Interventions to improve mental wellbeing and resilience in children and young people living in poverty

An evidence synthesis
Interventions to improve mental wellbeing and resilience in children and young people aged 7-18 living in poverty

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1. Key findings

This evidence synthesis investigated the effectiveness of family- and community-based interventions to improve mental wellbeing and resilience in children and young people (CYP) aged 7-18 years living in poverty. Five papers were included. The papers reported mixed results.

Just 2 of the papers (both in the US) showed a significant change in CYP’s mental health following the intervention. A housing mobility experiment for low-income families led to decreased psychological distress in girls but increased psychological distress in boys, and immigrant Latina mothers reported decreased internalising behaviours such as unhappiness and depression in their children after a parent training programme.

Drop out from the intervention was a problem in many studies. In 3 of the papers, researchers compared participants who had completed all or most of the intervention with those who had not. They found that completing the intervention was associated with significantly greater effects. This indicates interventions to improve mental wellbeing may be effective but only for those who complete them.

Interventions for this population are more likely to be effective if they include members of the population when designing the intervention. Staff delivering the intervention should be fully trained in, and engaged with, the theoretical principles of the intervention and not see it as a burden.

Interventions should be aimed at the CYP’s whole environment, including familial, social and physical factors, rather than solely the CYP themselves. Wider systemic changes aimed at relieving poverty in CYP could reduce the demand on mental health services, leaving greater resources for individual-level interventions.
2. Introduction

This evidence-synthesis report aims to investigate the effectiveness of family- and community-based interventions in promoting mental wellbeing and resilience in children and young people (CYP) aged 7-18 years living in poverty. The Evidence Synthesis Team in Research, Translation and Innovation in PHE has recently released a report on the effectiveness of mental health lessons in schools (Knowledge and Library Services webpage). Therefore, school-based interventions are not addressed in the current review.

It is widely acknowledged that growing up in poverty can be detrimental to all aspects of CYP’s health, including mental health (1, 2). The transition from childhood to adolescence and on to adulthood can also be a turbulent time for mental health (3). If these effects are not opposed or mediated at this stage, they may continue to be a negative influence throughout an individual’s life (4). Poverty and mental health have a cyclical relationship: poverty is linked with mental ill health which is linked with further poverty (5, 6). This cycle may continue over several generations if it is not interrupted.

Poverty is defined as “lacking the resources to obtain the types of diets, participate in the activities, and have the living conditions and amenities that are customary… in the societies to which [people] belong” (7) (p31). These resources may refer to money itself, along with other material resources such as healthcare access, good quality housing and free education. In the UK, poverty is understood as living on a household budget below 60% of the median national income. In 2017, 4 million children or 30% in the UK were living in poverty (8).

‘Resilience’ describes the ability to adapt to stress and adversity (9). The term is sometimes used as a synonym or proxy for good mental health or mental wellbeing. Table 1 details some of the factors that contribute to building resilience in CYP. Although stressful or negative life experiences are known to be linked with mental health problems, not everyone who has such experiences goes on to develop these problems. It has been argued that a key deciding factor may be an individual’s resilience (10). The World Health Organization (WHO) definition of general health specifies that health is “not merely the absence of disease or infirmity” but rather “a state of complete physical, mental and social well-being” (11) (p1). By this rationale we may say that mental illness and mental health are highly linked but still separate concepts; good mental health is not merely the absence of a diagnosable mental disorder (12). Interventions to improve mental health should not focus solely on preventing or treating mental illness; improving mental wellbeing generally is also a worthwhile endeavour which could benefit a large proportion of the population. Building mental wellbeing and resilience is a pathway towards this goal. For CYP living in
poverty, resilience may be a particularly important tool to allow “normal development under difficult conditions” (13) (p233).

**Table 1. Key points of resilience building in CYP**

<table>
<thead>
<tr>
<th>Key point</th>
<th>Resilience building</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have an adult they trust who helps them through life</td>
</tr>
<tr>
<td>2</td>
<td>Have support getting the very basics in life, such as food, clothing, transport and housing</td>
</tr>
<tr>
<td>3</td>
<td>Have access to activities, hobbies and sports</td>
</tr>
<tr>
<td>4</td>
<td>Have opportunities to practise problem-solving at home, school and in the community</td>
</tr>
<tr>
<td>5</td>
<td>Feel safe and can be themselves in home, school and community</td>
</tr>
<tr>
<td>6</td>
<td>Know how to calm themselves down and take charge of their feelings</td>
</tr>
<tr>
<td>7</td>
<td>Know what they are good at and are proud of it</td>
</tr>
<tr>
<td>8</td>
<td>Support other people through volunteering, peer mentoring, etc.</td>
</tr>
<tr>
<td>9</td>
<td>Are supported to understand how to build their resilience and support others</td>
</tr>
<tr>
<td>10</td>
<td>Know that all adults in their lives are enabled to help children build resilience</td>
</tr>
<tr>
<td>11</td>
<td>Have help to map out a sense of future (hope and aspirations) and build life skills</td>
</tr>
</tbody>
</table>

Adapted from (14). Points are listed in no particular order.

This review complies with and contributes to both the **PHE remit letter** and the **PHE business plan** for 2017-18 by building our knowledge regarding good mental health promotion and prevention of mental health problems and helping to reduce health inequalities experienced by those living in poverty.
3. Data context

Twenty-one percent of people aged 16-24 in the UK reported symptoms of anxiety and depression in 2013/14 up from 18% in 2009/10 (15). Their mental wellbeing also declined in this period (15). Data from Understanding Society in 2015 indicate that 16-19-year olds living in poverty are more likely to score negatively on measures of emotional wellbeing such as ‘feeling optimistic’, ‘feeling useful’ and ‘feeling like a failure’ than their more affluent peers (2). The prevalence of mental health disorders may be up to 3 times higher for children living in poor households than those living in rich households (16). Figure 1 illustrates the strong positive correlation between mental health disorders in children and income deprivation affecting children aged 5-16 years in England. The negative correlation between positive life satisfaction in 15-year-olds and income deprivation affecting children in England is shown in Figure 2.

**Figure 1. Estimated prevalence of mental health disorders in children aged 5-16 years vs. income deprivation affecting children in England**

![Image](source: PHE fingertips data)

**Figure 2. Positive satisfaction with life among 15-year olds vs. income deprivation affecting children in England**

![Image](source: PHE fingertips data)
4. Methodology

Literature review

This report employed a rapid review approach, which uses 1 or more recognised techniques to shorten the timescale compared to a traditional systematic review (17). In this review, we limited the number of databases searched and the location, language and publication year of papers. The research question was:

What family- and community-based interventions are effective in building mental wellbeing and/or resilience in CYP aged 7-18 years living in poverty?

The PICO framework was used to structure the search which stands for:

- **Population**: children and young people aged 7-18 years living in poverty
- **Intervention**: family- and community-based interventions to improve mental wellbeing and resilience
- **Comparator**: usual care or waiting list control
- **Outcomes**: change in mental wellbeing and/or resilience

Protocol

A protocol was produced by the review team before the review began, specifying the research question, parameters of the review, and inclusion and exclusion criteria. Some minor changes were made from the protocol to the literature search. The protocol is available to review upon request.

Sources searched

The following databases were searched:

- Embase
- Medline
- PsycINFO
- Cochrane Central Register of Controlled Trials

All were conducted via Ovid interface, except for Cochrane which used the Cochrane Library. As an example, the Ovid Medline search strategy developed by Knowledge and Library Services accompanies this report. Searches of other databases used similar key words and are available on request.
Dates of search

1 January 2013 to 26 July 2018.

Inclusion criteria are:

- location: Organisation for Economic Co-operation and Development (OECD)
- language: English
- study types: randomised controlled trials (RCTs), non-RCTs, pre-post studies

Exclusion criteria are:

- papers that examine the treatment of mental ill health
- papers that evaluate effectiveness of school-based interventions
- clinical or non-general population (for example CYP with traumatic brain injury, pre-existing depression or anxiety)
- interventions aimed at parents’ mental health, hoping for ‘knock-on’ effect in CYP mental wellbeing/resilience
- grey literature

Screening

The literature search initially retrieved 1,235 references for possible inclusion in the review. All citations were downloaded into an Endnote database and duplicates removed. All citations were then uploaded to EPPI-Reviewer 4 for screening. Remaining duplicates were removed.

An initial screen for clearly irrelevant studies was conducted by 1 reviewer. Of the remaining papers, 100 were screened first by 2 reviewers as a pilot to ensure consistency in applying the inclusion and exclusion criteria. This led to some refining of the criteria from the protocol, for example excluding interventions aimed at improving parents’ mental wellbeing hoping for ‘knock-on’ effect on CYP. All remaining papers were then screened by 2 reviewers, leaving 5 papers to be included in the review (Figure 3).

Data extraction tables were set up and agreed by the project team. The first reviewer conducted data extraction, and the results were checked by the second reviewer. Completed data extraction tables accompany this report.

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1 This does not include programmes aiming to improve parenting skills in order to directly affect their children’s mental wellbeing.
Both reviewers conducted quality appraisal of the papers using the Critical Appraisal Skills Programme (CASP) RCT checklists, including assigning an overall quality rating (18). At all stages, disagreements were first discussed by the 2 reviewers, and remaining disagreements were referred to a third reviewer to decide.

Internal and external review

All stages of the review were overseen by the advisory team, including research question design, protocol design, search strategy, inclusion and exclusion criteria, data extraction forms, and quality appraisal forms. The advisory team also reviewed the final report. The report was then reviewed by 3 external peer reviewers.
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Figure 3. PRISMA Flow Diagram (19)

Records identified through database searching
(Embase n = 975)
(Medline n = 371)
(PsycINFO n = 63)
(Cochrane Central Register of Controlled Trials n = 188)
(n = 1,235, duplicates removed)

Records after duplicates removed
(n = 1,134)

Records single-screened
(n = 1,134)

Records excluded
(n = 641)

Records double-screened
(n = 493)

Records excluded
(n = 478)

Full-text articles assessed for eligibility
(n = 15)

Full-text articles excluded:
(n = 1, wrong outcome
n = 6, wrong population
n = 3, wrong location)

Studies included in qualitative synthesis
(n = 5)
5. Results

From 4 databases, 1,235 papers were identified. Five RCTs were included in the evidence synthesis and are summarised in Table 2.

Table 2. Summary of included studies

<table>
<thead>
<tr>
<th>Study</th>
<th>n</th>
<th>Study type</th>
<th>Age</th>
<th>Location</th>
<th>Sample</th>
<th>Intervention type</th>
<th>Comparator</th>
<th>Outcomes of interest</th>
<th>Follow-up time</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>DuBois &amp; Keller, 2017 (20)</td>
<td>806</td>
<td>RCT</td>
<td>10-16 years</td>
<td>9 states, US</td>
<td>85.4% low-income households, plus at least 1 of: family low-income status; single-parent family; parent incarcerated.</td>
<td>Community-based youth thriving mentoring programme.</td>
<td>Standard mentoring services.</td>
<td>Hobbies, talents, growth mindset, and interests¹, growth mindset², indicators of thriving³, goal setting/pursuit.</td>
<td>15 months</td>
<td>No significant change.</td>
</tr>
<tr>
<td>Morris et al, 2017 (21)</td>
<td>511</td>
<td>RCT</td>
<td>13.9-16.6 (mean) years</td>
<td>New York City, US</td>
<td>81.4% single-parent households, 6 poorest neighbourhoods in NYC.</td>
<td>Family conditional cash transfer for education, healthcare, and parents' employment.</td>
<td>Usual benefits for low-income families.</td>
<td>Depression and anxiety.</td>
<td>30 months</td>
<td>No significant change.</td>
</tr>
<tr>
<td>Nguyen et al, 2013 (22)</td>
<td>2,829</td>
<td>RCT</td>
<td>12-19 years</td>
<td>Baltimore, Boston, Chicago, Los Angeles, New York City, US</td>
<td>Low-income families, eligible for rental assistance and living in public housing or project-based assisted housing in high poverty neighbourhoods.</td>
<td>Conditional or non-conditional family housing vouchers to move to a low-poverty neighbourhood.</td>
<td>Families given no further assistance but could remain in public housing.</td>
<td>Past-month psychological distress.</td>
<td>4-7 years</td>
<td>Significant increase in boys, decrease in girls.</td>
</tr>
<tr>
<td>Williamson et al, 2014 (23)</td>
<td>194</td>
<td>RCT</td>
<td>7-12 years</td>
<td>Santa Ana, California, US</td>
<td>Mothers are Latina immigrants; 63% report total household income less than $15,000 per year, all reported less than $50,000.</td>
<td>Community-based parent training delivered by female lay health worker of Latina descent.</td>
<td>Waitlist control.</td>
<td>Child internalising behaviours⁶.</td>
<td>3 and 9 months</td>
<td>Significant decrease.</td>
</tr>
</tbody>
</table>

¹ feel strongly about hobby/talent/interest and devote time to it. ² belief in ‘fixed’ intelligence and fixed personality. ³ competence, confidence, connection, character, caring, contribution, contribution. ⁴ extent to which individuals believe they can affect their own environment and destiny. ⁵ active way of tackling problems, palliative reaction to problems, searching for social support, passive reaction to problems, reassuring thoughts in reaction to problems. ⁶ for example child is sad, unhappy, or depressed.
Four papers were located in the US (20-23); the other took place in The Netherlands (24). Two papers reported on direct community-based interventions with the CYP (20, 24); 2 described whole-family interventions (21, 22); and 1 described a community-based parenting training intervention (23). Follow-up times ranged from 3 months to 7 years. Standard care was used as the comparator in 3 papers (20-22), and 2 used a waitlist control (23, 24). Self-reported outcome measures were used in 4 papers (20-22, 24), and 1 used reports from the mothers on their children’s behaviour (23). Four of the papers reported comparing all the participants in the intervention group with all those in the control group in the analysis, regardless of their level of actual exposure to the intervention, which maintains the sample size and allows for drop-out. All of the papers were rated as either high or medium quality.

Implementation fidelity and adherence were issues in several of the papers. In the mentoring programme, only approximately half of the participants in the intervention group “reported exposure to 3 or more of the 6 primary concepts and activities” (p1488) of the thriving mentoring model (20). Over a third of the mentor-participant relationships ended within 12 months, preventing completion of the delivery of the intervention. In the empowerment programme, authors noted that the “intervention as implemented deviated significantly from the prescribed intervention” (24) (p134). The authors state that this may have been necessary to keep participants involved, but it was unclear how these adaptations may have affected the outcomes. In the housing voucher intervention, just 51% of the treatment group families used the vouchers to move to a new house within the 90 day window (22). Conversely, 100 of the 113 mother-child dyads in the intervention group of the parent training programme successfully completed the intervention and follow-up (88.5%) (23). Where the authors conducted subgroup analysis on participants who completed most or all of the intervention as prescribed (20, 22, 24), level of exposure to the intervention as prescribed was found to significantly increase its effect on mental health outcomes, either positive or negative.

Two papers reported significant effects of their intervention, both in the US: a housing mobility experiment for low-income families led to decreased psychological distress in girls but increased psychological distress in boys (22); and immigrant Latina mothers reported decreased internalising behaviours (for example my child is sad, unhappy or depressed) in their children after a parent training programme (23). None of the other 3 papers reported significant effects in the outcomes of interest to this review.
6. Discussion

Just 2 of the papers included in this evidence synthesis reported a significant change in mental wellbeing or resilience of CYP living in poverty following a family- or community-based intervention (22, 23). Researchers in the housing voucher intervention reported increased psychological distress in boys and decreased psychological distress in girls (22). These opposite effects by gender were observed in earlier analyses of this intervention (25, 26); researchers suggest this may be due to a confluence of several effect-modifications aside from gender, including recent violent victimisation and health vulnerability at baseline. These differences by gender persisted in the final programme evaluation 10-15 years after randomisation (25). Mothers in the parenting programme reported decreased child internalising behaviours (for example child is sad, unhappy or depressed) (23). None of the studies included took place in the UK; however, themes emerged during synthesis that are transferable to PHE’s target population. The nature of public health interventions means that adaptation to the local context is always necessary. Characteristics of successful and unsuccessful interventions are detailed below and can inform this adaptation.

Implementation fidelity and adherence

Two key issues when evaluating the effectiveness of interventions are fidelity and adherence. Fidelity relates to whether the intervention was delivered as intended or whether changes were made during the evaluation for all or some of the participants. Low fidelity affects our ability to test whether the intervention was successful because we do not know exactly what the participants’ received. Adherence, or drop out, also affects our ability to test the effectiveness of an intervention because there is little data on which to base the statistical analyses and those that dropped out might be systematically different from those that did not. Both are somewhat related to whether the intervention was attractive to the participants. Low fidelity and high drop out are common problems in terms of evaluating the effectiveness of complex public health interventions such as those described in this report.

In this review, reported drop out ranged from less than 1% to 29.2% (drop out was not reported for the conditional cash transfer intervention (21)). The lowest rates of drop out were reported in the 2 interventions with significant results (22, 23). The housing voucher intervention reported less than 1% outcome data missing (22). This was a well-resourced government programme in which all participants had volunteered to take part, both of which may have contributed to the low drop out rate. Just over half of participants in the treatment group actually used the vouchers to move house, but a significant overall effect on CYP psychological distress was found in spite of this low rate of participation. Drop out can be reduced with preliminary work to test how appropriate the intervention is to the intended recipients. The parenting programme had
11.5% drop out in the intervention group (significantly lower than the control group, 23.5%, p = 0.02) and was developed in consultation with immigrant Latino families (23). Researchers addressed the participants' specific concerns (for example maintaining parental authority when their children speak English, but parents only speak Spanish) and cultural values (for example ‘familismo’ or “the importance of familial obligation, support, and authority”) (23) (p48). This consultation also informed the decision to use home visitation by ‘promotoras’ (female lay health workers of Latina descent) as the intervention delivery method. Making the intervention attractive and relevant to the target population may have helped to minimise drop-out and contributed to its effectiveness. Participants were also paid $50 at completion of each of the assessment periods, incentivising continued involvement. Measures were taken to optimise participation (for example weekly supervision of promotoras by licensed psychologists or social workers) and the authors do not report any concerns that these measures were unsuccessful.

Other researchers reported their efforts to maximise implementation fidelity and adherence, with less success. The mentoring programme allocated a liaison within each intervention setting to oversee implementation and provide coaching to the facilitators, and alternative delivery options were offered where feasible (20). Despite these efforts, approximately half of participants were exposed to fewer than 3 of the 6 primary concepts and activities of the intervention. This may have been due to both a relatively high drop out rate (29.2%) and variability in the level of ‘buy-in’ of facilitators. Some mentors saw the programme as a way to add value to their interaction with the CYP, while others viewed it as an “added burden for volunteers” (20) (p1489). If facilitators had been involved earlier in the process, perhaps these concerns could have been more effectively addressed.

Working with marginalised communities rather than dictating to them is likely to be an important step in terms of optimising intervention effectiveness. Nápoles et al described a multi-step process for adapting interventions for marginalised populations (27). This included creating a partnership between the researchers and the participating community, gathering information from multiple sources internal and external to that community, and adapting and integrating the intervention components for the population of interest (27). The theory of self-efficacy – a personal belief in your ability to achieve a goal or task – is thought to be important for effective health interventions. A study of college students in the US found that health self-efficacy significantly predicted their level of engagement in a health-promoting lifestyle (28). Positive relationships with intervention or healthcare providers has been found to build self-efficacy in HIV-infected adults, improving their medication adherence (29). Engaging with CYP, respecting them and acknowledging their expertise about their own lives may be crucial to building this self-efficacy and achieving beneficial results (30).
Intention to treat (ITT) analysis is the gold standard in terms of evaluating a public health intervention. It involves comparing all the participants in the intervention group with all those in the control group, regardless of their level of actual exposure to the intervention. ITT analysis therefore examines the intervention in a ‘real life’ setting. The 3 papers that reported subgroup analysis of participants with relatively high adherence and/or fidelity all reported differences between the results of these analyses and those of the overall ITT analysis.

In the mentoring programme, CYP who enjoyed the intervention and completed most or all of it reported improved supports from adults in their lives and increased intrapersonal resources for thriving (20). The ITT analysis result was not statistically significant. CYP with relatively greater support from adults at baseline were more likely to enjoy the intervention and complete most or all of it. This suggests CYP with an existing support structure may benefit more from this type of intervention than those without. Participants in the intervention group were slightly more likely to drop out in the first 6 months than those in the control group (43% vs 38%, although the difference was not statistically significant) (20). In the housing voucher intervention, authors concluded that the beneficial effect of the intervention on mental health doubled when only those who actually used the vouchers to move house were included in the analysis compared with the ITT analysis (22). Families who used the vouchers differed markedly from those who did not; for example, younger parents, parents enrolled in education at baseline, and those with a household member who had been victimised were more likely to move (31). Participants with these characteristics are therefore more likely to benefit from this intervention. In the empowerment programme, level of exposure to the intervention was found to be a significant moderator on the outcomes; CYP who received the full intervention with high fidelity (following the manual for 75-100% of at least 10 sessions) reported improved coping behaviour (24). Again, the ITT analysis showed no statistically significant effect of the intervention.

**Intervention scope**

The 2 studies which reported a significant change in mental wellbeing or resilience (22, 23) evaluated interventions aimed at the whole family, rather than solely aimed at the CYP. This may indicate that CYP’s mental wellbeing is a function of their whole environment, including familial, social and physical factors, and so cannot be effectively tackled in isolation. Intuitively we can understand that even a very well-designed intervention focused only on the CYP may not have a significant effect on their mental wellbeing if the CYP’s home and social life remains challenging. The mentoring programme (20) and the empowerment programme (24), neither of which reported a significant result, included attempts to involve the CYP’s parents and/or community in the intervention, with only moderate levels of success reported by the authors.
While it was an intervention aimed at the whole family, authors of the family conditional cash transfer intervention reported no significant effect (21). This could be because adolescents’ mental health was not a direct target of the programme, and using depression and anxiety measures to represent mental health outcomes may have failed to capture changes in less severe mental wellbeing and resilience outcomes.

In a study evaluating a parenting education series in the US, parenting programmes with mostly low-income participants resulted in significantly greater benefits in terms of positive changes to parenting skills and child behaviours (32). Researchers suggest that these programmes may provide low-income parents with information and resources that protect against some of the potential negative effects of living in poverty (33, 34). In the same study, programmes which served predominantly Latino parents resulted in greater gains in perceived child behaviour than in perceived parenting skills (32). Researchers suggest this may be due to improved strategies for identifying their children’s behaviour, and improved interpersonal skills of the whole family. This finding supports the findings of Williamson et al (23), included in this review.

A wider scope has contributed to the success of interventions targeting other groups of marginalised CYP. A report evaluating interventions aiming to reduce gang involvement, violence and crime in at-risk CYP found that programmes that worked with the whole family rather than the CYP individually were more effective (35). This held true for CYP at both medium and high risk of gang involvement. Conversely, 1 intervention that removed CYP from their family home and placed them in a quasi-military residence for 5 months was found to be ineffective (36).

**Individual versus systemic changes**

The British Psychological Society (BPS) has stated that any strategy that aims to improve mental health in CYP should focus on more than just support for the individual (37). Systemic, societal factors also need to be tackled, and BPS specifies poverty, social inequality, poor housing and degraded communities as priorities (37). Individual or even family-based interventions, such as those described in this report, can often be reactive rather than preventive. Along with targeting mental health and wellbeing in individual vulnerable CYP, it may also be effective to relieve those vulnerabilities on a society-wide scale. Individual interventions focused on personal responsibility, while usually cheaper and quicker to implement, have the least overall impact compared with systemic changes that emphasise the responsibility of society (38).

Systemic measures have been shown to be effective in mitigating social determinants of mental health. A strong social safety net has been associated with smaller changes in mental health of populations in countries experiencing financial crises (39). In Finland and Sweden during an economic recession and with increasing unemployment, health inequalities did not change and rates of suicide fell, possibly because social
benefits and services were not cut in this time (40-42). It has been shown that increased investment in active labour market programmes of $190 per head per year could fully mitigate the effects of rising unemployment on suicide rates (43). UK spending on welfare increased steadily year on year from 2000 to 2012, but since then has been gradually decreasing (44).

The community and national context in which CYP live (such as living in poverty, being socially isolated, or living in deprived neighbourhoods) can increase their risk of adverse childhood experiences (ACEs) (45). ACEs are sources of stress that may occur early in life and include various types of abuse and neglect, household violence and dysfunction, and community violence and dysfunction (45). ACEs increase the risk of poor health across the life course. The WHO estimates that 30% of adult mental illness in 21 countries may be attributable to ACEs (46). Programmes that aim to improve this context on both the community and national level can mitigate the negative effects of poverty, build resilience and improve mental wellbeing. These could include community efforts to renew the built environment and tackle social isolation, and national efforts to address low wages and benefits (45).

Individual and systemic approaches to improving mental health can and should be used in harmony. More emphasis on preventive, population-level measures would reduce demand from the individual as fewer CYP develop mental health issues, leaving more resources for those who do require individual interventions (37).

**Conclusion**

This review identified few papers, meaning the results should be treated with caution; more research on this topic, especially in the UK, would be helpful. Future interventions aiming to improve the mental wellbeing and resilience of CYP living in poverty should include members of the population when designing the intervention. Staff delivering the intervention should be fully trained in and engaged with the theoretical principles of the intervention. Interventions should be aimed at the CYP’s whole environment, including familial, social and physical factors, rather than solely the CYP themselves. Wider systemic changes aimed at relieving poverty in CYP could reduce the demand on mental health services, leaving greater resources for individual-level interventions.

**Limitations**

In line with rapid review methodology, the scope of the search strategy was limited in terms of number of databases searched, and the location, language, publication year and study design of papers. It is possible some key studies that fell outside these parameters were not included.
The first screen for clearly irrelevant papers was conducted by the first reviewer only. Some papers may have been excluded incorrectly at this stage. Data extraction was conducted by the first reviewer, with a subsequent full check by the second reviewer. Gold-standard reviewing methods would call for both reviewers to conduct data extraction independently, although the method employed here is in line with rapid review practices (17).

None of the included papers reported on an English population. The results could therefore be difficult to translate to PHE’s population of interest. However, the studies were from other OECD countries with similar contexts, so the themes identified in the successful interventions are applicable to England.
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