as possible it is extremely important for us to work closely with the people that we are developing them for.

Difficulties in emotional control in early life have been linked to poor socio-emotional functioning and psychological wellbeing in adulthood. As part of the Evaluation of Social and Emotional Wellbeing Interventions Study, we wish to ask participants to engage with, and discuss opinions related to: **classroom-based social emotional learning activities.** This will consist of three sessions: one exploring their thoughts on moving to secondary school, then two psychoeducational session focusing on mental health and resilience.

We aim for the components that we will evaluate in this study to help young people improve their wellbeing, emotion control abilities, and social competencies. The evaluative information we gather will be used to further develop the initiatives.

Where will the research take place?

The research will take place at your child's school and possibly via online platforms (such as Zoom). You will be contacted by the researchers to arrange a time for the interviews.

Who will be involved in collecting the data?

Dr Kate Woodcock, members of the research team at the University of Birmingham, and collaborators from international universities, including Alexandra Hosking, Alison Fulop, Alexander Topic, Claudia Pushpanathan, Grace Burden and Michaela Pawley.

What will we ask you to do during the study?

Your participation is entirely voluntary. We will ask your child to participate in one of the following:

1. **Individual interviews**: We will talk to your child about their experiences either face-to-face, by telephone or Zoom. This will not take longer than 45 minutes.

2. **Focus groups:** We will invite your child to group discussions at the University and/or via webinar. The groups will focus on the design of the tools we are evaluating. Each focus group should not take longer than 45 minutes.

Depending on the circumstances nationally and locally, we may ask your child to take part in these activities at school or at home using the internet.

We are also providing your child with an information sheet with a child information sheet, explaining the purpose and the aims of this research. Please read this information to your child and discuss the study with them to ensure that they understand and are happy to take part in this research.

What kinds of information will be recorded and what will we do with it?

1. Name and contact details

We will keep name and contact details until the end of the study. After this time, we will destroy this information unless you ask us not to.

When entering the study, we will give your child a unique participant number. We will use this number to identify all of the information we collect from your child. The only link between this number and your name will be stored securely at the University of Birmingham. This means that after the study has ended we can make sure that most of the information we have collected is made anonymous.

We will also keep your name and contact details on the written consent you will be asked to provide us with. We will keep an electronic copy of this securely for 10 years.

2. Sound recordings

Some research activities will be recorded. These recordings will not be linked to the other information we collect from you and your child. This recording may be temporarily saved on the servers linked to Zoom which might be outside the European Union. Once we have finished our activity, we will download the recording immediately and save it to our server at the University of Birmingham, where it is safe and secure. We will then delete the sound from the online server. We will keep these securely at the University until we have transcribed them. The University of Birmingham will hold the copyright for these recordings.

3. Other information

All other information we collect will only be linked to you or your child by the unique participant number. We will use this information to publish reports and present at conferences. However, it will be published in an anonymous way and it will not be possible for anyone to trace this information to you or your child.

Are there any risks that individuals taking part in the study might experience?

Some of the issues discussed may cause your child to experience some uneasiness or negativity. Sessions may ask your child to consider topics such as mental health, friendships, and difficult scenarios. It is important that they only take part in the activities that you feel are appropriate for your child and would not cause too much upset.

What are the potential benefits for participants for taking part?

There are no direct beneficial effects for participants of this research. However, research activities are designed to bring about reflective discussion of adaptive coping mechanisms to maintain good mental health. Teachers and parents taking part in groups may gain additional insights and benefit from sharing experiences in supporting youth.

Ultimately, we hope that the outcomes of this research will lead to improved assessment and intervention tools that benefit young people from a wide variety of backgrounds.

If your child participates, what will happen after that participation?

We expect to have finished with our data collection procedure by April 2023. Thereafter, you will receive a report detailing outcomes of this research. If we pursue further steps with developed assessment/intervention materials, you can request that we keep you updated about further research activities.

Confidentiality

For people who take part in groups, we will encourage group members to keep anything shared with the group confidential, but we cannot guarantee that.

It will be possible to identify your child from the sound we take. But we will only use these recordings indirectly in our analyses, for example by categorising what was said and/or done.

All other information we collect will be in written form and will only be linked to you or your child with your unique number, so it will be confidential.

It is important to note a possible exception to confidentiality in line with the University's Child Protection Procedures. If researchers have any concerns about the welfare of children they have a duty to disclose this to the University's Child Protection Officer. Confidentiality may be broken to ensure children's safety.

Consent

If you wish to receive any further information about this research before deciding upon participation, please contact a member of the research team. We will be happy to discuss the information provided in this sheet or answer any further questions.

If you decide that your child will participate in this research, you will be asked to provide your consent in writing. In case of your child's participation, you will need to ensure that your child is happy to take part. We will ask your child to verbally assent following your consent to participate. It is important that you make sure your child understands the purpose and procedures of this research as far as possible given their age and level of cognitive development. They should have given you reason to believe they are happy to participate.

Withdrawal

Your child can withdraw from the programme at any point, without being asked to provide any information why you wish to do so. Even after providing consent, your child can decide to stop participating at any time. **However, due to the nature of group activities, you cannot ask us to destroy information we have collected from focus groups because this will be inseparably linked to other information we will be using in an ongoing way to develop intervention materials.** For any other type of information (e.g. questionnaire responses, individual interviews), you can ask us to destroy this up to 1 week after data collection. Later than that, it will no longer be possible to erase your data, as we will have started using your data for our analyses.

What are the consequences of withdrawing?

If your child wishes to withdraw, there are no consequences for you or your child. This will not affect your eligibility for any treatment or education programme.

Compensation

You will be reimbursed for any expenses incurred as a result of your participation (e.g. travel expenses).

What if there is a problem?

Should you encounter any difficulties, or have further questions, please contact the Kate Woodcock Research Group on [redacted] or Kate Woodcock at [redacted] or the Research Governance Team on researchgovernance@contacts.bham.ac.uk for assistance.

Review

The programme of work has been approved by the Research Ethics Committee at the University of Birmingham.

Further information

Please contact the Kate Woodcock Research Group on [redacted] or Kate Woodcock directly on [redacted]

Ongoing research participation database

If you have no interest in hearing about future research we are doing, there is no need to read any further.

If you are interested in hearing about future research we are doing that we think might be relevant for you, you can provide your consent for us to keep your contact details after the end of the study. We would only use these details to contact you about other research that we do in future, which we think may be relevant for you. Every time we contact you we would check that you are still happy for us to keep your contact details, and if you are not happy with this we would destroy them. You could also contact us at any time and ask us to destroy your contact details. We would keep your contact details securely at the University of Birmingham.

Appendix L

Figure L1

Young People Assent (completed verbally)

Study Director: Dr Kate Woodcock

Please fill in this form if you want to take part in our research and you have told your parent(s). Please circle the YES or NO to answer each question.

1	Have you read the information about our research or asked someone else to read it to you?	YES NO
2	Do you understand what the project is about?	YES NO
3	Have you asked all of the questions you want?	YES NO
4	Has someone answered all your questions so that you understand the answer?	YES NO
5	Do you know who you should ask if you think of any more questions?	YES NO
6	Do you understand that it is up to you if you take part or not, and that nobody else can decide for you?	YES NO
7	Do you understand that even if you tell us you want to take part now, you can still change your mind and stop?	YES NO

8	Do you understand that we will be recording during group discussions and interviews, to record the conversation?	YES NO
9	Do you understand that we will use the information we have collected to write reports and tell other people about what we have found, but the information we share will not contain your name?	YES NO
10	Are you happy to take part?	YES NO

Figure L2

Parent/ Guardian Consent Forms

Study Director: Dr Kate Woodcock

[redacted]

Please initial box to indicate your agreement with the following statements.

1	I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2	I understand that my participation and that of my child is voluntary and that I am free to stop completing the assessments at any time, without my or that of my child's medical care or legal rights being affected.	
3	I understand that my child's data will be recorded either during a face to face interview/focus group, or recorded on Zoom before being uploaded to the University of Birmingham data storage systems	
4	I understand that if I do withdraw, I cannot request that information collected from my participation in any focus groups or workshops is destroyed.	

5	I understand that if I do withdraw, I can request that information collected, other than that specified in item 3, is destroyed. I have up to 1 week from when this information is collected to request that it is destroyed.	
6	I understand that information I provide during focus groups and workshops will be immediately available to other members of the group and it cannot be guaranteed that this will be kept confidential.	
7	I understand that all data except that provided in focus groups and workshops will be kept confidential throughout the study.	
8	I understand that following the end of the study, data may be shared with other researchers in anonymous form (so it cannot be linked back to me or my child).	
9	I agree to take part in this research.	

Please only sign this form after you have initialled all of the boxes to indicate that you agree with the statements on the previous page

Name (please print): _____

Address: _____

_____

Mobile telephone number: _____

Email address: _____

Relationship to child I care for: _____

Signature: _____

Date: _____

Email or text consent protocol for parents/guardians

Alternatively, the following email may be sent to parents to obtain consent:

Dear [name of parent],

Thank you for your interest in this research project with the University of Birmingham.

For more information about the project and what that would entail for you and your child, please read the caregiver information sheet and consent form sent to you. Please don't hesitate to contact us if you have any questions about the study.

If you would like to provide your consent to take part, but you would prefer to do this via email instead of signing the form and returning it to us, please copy and paste the consent statement below:

"I confirm I have read the information sheet and consent form about this research and I consent to take part".

[include if children will be involved] We have also provided a child information sheet. As your child will also be involved in the research activities, we also require their consent to take part. Please use this sheet to help explain the research to your child. If your child is happy to take part in the research, please include the following statement in your response to this email:

"*I can confirm I have explained the research to my child as far as is appropriate given their age/understanding, and to the best of my knowledge, they are happy to take part".*

Finally, please tell us whether you would be willing for us to keep your contact details after the end of the study using the following statement (deleting as appropriate):

"I would/ would not be willing for you to keep my contact details after the end of the study."

When we receive a response to this email with these statements, we can use this as your official consent and your child's assent to take part in the study.

Again, if you have any questions, please get in touch.

We look forward to hearing from you in due course.

Kind regards,

Alexandra Hosking
Trainee Clinical Psychologist

Dr Kate Woodcock
Senior Lecturer,

Appendix M

Materials for the sessions

Figure M1

Manual for the Mental Health Session

Session Aims:

- Build mental health literacy
- Reduce stigma
- Inform about Worry
- Promote help-seeking behaviour
- Identify social resources

  Inform about support services

Activity 1:
Icebreaker

This activity will help the children become more comfortable to begin discussing the topic of mental health with each other.

Activity aims:

- Allow the children to get to know the session leaders and vice versa
  Break the barriers to conversation

Materials

- Hand Sanitiser
- No materials required

1 Gather the group to play the Human Web 1 minute

The ideal number of players for this game is 8 - 20, though this game can be played with as few as four people

2 Explain the rules 2 minutes

Players must circle up and join your hands together to form a human knot out of your arms. The goal of the game is to untangle without letting go of the hands players are holding. After untangling, players will be standing once again in a regular circle, without any joined hands in the middle.
Game can be made more challenging by adding a timer.

3 Knot all players together by joining hands 2 minutes

Circle up with the rest of the players so that each person is standing closely to the next. Player will to have to reach across the circle to form your human knot, so with large groups of people you may have to scrunch together tightly. After you're in your circle, reach out and hold hands with two different people in the circle, excluding the two people to either side of you. Each left hand should hold a left hand, and each right hand a right.

Although it's against the rules to let go of the hands you are holding while playing the game, you may have to readjust your grip at some point. You'll likely have to bend and twist to untangle. Readjusting your grip is perfectly acceptable for players to be more comfortable while playing

4 Inspect the knot you have formed 4 minutes

Communicate with the other players in your Human Knot to figure out where to begin untangling. You and the other players should be ready to bend, twist, and move in any way that is required for untangling your knot. You may find you or others need to duck under the hands of other players, step over a pair of hands, or do similar moves to untangle your knot.
You'll notice, as your knot becomes untangled, that a circle will start to form. Some people may end up facing the inside of the circle, some the outside, but by the time you've finished untangling, you should have an unbroken circle of joined hands.
Congratulations! You've untangled the Human Knot!

Activity 2 - Introduction to mental health — 15 minutes

This activity will encourage children to explore and challenge their understanding of and attitudes towards mental health.

Activity aims:

- Introduce mental health
- Encourage children to consider their understanding of and attitudes towards mental health
- Discuss mental health as a spectrum
- Challenge misconceptions and negative attitudes

Materials

- Whiteboard/blackboard
- Whiteboard pen/chalk
- Sticky notes
- Pens/pencils

1 Opening the session — 2 minutes

Introduce the session. Inform pupils that they will be learning about mental health. Outline that this can be a sensitive topic which can bring up lots of different emotions. Provide children with a course of action should they begin to experience any distress or should they no longer wish to take part in the session.

2 Defining mental health — 4 minutes

Write 'poor mental health' on one side of the board and 'good mental health' on the other.

Provide each pupil with two sticky notes. Ask pupils to write down what they think poor mental health is on one sticky note, and what they think good mental health is on the other. Let pupils know that they may write one word or a whole sentence, and that their thoughts may be positive or negative. Ask pupils to come up to the front of the room and stick their sticky notes next to the corresponding term once they have done this.

As pupils are sticking their sticky notes on the board, draw a line with arrows between the two terms and write the following adapted definitions [1] near to the corresponding term.

Poor mental health
Changes to the way someone is thinking, feeling, or behaving, that causes them upset or problems in their relationships, work, or at school.

Good mental health
Managing daily life well, having good relationships, and being able to cope with difficulties and adapt to change.

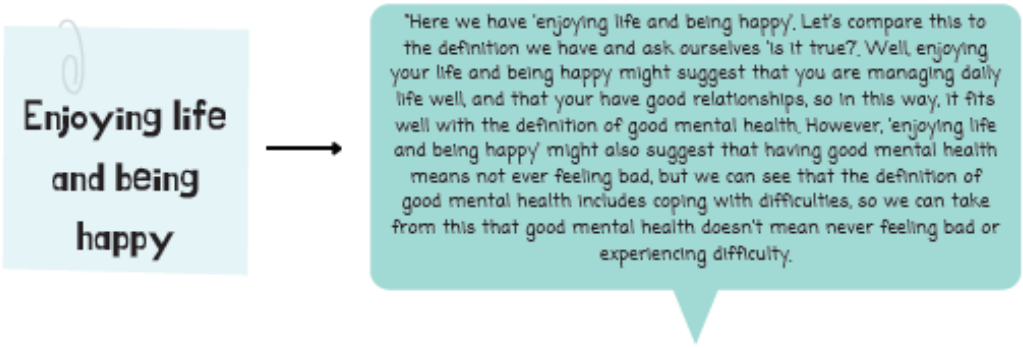
Your board should now look something like this:

1. APA. (2018, August). *What is mental illness?* https://www.psychiatry.org/patients-families/what-is-mental-illness#:~:text=Mental%20illnesses%20are%20health%20conditions,Mental%20illness%20is%20common.

3 Class discussion — 9 minutes

Begin comparing the suggestions from the class to the definitions written on the board.

Read out one of the two definitions to the class (either poor mental health or good mental health) and ask the class to start thinking about how well they think the sticky notes on the board fit with the definition, by asking the question, 'is it true?'. Work through one sticky note as an example.
For example:



Then, pick out another sticky note and ask the class how well they think this sticky note fits with the definition and in what way they think it fits or does not fit with the definition, through asking themselves the question, 'is this true?'. Complete this with a number of sticky notes. Then, move on to the second term (either good mental health or poor mental health), and repeat.

Summarise that mental health is all about how we are thinking, feeling, and behaving. Introduce mental health as a spectrum. People do not either have poor mental health or good mental health, but can be anywhere on the line between the two. Where someone is on this line is not fixed, we all move up and down this line throughout our lives.

Introduce stigma. Sometimes people can have beliefs about what it means to have poor mental health that aren't true (you may have observed this in the current activity). Sometimes these beliefs that aren't true can be negative. Thinking negatively towards people with poor mental health, using words that match these negative thoughts (words which are hurtful or dismissive), and treating people differently because of these thoughts, is called stigma [2, 3].

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2. Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*(7), 614-625. https://doi.apa.org/doi/10.1037/0003-066X.59.7.614
3. Mind. (2017, October). *Mental health problems – an introduction. How can I deal with stigma?* https://www.mind.org.uk/information-support/types-of-mental-health-problems/mental-health-problems-introduction/stigma-misconceptions/

Activity 3 - Mental health quiz 10 minutes

This activity is an opportunity for children to work in groups to increase their knowledge of mental health and to challenge any misconceptions or negative attitudes they may have. Group work allows learners to exchange information, which enhances the learning experience [4].

Activity aims:

- Increase knowledge and awareness of mental health
- Encourage children to consider their understanding of and attitudes towards mental health
- Challenge misconceptions and negative attitudes (stigma)

Materials

- 'Mental Health Quiz' sheets
- Pens/pencils
- 'Mental Health Quiz Answer Sheet'

1 Introducing the activity and setting up 3 minutes

Introduce the activity (see above). Place children into groups of about three or four, being conscious not to place bullies in groups with victims. Hand out one 'Mental Health Quiz' sheet per group and give pupils and moment to decide on a team name.

2 Mental health quiz 3 minutes

Before starting the quiz, inform pupils that some questions are true or false questions, and that for these questions, there is only one right answer; inform pupils that the rest of the questions are multiple choice questions (a, b, c) and that for these questions, there may be more than one correct answer.

Read out the quiz questions to the class. Give pupils about 20 seconds after each question to discuss the question in their groups and to decide upon an answer.

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4. Webb, N. M. (1995). Group collaboration in assessment: Multiple objectives, processes, and outcomes. *Educational Evaluation and Policy Analysis, 17*(2), 239-261.

3 Marking the quiz and class discussion 4 minutes

Ask pupils to swap their quiz sheets with another group in the class.

Read out the answers to each question using the 'Mental Health Quiz Answer Sheet'. Allow one mark for each correct answer; two marks are available for Question 2, in which two of the three answers are correct, and three marks are available for Question 6, in which all answers are correct.

Ask pupils to swap their quiz sheets back and ask each group in turn whether there were any answers that they were surprised by (what did their group answer and why did they choose this; what was the correct answer and why did this surprise them; where does this come from). Allow for discussion as a class.

Mental Health Quiz

Team Name: ..... /11

How many people in England who are between 5 and 19 years of age experience problems with their mental health?

a) 1 in 4
b) 1 in 8
c) 1 in 12

True or false - girls are more likely to experience problems with their mental health than boys.

a) True
b) False

Which of these are types of mental health problems?

a) Depression
b) Schizophrenia
c) Migraine

True or false - people with mental health problems are likely to be dangerous or violent?

a) True
b) False

Which of these is the best description of Obsessive Compulsive Disorder (OCD - a type of mental health problem)?

a) People with OCD just like things to be neat and tidy
b) People with OCD have a difficult relationship with food
c) People with OCD have unwelcome thoughts which appear in their minds and have repetitive activities that they do to help with these thoughts

Mental Health Quiz

Which of these famous people have experienced problems with their mental health?
a) Demi Lovato
b) Zayn Malik
c) J K Rowling

True or false - it is impossible to recover from a mental health problem.
a) True
b) False

How long do the majority of people with a mental health problem wait before telling their closest family and friends about it?
a. 2 months
b. 7 months
c. Over a year

How many people with mental health problems are negatively affected by stigma?
a) 2 out of 10
b) 5 out of 10
c) 9 out of 10

What proportion of people with mental health problems reported stigma affecting their friendships?
a. 15%
b. 44%
c. 65%

Mental Health Quiz Answer Sheet

1. How many people in England who are between 5 and 19 years of age experience problems with their mental health?[5]

a) 1 in 4
→ b) 1 in 8
c) 1 in 12

2. True or false - girls are more likely to experience problems with their mental health than boys.

a) True
→ b) False

Overall, a similar number of boys and girls between the ages of 11 and 16 experience problems with their mental health [5, 6]. However, research has found differences in the types of mental health problems girls and boys tend to experience [5].

Which of these are types of mental health problems?[7]

→ a) Depression
→ b) Schizophrenia
c) Migraine

True or false - people with mental health problems are likely to be dangerous or violent?

a) True
→ b) False

The most common mental health problems are not related to dangerous or violent behaviour towards others [3].

Which of these is the best description of Obsessive Compulsive Disorder (OCD - a type of mental health problem)?

a) People with OCD just like things to be neat and tidy
b) People with OCD have a difficult relationship with food
→ c) People with OCD have unwelcome thoughts which appear in their minds and have repetitive activities that they do to help with these thoughts

Mental Health Quiz Answer Sheet

Which of these famous people have experienced problems with their mental health?

→ a) Demi Lovato - bipolar disorder
→ b) Zayn Malik - anxiety
→ c) J K Rowling - depression

All. Many famous and successful people have experienced problems with their mental health. Mental health affects everyone - the important thing is to reach out if you are struggling.

7 True or false - it is impossible to recover from a mental health problem.

a) True
→ b) False

It is completely possible to recover from a mental health problem. Many people recover, especially once they have got professional support [8].

How long do the majority of people with a mental health problem wait before telling their closest family and friends about it?

a. 2 months
b. 7 months
→ c. Over a year

A Time to Change survey showed that 60% of people with a mental health problem waited over a year to tell the people closest to them about it.

How many people with mental health problems are negatively affected by stigma?

a) 2 out of 10
b) 5 out of 10
→ c) 9 out of 10

9 out of 10 people with mental health problems have said that stigma has had a negative effect on their lives [9].

What proportion of people with mental health problems reported stigma affecting their friendships?

a. 15%
b. 44%
→ c. 65%

Time to Change's 2014 'State of Stigma' survey also showed that 57% reported stigma in their family life, and 38% said they had experienced it in dating and relationships.

Activity 4 - Introduction to feeling worried — 13 minutes

Situations in which children feel unable to cope result in them feeling worried [1]. This activity looks to build resilience by helping children to recognise what it feels like to be worried and to identify situations which have the potential to make them feel worried.

Activity aims:

- Recognise signs of feeling worried
- Identify situations which have the potential to make children feel worried

Materials

- Whiteboard/blackboard
- Whiteboard pen/chalk
- 'Worry' worksheets
- Sticky notes
- Pens/pencils

1 Opening the session

introduce the session. Inform pupils that they will be thinking about worry; how they can recognise when they are feeling worried and which situations may make them feel worried. The idea is if we can recognise the signs, it can help us reach out for help. We will also start to think about where they can get help from. Provide children with a course of action should they begin to experience any distress or should they no longer wish to take part in the session.

'Worry' worksheet — 4 minutes

Inform pupils that they will now be thinking about what it feels like to be worried and the situations in which they feel worried. Hand out one 'Worry' worksheet to each pupil. Read out the instructions from the worksheet to the class. Prompt pupils that for the first part of the worksheet they might like to think about the worries that they had or still have as part of their move from primary school to secondary school. Alternatively, they might like to think about times that they are worried at school more generally. Give pupils about 4 minutes to complete their worksheets.

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1. Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer.
2. Mind. (2017, November). *How to manage stress. How can I be more resilient?* https://www.mind.org.uk/information-support/types-of-mental-health-problems/stress/developing-resilience/
3. Mind. (2017, October). *Mental health problems - an introduction. What are mental health problems?* https://www.mind.org.uk/information-support/types-of-mental-health-problems/mental-health-problems-introduction/about-mental-health-problems/

2 Feeding back and class discussion 5 minutes

As pupils are completing their 'Worry' worksheets, hand out four sticky notes to each pupil. Write the following headings on the board: 'Situations', 'Body', 'Thoughts', and 'Behaviour'.

As pupils are finishing their worksheets, ask them to write one of their ideas from each of the sections on the worksheet onto each of the sticky notes and to come up to the front of the room and to stick each of their sticky notes next to the corresponding heading.

To illustrate, each pupil will have: a sticky note with a time they feel worried or unable to cope and this should go under the heading 'Situations'; a sticky note describing one way worry feels inside their body and this should go under the heading 'Body'; a sticky note with a thought they have when they are worried and this should go under the heading 'Thoughts'; and a sticky note with one way they behave when they are worried and this should go under the heading 'Behaviour'.

Let pupils know that they do not have to share anything on their sticky notes that they do not feel comfortable with.

Read out some of the pupils' suggestions from the sticky notes under each heading to the class. Ask pupils whether they can see any similar reactions across the class.

Introduce the idea that people have different reactions to feeling worried and unable to cope. The way that one person feels when they are worried may not be the same as someone else. Ask the children to look at whether there are any suggestions from the class that do not apply to them, but that they can appreciate must apply to someone else.

Ask children whether they can think of any positive reactions to feeling worried. For example, thoughts such as 'I need to sort this problem out' or 'I can do this'. Point out any positive sticky notes to the class.

Give pupils a moment to add any suggestions that they feel apply to them but that they did not think of earlier to their worksheets (including any new positive reactions).

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2. Mind. (2017, November). *How to manage stress. How can I be more resilient?* https://www.mind.org.uk/information-support/types-of-mental-health-problems/stress/developing-resilience/

When do I feel worried?

Think about times at school that you might feel worried or unable to cope and list three of these times below.

E.g. When I have forgotten my homework for a class with a strict teacher

1. _____

2. _____

3. _____

What are the signs I feel worried?

Think about one of the times that you have written above and answer the questions below.

What does worry feel like in my body?

E.g. I can't do this

What thoughts do I have when I am worried?

How do I behave when I am worried?

E.g. fidgeting

E.g. feeling sick

Activity 5 - Identifying resources and seeking help — 15 minutes

Social support and encouragement from others facilitate mental health help-seeking [17]. This activity will help children to identify their sources of social support and will remove lack of knowledge about support services as a barrier to seeking help. Role-play will allow pupils to safely practise seeking help and supporting one another, in the context of school transition, and will help to create a positive classroom culture towards help-seeking.

Activity aims:

- Identify sources of social support
- Inform about support services
- Practice seeking help from a peer
- Practice supporting a peer who is seeking help
- Create a positive classroom culture towards help-seeking

Materials

- 'Social Support' worksheets
- Pens/pencils
- 'Support Services' sheets
- Conversation prompts sheets
- 'Scenarios' cards

1 Introducing the activity and setting up — 1 minutes

Introduce the activity (see above). Inform pupils that the last part of this session will be focusing on where they could reach out to when they notice some of the signs that they might need help and practicing doing this. Hand out one 'Social Support' worksheet and one 'Support Services' sheet to each pupil.

2 'Social Support' worksheet — 5 minutes

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17. Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry, 10*:113. https://doi.org/10.1186/1471-244x-10-113

Inform pupils that they will be first be thinking about the people in their lives they might reach out to for support. Pupils are to complete the 'Social Support' worksheet. Read out the instructions from the worksheet to the class and give an example for each of the groups on the worksheet. For example, for community and others, you may use the example of a place of worship or a local club. Inform pupils that this work is private and won't be shared with the class.

Let pupils know that they might not be able to think of anyone they would feel comfortable reaching out to for support or there might be situations where they don't want to reach out to any of the people from the worksheet (family, friends, teachers, community and others). This is okay; let pupils know they can always add people to their worksheets later, if they think of anyone, and introduce the 'Support Services' sheet to them. The 'Support Services' sheet details five places pupils could contact for support and a description of what each place might be able to help them with. Whether it's something big or small, let pupils know they can contact these places and they will listen to them and support them.

Give pupils about 3 minutes to complete their 'Social Support' worksheets. Provide pupils who appear to be struggling with prompts or ideas and/or direct them to look at the 'Support Services' sheet and consider who from this sheet they could contact.

3 Conversation practice 6 minutes

Inform pupils that they will now be practicing reaching out to a friend for support and being a supportive peer.

Place pupils into pairs, being conscious not to group bullies with victims. If possible, pair children who are socially competent with children who are less socially competent. Hand out one conversation prompts sheet to each pupil, and one set of 'Scenarios' cards to each pair.

Introduce and explain the following task to pupils.

Pupils are to practice in their pairs reaching out to a friend for support and being a supportive peer, using the 'Scenarios' cards they have been given.

Pupils should start with 'Scenario 1' (see the numbers on the corner of the 'Scenarios' cards). One pupil should pretend to be 'Person A' and the other pupil should pretend to be 'Person B'. Pupils should read the descriptions on their cards and then practice either reaching out for help and support (if they are playing 'Person A') or being a supportive peer (if they are playing 'Person B'), based upon the 'Scenarios' cards. Pupils may use the conversation prompts sheet to help them with this.

Once pupils have completed 'Scenario 1', they should swap roles and repeat with 'Scenario 2'.

Allow pupils 2-3 minutes to complete 'Scenario 1'. Then ask pupils to swap roles and allow pupils 2-3 minutes to complete 'Scenario 2'.

4 Class discussion — 2 minutes

Collect the cards back in and ask pupils about their experiences of this practice. You may wish to use the following prompts.

- How did it feel to be 'Person A'?
- How did it feel to be 'Person B'?
- Was there anything that was difficult?
- What did 'Person B' do when you were 'Person A' which was helpful?
- What did 'Person B' do when you were 'Person A' which was unhelpful?

Let pupils know that although the scenarios they have practiced are set in schools, they can use what they have learnt in any and all areas of their life, and they can use the conversation prompts for anything that may be bothering them.

5 Closing the session — 1 minutes

Remind pupils of the things that have been covered in this session. This session has focused on building their understanding of mental health, learning to recognise some of the signs that they might need help, and identifying where they might reach out to if they notice any of these signs.

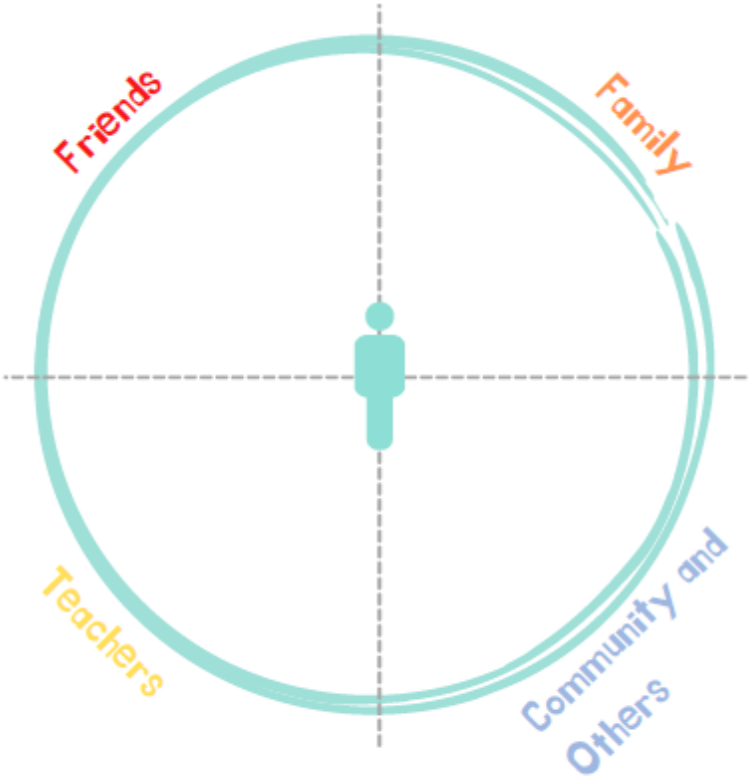
Check in with pupils regarding how they are feeling and their understanding of the session. Allow for any questions about the session.

Acknowledge that this session may have brought up lots of different emotions and that some pupils may feel they would like further support. Remind pupils about the 'Support Services' sheet and provide details of your school's pastoral or well-being lead. Let pupils know that they can speak to you privately about the session or any worries that they may have if they wish to do so.

Where can I get help?

SOCIAL SUPPORT

Fill in each part of this circle with the people you could talk to if you needed some help. This might be people you see everyday or people you haven't seen for a while.



Who would you talk to first? List three people below.

1. _____

2. _____

3. _____

Where can I get help?

SUPPORT SERVICES

YoungMinds

YoungMinds offer mental health support to young people. You can contact them 24 hours a day using their messenger service. Here are some of the things they offer support for:

- Abuse
- Anger
- Body image
- Bullying
- Eating problems
- Exam stress
- Grief and loss
- Loneliness
- Panic attacks
- Problems at school
- Sleep problems
- Thoughts about hurting yourself or ending your life

Website: https://youngminds.org.uk
Crisis Messenger: Text YM to 85258

Struggling and want to know more? Take a look at their feelings and symptoms page.

Shout

Shout is a free text service available 24 hours a day. They offer support and guidance to people in distress.

Mind

Mind offer support to anyone experiencing mental health problems. Call their Infoline or email them to ask about mental health problems, treatment options, and where to get help near you.

Website: https://www.mind.org.uk
Infoline: 0300 123 3393
Email: info@mind.org.uk

GP

You should see your GP if you have noticed changes to the way you are thinking or feeling over the last few weeks or months, and this is causing you upset or worry.

Ask your parent or guardian to help you book an appointment with your GP.

Childline

Childline offers support to people under 18 years old. You can contact them via phone, email and webchat. They offer support for whatever may be on your mind.

Website: http://www.childline.org.uk
Phone: 0800 1111
Use webchat and email with a Childline account.

How do I ask for help?

Here are some ways you might have a conversation about your mental health.

How do I respond?

Here are some ways you might respond to someone talking about their mental health.

How do I ask someone if they need help?

Here are some ways you might start a conversation with someone about their mental health

How do I respond?

Here are some ways you might respond to someone talking about their mental health

Scenarios

SCENARIO 1

1

PERSON A

The last few months, you have been feeling really down. You've been spending less and less time with your friends because you're worried they think you're boring to be around. You used to really enjoy going to drama club at lunch, but lately you've not been enjoying it and you've stopped going. You feel tired a lot of the time and sometimes it feels like it will never get better.

At breaktime at school, you see your friends sitting together. You think about going to sit with them, but you're worried that you'll just bring them all down. You decide to find somewhere to sit alone.

1

PERSON B

Over the last few months, you have noticed that one of your best friends seems really down. They have been spending more and more time alone and they've stopped coming to drama club with you. When you do spend time with them, they seem really tired and they speak slowly. At breaktime at school, you see them glance over at you but then go and sit by themselves. You decide to go over to them and ask them what the matter is.

Scenarios

SCENARIO 2

2

PERSON A

Lately, you have been feeling really worried whenever you are around other people. It all started about two months ago, when you tripped at breaktime at school in front of everyone. All of your things flew out of your hands and slid across the floor, and everyone around you laughed. You could still hear them all laughing as you picked up your things and walked away. You felt so embarrassed. Since then, you've been avoiding spending time with other people. Whenever you think about being around other people, you worry that you will make a fool out of yourself and that people will laugh at you.

You have to give a short speech to your English class later today. You can't stop worrying that people will laugh at you again. You can feel your heart pounding and the tears welling up in your eyes when your friend walks by.

2

PERSON B

Over the last few months, one of your best friends has been spending less and less time with you. You've noticed that they don't seem to take part in any group activities anymore, and they spend a lot of time alone. You walk past them at breaktime at school and they seem shaky and teary. You decide to go over to them and ask them what the matter is.

Figure M2

Manual for the Resilience Session

Session Aims:

- Promote well-being, happiness, and life satisfaction
- Identify what it feels like to be worried
- Identify the situations in which children may feel worried
- Teach children strategies for coping with situations in which they feel worried

1 Opening the session

4 minutes

Introduce the session. Inform pupils that in this session they will be thinking about resilience and the ways in which they can be more resilient. Provide children with a course of action should they begin to experience any distress or should they no longer wish to take part in the session (see 'Teacher Information' page).

Introduce the concept of resilience. Write the following definition on the board:

Resilience

Resilience is about being able to adapt to new and difficult circumstances, at the same time as maintaining your mental health (the way you are thinking, feeling, and behaving) [2, 3].

Some examples of a new or difficult circumstance may be moving to a new school or if someone you love passes away. Ask pupils whether they can think of any other new or difficult circumstances. Write any examples from the class on the board.

An important part of resilience is adapting to new and difficult circumstances *at the same time as maintaining your mental health*. Ask pupils whether they can think of any ways they might maintain their mental health during new or difficult circumstances (you might direct them to think about the things discussed in the previous session). Write any suggestions from the class on the board.

Referencing the examples written on the board, summarise that being resilient is not about not being affected by any of these new or difficult circumstances, but is about adapting to these circumstances and maintaining your mental health as you do this.

Let pupils know that resilience is not fixed (something that you either have or you don't have). Similarly to a muscle, you can build up your resilience over time. You can develop your resilience by finding ways to manage your worries and by supporting your well-being [2].

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2. Mind. (2017, November). *How to manage stress. How can I be more resilient?* https://www.mind.org.uk/information-support/types-of-mental-health-problems/stress/developing-resilience/
3. Mind. (2017, October). *Mental health problems - an introduction. What are mental health problems?* https://www.mind.org.uk/information-support/types-of-mental-health-problems/mental-health-problems-introduction/about-mental-health-problems/

Activity 1 - Coping with worrying situations — 20 minutes

Situations in which children feel unable to cope result in them feeling worried [1]. We started thinking a bit about how we can get help when we feel worried. This activity will teach children strategies that they can use in worrying situations, as a way of helping them to feel able to cope and developing their resilience. Children will be given the opportunity to practice applying the strategies to situations they have identified as having the potential to make them feel worried.

Activity aims:

- Discuss coping strategies
  - Problem-solving
  - Changing thoughts
  - Social support
  - Distraction
- Practice applying coping strategies to worrying situations

Materials

- Flipchart paper
- Dry marker pens
- 'Worrying Situations' worksheet
- Pens/pencils

1 Introducing the activity and setting up — 1 minutes

Introduce the activity (see above). Inform pupils that they will now be looking at some strategies for managing worries, as a way of developing their resilience. Place children into groups of about 4 or 5. Provide each group with a piece of flipchart paper and dry marker pens and provide each pupil with a 'Worrying Situations' worksheet.

2 Coping strategies and class discussion — 19 minutes

Introduce the worksheet to pupils. The worksheet outlines four coping strategies that pupils can use in worrying situations. — 1 minutes

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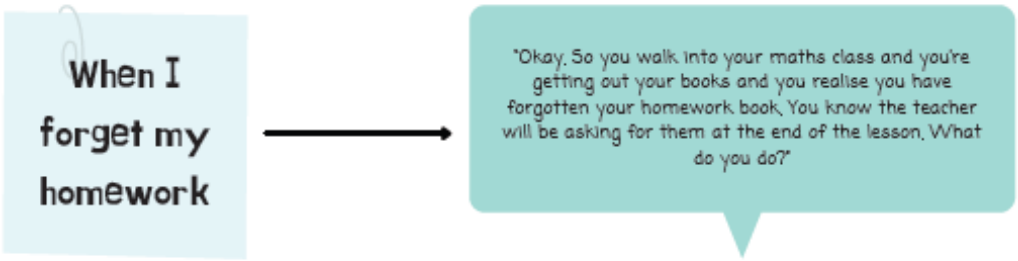
1. Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer.

Pick out one situation from the sticky notes on the board and build a brief narrative around it. Present this to the class. 1 minutes

For example:



Problem-solving *7 minutes*

Introduce the first strategy to the class. Problem-solving describes planning or thinking about ways to solve a problem (including possible choices and the consequences of these choices) and taking action following this [4]. Review the steps to using this strategy, outlined on the worksheet, with the class. 1 minutes

Ask pupils to brainstorm in their groups how they would use problem-solving in the situation you have presented, by following the steps on the worksheet. Ask pupils to record their thoughts and discussions on their flipchart paper. 4 minutes

Ask each group to share with the class the solution(s) they came up with. Allow for discussion around these solutions as a class (did groups come up with similar solutions?). Highlight that different solutions may be equally good. 2 minutes

Balancing Thoughts *7 minutes*

Introduce the second coping strategy to the class. Balancing thoughts outlines trying to think about a situation in a more holistic way, by thinking about how you can balance the positive and negative thoughts you have. Balancing your thoughts in worrying situations can help you to understand the situation better, and to cope well. Review the questions used to balance thoughts, outlined on the worksheet, with the class. 2 minutes

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4. Ayers, T. S., Sandler, I. N., West, S. G., & Roosa, M. W. (1996). A dispositional and situational assessment of children's coping: Testing alternative models of coping. *Journal of Personality*, 64(4), 923-958. https://doi.org/10.1111/j.1467-6494.1996.tb00949.x

Ask pupils to discuss in their groups how they could balance their thoughts in the situation you have presented, by using the questions on the worksheet. Ask pupils to record their thoughts and discussions on their flipchart paper. 3 minutes

Ask each group to share how they thought they could balance their thoughts. Ask the class about their experience of balancing their thoughts. For example, how easy/difficult did pupils find thinking about the positives of a worrying situation? Were the questions on the worksheet helpful? Discuss this as a class. 2 minutes

Social support *2 minutes*

Introduce the third strategy to the class. Social support describes reaching out to other people, either for help with finding a solution to a problem or for emotional support [4]. Remind pupils of their sheets from last session ('Where can I get help?') for the people they might talk to. Ask each pupil to spend a moment thinking about who they would talk to in the situation you have presented.

Distraction *3 minutes*

Introduce the final coping strategy to the class. Distraction outlines efforts to avoid thinking about the situation by engaging in a distracting activity [4]. Any effort to physically relax can be included here.

After the final strategy (distraction) allow pupils a minute to fill in the activities they might do to distract themselves in a worrying situation on their worksheets.

Summarise that there are many different ways to approaching a difficult or worrying situation. Where one strategy seems like a poor fit, another may be helpful.

Remind pupils that whilst the situation discussed in this session is a worrying situation specific to school, these strategies can be used in any situation that makes them feel worried or unable to cope.
Note: If the situation you have presented initially is a poor fit for any of the strategies as you move through this activity, you may pick a new sticky note from the board and present a brief narrative around this, for pupils to discuss instead.

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4. Ayers, T. S., Sandler, I. N., West, S. G., & Roosa, M. W. (1996). A dispositional and situational assessment of children's coping: Testing alternative models of coping. *Journal of Personality, 64*(4), 923-958. https://doi.org/10.1111/j.1467-6494.1996.tb00949.x

What can I do in worrying situations?

1. SOLVE THE SITUATION

One thing you can do in a worrying situation is try to solve it. Follow the steps below.

1. Write down what the problem is.

I snapped at my friend earlier and now I am worried that they are mad at me.

2. Brainstorm all possible solutions to your problem - even the ones that sound silly!

Apologise to my friend?
Avoid my friend?

3. Look at each of your solutions one by one and think about the positives and negatives. Write your thoughts down.

Apologise to my friend?	They might accept my apology	Makes me nervous
Avoid my friend?	I wouldn't have to worry about them being mad	I can't avoid them forever

4. Pick the best solution.

Apologise to my friend.

5. Make a plan to put your solution into action.

I'm going to talk to them at break.

2. INVESTIGATE YOUR THOUGHTS

Another thing you can do in a worrying situation is try to think about the situation in a different and more positive way. Imagine you are a detective and use the questions below to investigate your thoughts.

1. What evidence is there that my thought is true?
2. What evidence is there that my thought is not true?
3. Are there any facts I have overlooked?
4. What other ways are there of viewing the situation?
5. How might someone else view the situation?
6. What is the likelihood my worst thought will come true?
7. Does it help me to think this way?

What can I do in worrying situations?

3. REACH OUT FOR SUPPORT

Another thing you might do in a worrying situation is talk to someone else about it. You might talk to someone for:

- Advice
- Help with solving a problem
- Support with how you are feeling
- Someone to listen to you

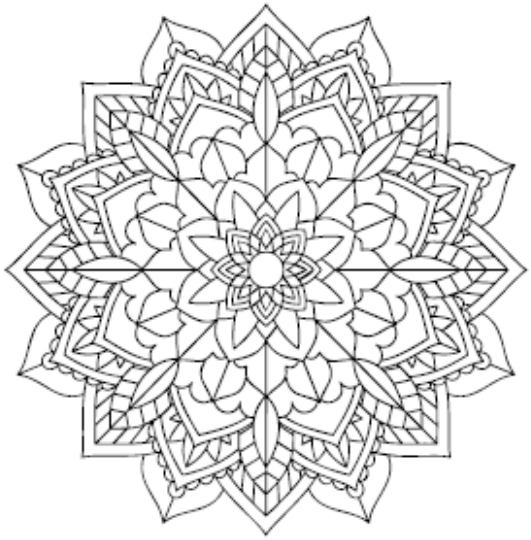
Take a look at your 'Where can I get help?' sheets for some people you might talk to.

4. DISTRACT YOURSELF

Another thing you might do in a worrying situation is distract yourself to help yourself feel better. Use the space below to list some activities you might do to distract yourself when there is a worrying situation.

1.
2.
3.
4.
5.

Colour me in!



Activity 2 - Well-being and happiness 18 minutes

Well-being encompasses happiness and life satisfaction [5, 6]. This activity will promote the Six Ways to Well-being [7], which are simple evidence-based actions that people can do in their everyday lives to improve their well-being, as a way of developing their resilience.

Activity aims:

- Discuss the Six Ways to Well-being [7]
- Promote well-being, happiness and life satisfaction

Materials

- 'Well-being' worksheet
- Flipchart paper
- Dry marker pens
- Blu Tack
- Pens/pencils

1 Introducing the activity 1 minutes

Keep pupils in their groups and introduce the activity (see above). Inform pupils that this last part of the session will be focused on supporting and improving their well-being, as a way of developing their resilience.

2 Six Ways to Well-being 4 minutes

Hand out one 'Well-being' worksheet to each pupil. Direct pupils to look at their worksheets and introduce that there are six ways to well-being. These are connect; be active; keep learning; give; take notice and take care. Each of these can be thought of as a pillar supporting well-being.

The 'connect' pillar is about connecting with the people around you [7]. This might be family, friends, or neighbours. You might connect with people at school, home, or in

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5. Mackay, L., Egli, V., Booker, L-J., & Prendergast, K. (2019). New Zealand's engagement with the Five Ways to Wellbeing: Evidence from a large cross-sectional survey. *New Zealand Journal of Social Sciences Online, 14*(2), 230-244. https://doi.org/10.1080/1177083X.2019.1603165
6. Diener, E., Scollon, C. N., Lucas, R. E. (2009). The evolving concept of subjective well-being: The multifaceted nature of happiness. In E. Diener (Eds.), *Assessing Well-Being. Social Indicators Research Series Vol 39* (pp 67-100). Springer.
7. Aked, J., & Thompson, S. (2008). *Five Ways to Wellbeing. The Evidence.* The New Economics Foundation (NEF).

your local community. Building and maintaining these connections helps you to feel good.

The 'be active' pillar is about being active [7]. This can be through any physical activity you enjoy. For example, walking, running, cycling, dancing or gardening. Exercise helps you to feel good.

The 'keep learning' pillar is about learning and trying new things [7]. For example, you might decide to learn an instrument, join a new club, go to a new place, or start doing something you used to do again. Learning and doing new things is fun and can help you to feel confident.

The 'give' pillar is all about giving back to others [7]. This might be doing something nice for a friend or volunteering your time to a good cause. It can be as simple as thanking someone or smiling. Giving back helps you to feel good. It can be incredibly rewarding and can help to create connections with others.

The 'take notice' pillar is all about being in the moment and taking notice of the world around you [7]. For example, you might notice the changing seasons, birdsong, or a nice moment with friends. Taking notice helps you to appreciate the things that are important to you.

The 'take care' pillar emphasises the need to take time to focus and take care of your physical and mental self. This includes ensuring that you eat healthily, drink plenty of water and to sleep well. This also includes making time for yourself to take breaks from activities and to reflect on your thoughts to "check in" with yourself.

3 Brainstorming and 'Well-being' worksheet part one — 5 minutes

Provide each group with a piece of flipchart paper.

Direct pupils to look at their worksheets. Ask pupils to brainstorm in their groups answers to the prompting questions in the boxes on the third page of the worksheet. The questions focus on the first four pillars of well-being: connect, be active, keep learning, and give. Let pupils know they will be focusing on the last pillar (take notice) later. Read out the questions and the examples from the worksheet to the class.

As pupils are brainstorming in their groups, give each group some Blu Tack.

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7. Aked, J., & Thompson, S. (2008). Five Ways to Wellbeing. The Evidence. The New Economics Foundation (NEF).

4 Reviewing the brainstorming — 3 minutes

Ask groups to come to the front of the class and Blu Tack their flipchart paper to the board. Assist them in this if necessary.

Review the group work. Read out some of the suggestions made by the groups for each of the prompting questions from the worksheet.

Ask pupils to write on their individual worksheets the suggestions that they personally would like to have a record of for each of the four pillars.

5 'Well-being' worksheet part two — 6 minutes

Direct pupils to look at the page focusing on the fifth pillar of well-being: take notice. The 5, 4, 3, 2, 1 exercise asks pupils to name 5 things they can see, 4 things they can feel, 3 things they can hear, 2 things they can smell, and 1 thing you they taste, as a way of helping them to be in the moment and notice the things around them. Inform pupils that this exercise can also be a good way to manage the sorts of feelings they get when they are worried. Give pupils 3 minutes to complete this page.
Following this, get them to look at the final page; take care. This is the final pillar, and is about what helps them stay 'well'. They can complete this now or when the session finishes.

6 Closing the activity — 2 minutes

Remind pupils of the things that have been covered in this session. This session has focused on learning how to recognise and manage worry, and support well-being, as a way of developing resilience (being able to adapt to new and difficult circumstances, at the same time as maintaining your mental health).

Check in with pupils regarding how they are feeling and their understanding of the session. Allow for any questions about the session.

Acknowledge that this session may have brought up lots of different emotions and that some pupils may feel they would like further support. Remind pupils about the 'Support Services' sheet and provide details of your school's pastoral or well-being lead. Let pupils know that they can speak to you privately about the session or any worries that they may have if they wish to do so.

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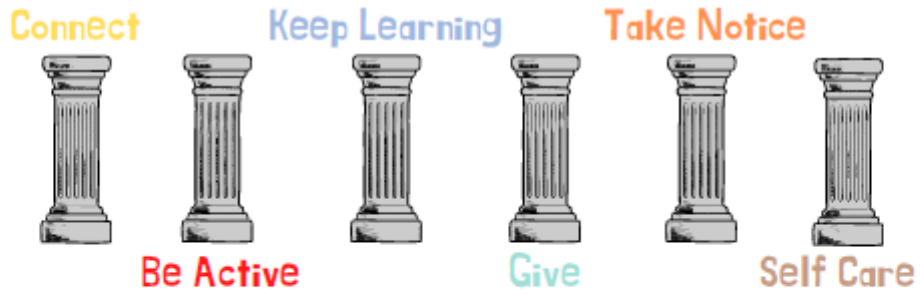
7. Aked, J., & Thompson, S. (2008). Five Ways to Wellbeing. The Evidence. The New Economics Foundation (NEF).

How can I keep myself well?

SIX WAYS TO WELL-BEING



Like how pillars support a building, here are six ways you can support your well-being [7].

1. **Connect** with the people around you. This might be family, friends, or neighbours. You might connect with people at school, home, or in your local community. Building and maintaining these connections helps you to feel good.

2. **Be active** through any physical activity you enjoy. For example, walking, running, cycling, dancing or gardening. Exercise helps you to feel good.

7. Aked, J., & Thompson, S. (2008). *Five Ways to Wellbeing. The Evidence.* The New Economics Foundation (NEF).

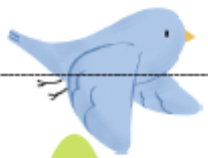
How can I keep myself well?

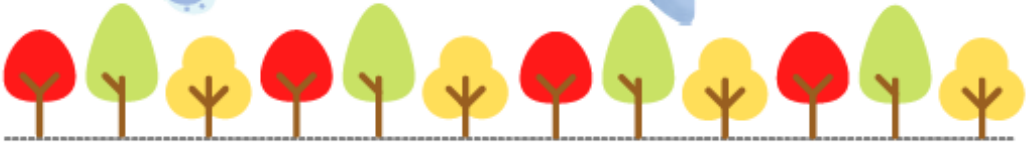
3. **Keep learning** and trying new things. For example, you might decide to learn an instrument, join a new club, go to a new place, or start doing something you used to do again. Learning and doing new things is fun and can help you to feel confident.

4. **Give** back to others. This might be doing something nice for a friend or volunteering your time to a good cause. It can be as simple as thanking someone or smiling. Giving back helps you to feel good. It can be incredibly rewarding and can help to create connections with others.

5. **Take notice** of the world around you and be in the moment. For example, notice the changing seasons, birdsong, or a nice moment with friends. Taking notice helps you to appreciate the things that are important to you.

6. **Take care** of your physical and mental self by making sure that you eat, sleep and drink well. Take breaks when you feel you need to relax and reflect.





7. Aked, J., & Thompson, S. (2008). *Five Ways to Wellbeing. The Evidence.* The New Economics Foundation (NEF).

How can I keep myself well?

1

Connect

How could you connect with the people around you?

E.g. start a conversation with someone new

2

Be active

How could you be active?

E.g. football club

3

Keep learning

How could you keep learning?

Is there something new you would like to try?

Is there something you used to do that you would like to try again?

E.g. join the school choir

4

Give

How could you give back?

How can you be kind at school?

Are there any ways you might volunteer your time?

E.g. stand up for a friend

How can I keep myself well?

Take notice

Be in the moment and take notice of the world around you with this simple exercise.

Name five things you can see.

Example: Trees outside the window

1.
2.
3.
4.
5.

Name four things you can feel.

Example: Myself against my chair

1.
2.
3.
4.

Name three things you can hear.

Example: Gentle music

1.
2.
3.

Name two things you can smell. If you can't smell anything, name smells you like.

Example: Freshly cut grass

1.
2.

Name one thing you can taste. If you can't taste anything, name one taste you like.

Example: Strawberries

1.

How can I keep myself well?

Take care

What else can you do to look after yourself? What helps your physical and mental self?

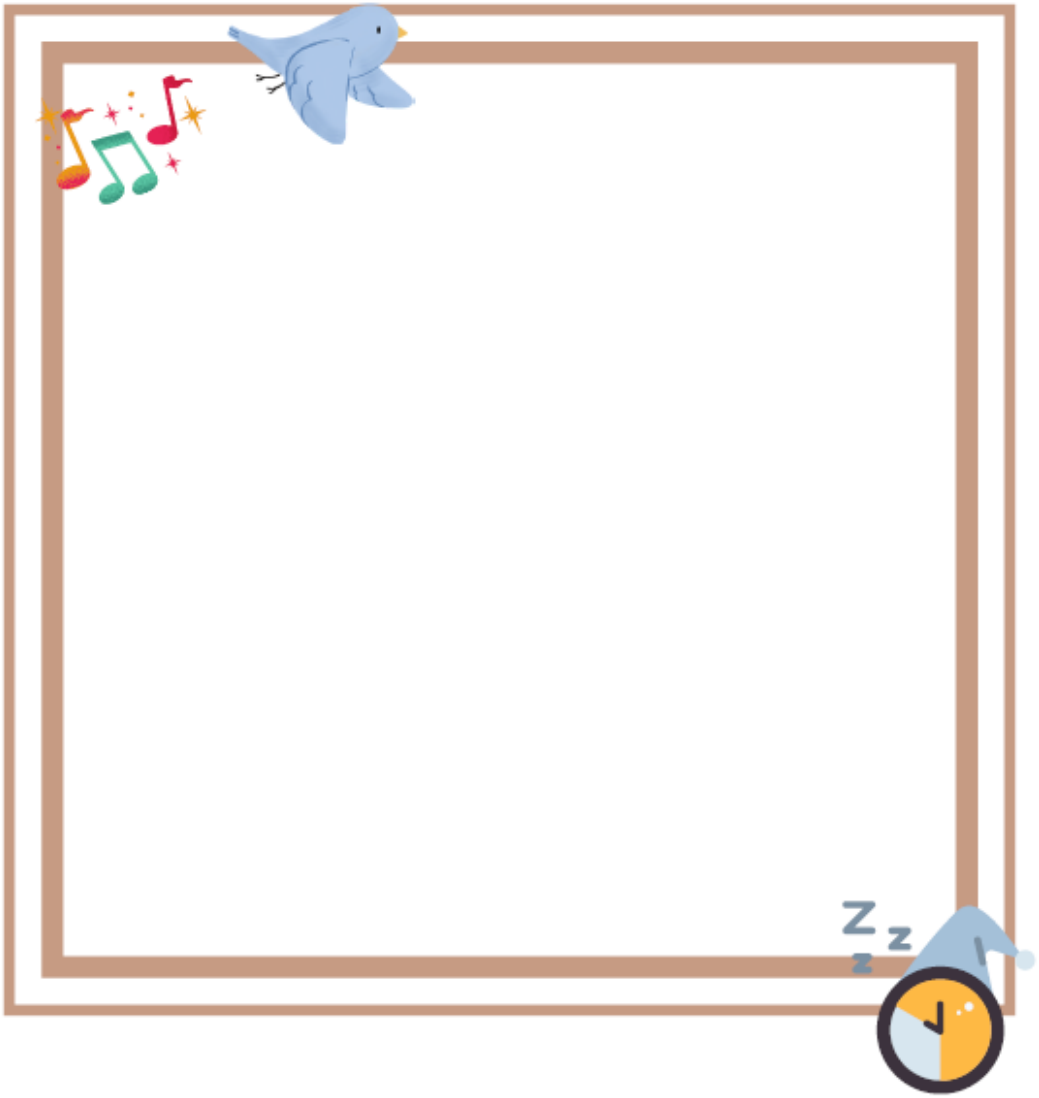


Figure M3

Characters used to facilitate discussion

Appendix N

Semi- structured Interview Schedule

<u>Interview schedule:</u> Outline of what to say/questions that we want answered

Thank you for agreeing to having a chat with us/me about the sessions. As you know, this project is about understanding your experiences of taking part in the mental health and resilience lessons as well as understanding what young people experience when moving schools, to see if these sessions/skills may be helpful. For the recording, could you just state your initials?

Opening questions: *Ice breaker/getting to know them. Not necessary for transcript.*

- Tell me about yourself.
    - **Prompts:** Age, family etc.
- What sort of things do you like doing?
    - (e.g. favourite TV programme/game/sports etc).
- School; favourite things/least favourite things

1) Moving schools

As we've mentioned, alongside getting an understanding of the experiences of the sessions, we want to better understand what moving from primary school to secondary school is like for young people. So first of all, lets talk about that.

- *Get an idea about where they are going, do they know others going etc.*
- *Support that they have had/will have*
    - *What have they done?*
    - *What would they have liked/found useful?*
- ***First ask about a fictional person moving school, what they might be feeling?***
    - *Prompt for feelings first, then move on to what he might be worried about/looking froward to.*
- ***Then ask about themselves; How do you feel about moving to secondary school?***

2) Mental health and resilience; explore knowledge and insight into self and others.

I would like to ask some questions about the things that were talked about in the sessions. First of all, I want us to think about what you knew about mental health *before* the sessions:

- *Before*, had you heard mental health being talked about? In what ways was it talked about?

    - *Prompt for specific phrases/meanings/context- try and understand if they thought it was relevant to themselves.*
- *Before***,** how would you have described mental health to a friend.

And now, lets think following the sessions: ***Use the worksheets/activities as prompts***

- What do you understand now by the term 'mental health'?
    - *Ask them to explain to a friend*
    - *Prompt with the good vs poor MH slide; ask what was put under those two titles and explore with them.*
- Do you think that these sessions helped you learn more about mental health? If so, why?
    - *Try and get a link to specific parts of the sessions*
- Did the sessions change your any views you might have about mental health?
    - *Ask for examples of things that came up in the brainstorming session on MH- any specific words or phrases that surprised them/didn't surprise them.*
    - *Link to stigma beliefs, people being treated different (MH quiz)*
- Explain to me what 'worry' is?
    - *Prompt with the worry activity; did they complete it for themselves? If they did, what did they notice?*
    - *Differences/similarities between friends.*
    - *What would they notice in others if they were worried? (link to best friend)*

[If the interviewer needs to scaffold the answer for the participant, provide the definition below if they are struggling].

Mental health is all about how we feel, think, and act. Mental health is like physical health; everyone has it and it can range from good to poor. Good mental health might look like managing your daily life and the stresses that come with this well. It might look like having healthy relationships, working well at school or at work, and being able to cope with difficulties and adapt to changing circumstances. Poor mental health might be changes to the way someone is feeling, thinking, or behaving, that is causing them upset or problems. This might in their relationships, at work, or at school. (Mind)

- What have these sessions made you think about in terms of **YOUR** mental health

- *Prompt about what they have noticed; times when they have been better/worse. Can they talk about times they have noticed when they might be feeling **worried- try and link to any worries raised about moving schools.***
- *Then go on to exploring if there were things they could use from the sessions and why to help with that worry?*

Now we want to focus on what you knew about resilience/wellbeing *before* the sessions:

- *Before*, had you heard resilience being talked about? In what ways was it talked about?
- And how about wellbeing?
- *Before,* how would you have described resilience/wellbeing to a friend.
  - *Prompt re relevance to them- did they think it was relevant to them?*

And now, lets think about after the sessions: ***Use worksheets as prompts***

- What do you understand about what 'resilience' and wellbeing means?
  - *Prompt for specific phrases/meanings/context- try and understand if they thought it was relevant to themselves. If struggling, how would they explain it to a friend?*
  - *If focus is on just keeping going, use the quote below and prompt for opinions.*
- Do you think the sessions helped you learn more about what resilience and wellbeing means? (for self and others) If so, how?
  - *Ask about coping with worry and their wellbeing- has it developed their confidence/knowledge of/ ability to etc*

[The interviewer should scaffold the answer for the participant and may provide the definition below if they are struggling].

Resilience is not just about bouncing back. It is your ability to adapt to changing and difficult circumstances, while keeping mentally healthy. You can develop your resilience by supporting your wellbeing and by finding ways to manage your stress to reduce the impact of this on you. (Mind)

- Thinking about resilience and wellbeing, are there things that during the session you noticed you were already doing that affected your wellbeing (either positive or negative)
  - *Prompt with some examples, i.e. sport and how it helped/didn't*

- *Ask about examples of times they have coped well/not so well when they have felt worried or been struggling- reasons behind this.*

Now lets think about *after* the session:

- What has changed with your understanding of your own wellbeing and resilience?
  - *Do they see this as important and why; what does wellbeing mean to them?*
  - *Prompt for specific examples of why this might be useful/not useful.*
  - *Things that they do/are starting to do to help with their wellbeing.*
  - *Ask about examples from life where they have coped well/not so well if struggling.*
- And what about other peoples?
  - Things they noticed other people did/didn't do and their understanding of why.

3) Benefits and usefulness of sessions

We now want to ask about whether you think the things in the sessions are useful, and specifically, if you think they might be helpful when you or others move schools.

- How interested in mental health and resilience were you when you found out we would be running these sessions?
  - *Prompt for reasons*
- What were the key things that you learnt during these sessions?
  - *Why were they important/useful?*
- Can you tell me about a time where you might use something from this session or a time where something from this session might be important (who/what situation/where)?
- Can you tell me about something that is going to be helpful *now* with how you *feel* now about moving?
  - *If so, how and why?*
  - *Focus on what they mentioned in section 1- what they might use to cope etc*
- Can you tell me about something that is going to be helpful from these sessions when you have *moved* schools?
  - *If so, how and why?*
  - *Focus on what they mentioned in section 1- what they might use to cope etc*

- Do you think these sessions could help other young people who are moving from primary school to secondary school?
    - *Prompts; if yes- why. If no, do they have ideas about what would help?*

4) Evaluation of the sessions

- Can you tell me about your favourite parts of the sessions and why?
- Which parts of the sessions helped you learn the most about mental health and resilience?
    - *Prompt for specific examples from the sessions*
- Can you tell me about your least favourite parts of the session and why?

[If participants are struggling to work out why they liked/didn't like elements of the sessions, you may wish to ask them to compare the activities/parts to those they liked more/less. For example, how did this part compare to parts of the session that you didn't like as much/you liked more? Where are they the same? Where are they different?]

[With the next set of questions, you could also try and link them back to the concerns raised about moving to prompt conversation if they are not very talkative]

- When you think of the things talked about in the sessions, was there anything that you talked about or did that you wanted to know more about?
    - *Prompt for specifics and why.*
- Were there any things that can came up that you didn't want to know about or thought we talked about it too much?
    - *Prompt for specifics and why.*
- During the sessions, was there anything that came up for you that was difficult? *[feelings/understanding etc]*
    - *Prompt for specifics. Remind them of where they can access help if they are struggling*
    - *If anything comes up, explore what ways we could have support differently/better etc*

5) Improvements to the sessions

Final set of questions! We would like to ask you about how we can make these sessions better.

- What changes to you think we could make to the sessions to help young people with their mental health and resilience?

- *Activities, content etc*

- Do you think these sessions would be better run by your teachers or people like us, who don't work at the school?
- If you could add something of your own, what would it be and please talk me through it.

6) Closing the interview

I think that is everything that I had to ask about, have you got anything else that you would like to say or any final thoughts? Is there anything that hasn't been discussed that you feel is important?

Are you happy for me to stop the recording?

[Thank the participant for their time and their willingness to talk. Ask the participant if they have any questions. Provide participants with the debrief sheets; point out Kate's contact details and the contact details for further support (Forward Thinking Birmingham).

Appendix O

Debrief for children and young people

Thank you for taking part in the evaluation of our social and emotional wellbeing interventions!

The main things we wanted to find out are:

What do young people think about the specific learning activities at school?

How can these support young people's knowledge and understanding of controlling emotions, social skills, mental health and wellbeing.

How can we improve our lessons that focus on controlling emotions, social skills, and mental health and wellbeing?

How could these lessons be used to support young people moving from primary school to secondary school?

The activities you completed will help us to answer these questions.

If you change your mind about letting us use your information, you can tell us to throw it away. You can only ask us to throw away your information up to 1 week after you take part in the study.

But if you took part in a group, we cannot throw away that information because we can't separate it from the information we got from other young people in the group.

If you have any questions, just telephone or email us [redacted] (Kate) or [redacted] (Ali).

You can also ask your parent or guardian to contact us on your behalf. If you feel bad after the study, you can tell your parent/guardian or a researcher directly and we will find someone who will be able to help you.

If you feel bad but you don't want to tell anyone how you feel, you can contact Childline on: 0800 1111. They are trained to help young people who experience lots of different kinds of difficulties. They also have an online chat you can use on their website: https://www.childline.org.uk/

Very importantly, if you have any concerns about the way that the study was conducted, you should contact the Research Governance Team on researchgovernance@contacts.bham.ac.uk.

Debrief for parents/guardians

Thank you for consenting for your child to take part in the Evaluation of Social and Emotional Wellbeing Interventions Study.

Difficulties in emotional control in early life have been linked to poor socio-emotional functioning and psychological wellbeing in adulthood. We aim to evaluate classroom-based social emotional learning activities.

The activities that your child completed helped us to address these aims. Specifically, through the engagement with and discussion of classroom-based social emotional learning activities, we were able to find out how effective, feasible and acceptable they were.

We will now analyse the data to generate plans for further refinement of these interventions, which we will then be able to test in larger scale evaluation studies in the future.

If you feel that additional emotional or behavioural support may be beneficial for your child, please get in touch with Pause, Forward Thinking Birmingham, using the contact details below:

Website: https://www.forwardthinkingbirmingham.org.uk/

Telephone: 0300 300 0099

You may also contact the pastoral care at your child's school.

If you would like further help and guidance in identifying other forms of support that may be available to you, please get in touch with Kate on [redacted] or at [redacted]

Additionally, you or your child can request that we destroy their research data up to [1 month] from when we collect it. If you took part in a group discussion, we cannot destroy this information.

If you have any further questions, please contact the Kate Woodcock Research Group on [redacted] or Kate Woodcock on [redacted] or at [redacted]

If you would like to discuss a specific concern in relation to how the study was conducted please contact the Research Governance Team on researchgovernance@contacts.bham.ac.uk.

Appendix P

The Researcher's Approach to Reflexive Thematic Analysis (RTA)

1. Data Familiarisation

Through being actively involved with interview schedule development, carrying out the majority of the interviews, repeated listening to the recordings I was fully immersed in the data from the outset. By being involved in the interviews it felt that I was able to engage with the young peoples experiences, and were guided by what appeared to be meaningful to the interviewee. A key principle I held in mind throughout this process was to reflect the young people's own accounts of their attitudes, opinions and experiences as faithfully as possible, whilst holding in mind my own interpretations as the researcher. Alongside this I used my reflective journal to take preliminary notes on my thoughts, feelings and impressions.

Transcribing, reading and re-reading the data was particularly helpful to achieve a great contextual understanding of the data. Initially, this was completed by an "active listening" phase, focusing on listening and not doing anything else. This helped reflect back on the interviews, and to recall any gestures or mannerisms that I might not have noted (i.e. how timid a young person appeared until talking about practicing music) as well as any helpful contextual information, such as how a young person appeared. The manual transcribing then allowed for slowing down, pausing, making notes and re-listening to ensure the interviews were transcribed verbatim. Following interviews and transcription, I made reflective notes in a diary about my thoughts and feelings regarding the data and the analysis process, alongside any potential trends or areas of interest. This allowed for the initial stages of reflecting back on the research question.

2. Generating initial codes

This began by using a line-by-line analysis, noting any patterns or areas of meaning in specific words or phrases. The preliminary iteration of coding was conducted using the 'comments' function in Microsoft Word (2016), alongside using colour coding to indicate the passages I was linking to the code (example of this is in in appendix R. During this stage, the focus was more on summarising the data, rather than reducing down therefore tried to produce codes that were succinct and descriptive whilst providing enough context so if the raw data was removed it would convey the same meaning.

I aimed to maintain the individual perspectives whilst starting to note any general patterns of meaning. Semantic codes were focused on initially, before going back to develop the codes on a deeper interpretive level (latent), following collating the codes onto a Microsoft Excel Spreadsheet. The quantity of data (46, 334 words) meant this was a time-consuming process, requiring multiple systematic reviews of the data, sometimes refining codes across multiple data items as I went along (i.e. I moved back and forth between interviews, making notes on previous interviews as well as the one I was currently coding), and in multiple different (i.e. on the train travelling to work, in coffee shops, the library at University) ! I found it particularly helpful to get out of my office, sometimes re-listening on a walk or re-viewing

transcripts on the train. It allowed for a fresh view and a step away. This helped ensure the rigour of the coding process, alongside helping me change my perspective and explore potential missed codes and disrupting the familiar flow of the dataset. This was an independent process, but at times I consulted with my research supervisor to discuss the meaning I was taking away from the transcripts.

I then collated all codes on a Microsoft Excel spreadsheet, categorised under each individual participant. When I noticed any patterns, I started to explore ideas by mapping out on a piece of paper words and themes I felt were indicating a potential relationship. There were three iterations on coding before reaching initial themes.

3. **Generating (initial) themes**

Initially this involved combing through the codes to look for any repeated ideas or patterns of meaning. I did this by merging similar codes into categories on a Microsoft Excel Spreadsheet. This was to help me start getting a deeper understanding of the data, further exploring how I felt the codes could be grouped together. Despite each participant having their own experiences and perspectives, this helped me develop a way of starting to capture the similarities in the data. During this time, I frequently re-visited the raw data, reflective diary, my initial musings to continually develop thinking around the patterns I had identified. This helped me ensure I stayed grounded in the raw data.

Similar codes were developed into initial themes and subthemes, which were informed from the multiple coding iterations made. I reviewed the data for relevant examples for the initial themes, creating additional themes where necessary and rejecting themes if there was insufficient evidence to support it. This led to six provisional themes, with five sub-themes. I defined these independently before exploring with my supervisor to refine these further.

4. **Reviewing Potential Themes**

Similarly, this process required going back and forth between the transcripts, to ensure the 'fit' of the provisional themes. This helped ensured that the interpretation hadn't missed any crucial aspects to the data, and that the interpretation hadn't moved from what was said in the transcripts. This involved revision of potential themes, developing subthemes and using quotes form the data to illustrate my ideas. Any themes that did not add anything to the overall analysis were discarded. The focus was on how well the themes answered the research questions, whilst remaining true to the raw data. I kept coming back to the theme development spreadsheets during this time, to identify any overlapping themes or whether themes could be merged. I also found myself sketching ideas out (very messily!), Appendix R, to map out my thought process and help explore the themes and how they may relate to one another.

5. **Defining & Naming Themes**

Developing the thematic maps (Appendix R) and returning to the data helped me discover any overlapping areas which helped refine the themes, determining the story I felt was being told in each theme. This was aiding by selecting data extracts that felt were relevant and encompassing of the theme and the research question.

However, as noted in my reflective journal, I found this stage difficult. I was stuck on the 'right' way to do it, despite knowing the subjective process that is key to this form of analysis. I found myself getting stuck with whether I had missed something, so found myself returning to earlier stages which helped in reassuring myself that I what I was trying to name and reflect was what was grounded in the data. My research supervisor was key to this process too, to help with sense checking and verbalising my thought patterns. I also found myself recording myself speak about each theme, as I found this helpful when exploring any overlaps and what the story was. This also helped with deciding which ones weren't as good a fit with the data or didn't answer the research question. This led to three themes, with three subthemes.

6. **Write- Up**

The analysis used both analytic and illustrative processes, frequently presenting data extracts alongside my analytical narrative. This also allowed for re-engaging with the previous literature, to find insights that either corresponded or deviated from the findings. This did get me questioning my interpretation of my data, but also helped my understanding of the participants experiences and stories that had developed. It also allowed me to reflect back on the process as a whole, really noticing how difficult I had found it but also how rewarding it was engaging the voice of young people.

Appendix Q

Reflective Diary Excerpt

Struggled with getting started with theme development ; overthinking the 'how' and the 'right way of doing it' vs how I felt it should be done.

Pulled coding together onto an excel spreadsheet, then find myself noting down random thoughts. Felt scattered so needed to go back to the beginning to start building a sense of focus and purpose again. Recognised that I struggled with lack of "step by step" guide to this.

Going over and over the transcripts to generate grouping of the data; found this curious as after being so nervous for so long about going back to the data, I was surprised to notice how familiar it all is- all that initial time taken to familiarise myself with the data works! I can vividly remember each of the individual young people I interviewed, remember how they came across either confidently or quietly. I remember reflecting a lot about how I was at primary school, how I would have come across and one particular young person (P7) I felt connected with due to their timidness. Found myself feeling particularly protective over.

I also recall being taken aback by the eloquence of some young people, and their abilities to reflect on the past as well as thinking about the future.

Noticing my influence on that data; shaped by my current role using compassionate focused therapy/acceptance and commitment therapy with clients. Noticing pattern of recognising value/humanity of all emotions, not focusing on mental health as being "happy" all the time. This felt uplifting for me as this is what I speak about daily; the importance of noticing and doing something about it, to allow ourselves to prioritise what helps us manage life stressors. Reflected that the young people predominantly focused on the here and now; made me think if this type of programme is more beneficial after the move, as we notice the shift in the ability to connect with the here and now rathe than in their heads. Was I being too much like a therapist? Helpful in quickly building trust, rapport and understanding. Knowing how to ask a question and when to wait.

My experiences of having moved school during primary school years, then again relocated to a completely different county for secondary school. I was small, shy, quiet. Had been bullied at primary school so for me, whilst it came with a lot of fear going to a secondary school where I knew no one, it was also a chance for reinvention. I had my big brother with me, whom I have an amazing relationship with. Helped me feel slightly more okay than I would have had he gone elsewhere. Remember thinking for both me and my brother, this was a second chance. Feels reflected in how I am noticing the narrative- or am I overthinking this?! Is this my interpretation as this was for me… Felt very protective over one young person as I felt they mirrored me; different ethnicity and family structure, however was quiet, very small. I think I surprised myself by how many appeared okay about the move, however also held in mind that they are young and that forward thinking may be difficult.

Appendix R

Thematic Development and Maps

Figure R1

Examples of initial theme development

3rd iterations informing theme development	Potential themes	Subthemes?
Being alone makes you feel "weird"/uncomfortable/vulnerable/"odd one out"	**It's weird being alone... (1)**	*Protective/safe* *Increase confidence* *Manage worries* *Importance of?*
Relationships are key to creating a sense of safety/maintaining wellbeing?		
Having a sibling at school means having someone who will always look out for you, and for you to look out for. An anchor in the uncertainty? (something about shared history/closeness/link to confidence?)	**Power of connection (2)**	
Confidence/ sense of safety? can impact on how you manage change	**Confidence is key in in managing change/creating a sense of safety?**	
Importance beyond childhood/this current situation ("in the real world when they're grown ups...they will need to make sure they are the best they can be"	***Not sure how to explore this...confidence came up regarding managing worries (following sessions) through more tools, knowing who to turn to but also how confidence helps them manage uncertainty in general. Linked to personality traits?* Can't develop this; feels additional to following learning.**	
Confidence/ sense of safety? can impact on how you manage change		
Developing a more attuned self (and the importance of? Learning from the sessions- empowering them to notice and taken action, finding balance- confidence)	**Helpful/valued learning experience**	*Insight, recognition and management (reduction in stigma and increase in help seeking)* *Nothing new.../For others, not them?* *Others perspectives? Helpful for learning* *Confidence? (recognition, management)* *Importance of....here and now and beyond childhood*
Awareness of others (how to help others)		
Needing to do something about worries ("clears my head"- difficult with sitting with an allowing, liking the problem solving and solutions more?)		
Different perspectives- important to learning, quiz, learning		

Figure R2

Theme Development Continued

Potential themes	Refined themes (1)	*Additional thoughts*	evidence examples
It's weird being alone... **Relationships appear key in all aspects; helps with confidence, lessen anxiety, increase knowledge of who to turn to (both prior knowledge but also learnt?) (2) (Lockdown examples to- missing connection with others)/different types of relationships?** **?Others opinions of them? New relationships? Not sure about this one- feels relevant and linked to connections/newness?** **Having a sibling at school means having someone who will always look out for you, and for you to look out for. *An anchor in the uncertainty?* (something about shared history/closeness/link to confidence?)**	**It's important to feel connected to feel safe/confident/content**		Sam: [[talking about having his little brother at school with him]] "I like looking after him and um (.) I suppose it's just nice. Having him here with me", "I'm going by myself...I met some friends on transition day". "R: Yeah? So you felt bit nervous before you went, then it felt a bit better. Why do you think it felt better? Sam: : I just feel like the whole atmosphere and me thinking that I'd be the only one in my class...yeah...not to know anyone. R: So you made some friends? Sam: Yeah and so like I feel more confident. Because I know people...its um easier thinking about starting". Ada: "R: So is there anything that you are looking forward to with moving to secondary school? Ada: Seeing my brother and his friends R: And how does it feel knowing you've got friends going with you? Ada: Um I'm a little more happy....Because I like someone there....Because I know some of his friends and if I need help I can just ask him....I get a bit nervous talking to new people...a little bit scary...because it's like a first impression and I don't want to ruin it."
	exposure to situation helps with feeling ready/readiness to change- Move to normality of change	*both related to understanding of mental health and changes; individuality/commonality*	Sam: We um just had a feel of what it would be like moving to different places, like we had an English lesson and break time and just getting a feel for the whole secondary school...: I was a bit nervous coz I was the only one in my class. I saw loads of other classes and I was a bit intimidated But when I got into my class I felt a bit more comfortable I was in a smaller space and I got to meet other friends", "like me getting lost I was a bit worried about getting lost but we were showed around by the prefects at the school and when they showed us around I didn't feel as worried as before"
Specific skills learnt/valued learning experience- throughout all themes noticing how it is helpful to learn **Moving from "us and them" to "you are not alone"/Universal experience of emotional wellbeing/psychological responsibility**	**Possibly something about what they learnt?**	*it's okay to not be okay? insight, recognition and management* *Development of supportive relationships?*	human being and like you can't just say I don't want it because its like if you have your line like you have your good moments, you have your bad moments and yeah...i
Group learning important and helpful; differing views	**Group learning important and helpful; differing views- separate of combine?**		

Figure R3

Early thematic map

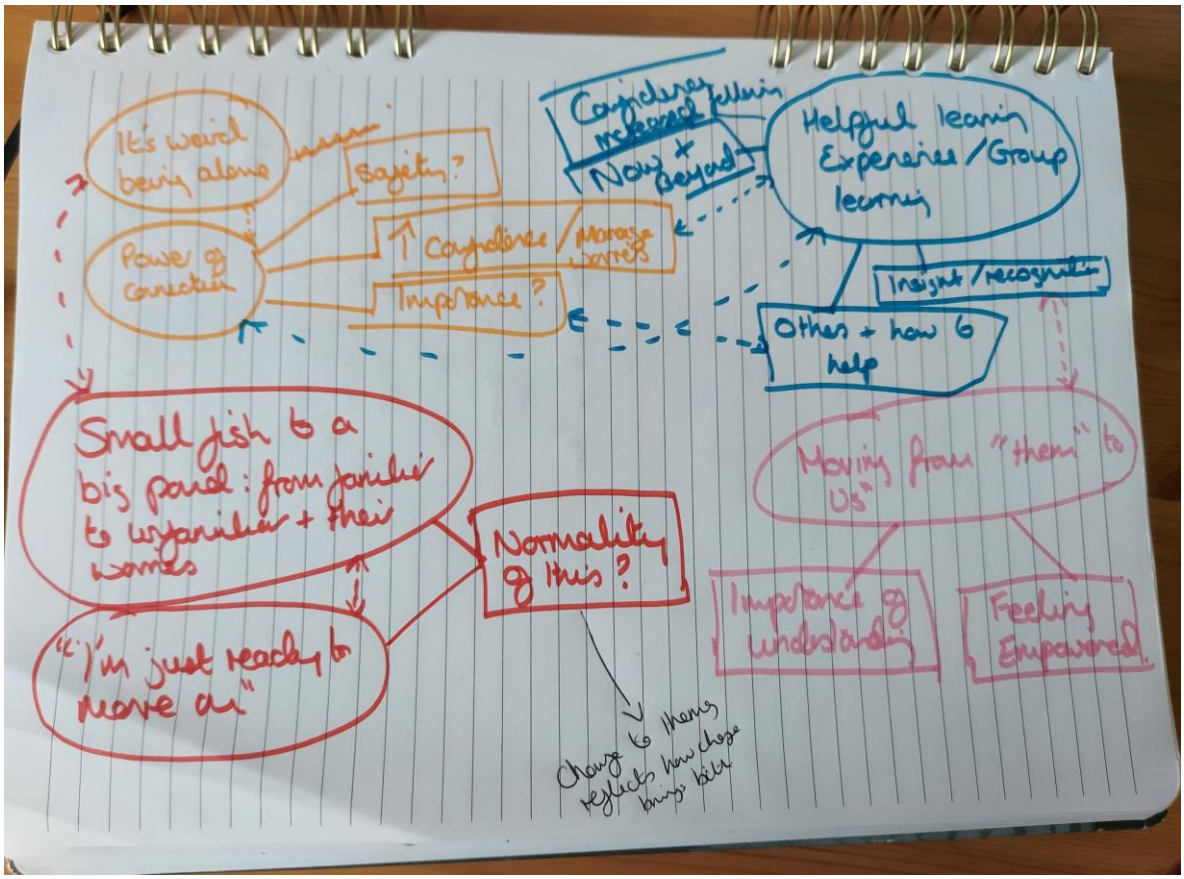


Figure R2

Final thematic map