



Public Health
England



UCL Institute of Health Equity

Local action on health inequalities:
**Building children
and young people's
resilience in schools**



About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

About the UCL Institute of Health Equity

The Institute is led by Professor Sir Michael Marmot and seeks to increase health equity through action on the social determinants of health, specifically in four areas: influencing global, national and local policies; advising on and learning from practice; building the evidence base; and capacity building. The Institute builds on previous work to tackle inequalities in health led by Professor Sir Michael Marmot and his team, including the 'Commission on Social Determinants of Health', 'Fair Society Healthy Lives' (The Marmot Review) and the 'Review of Social Determinants of Health and the Health Divide for the WHO European Region'. www.instituteofhealthequity.org

About this evidence review

This evidence review was commissioned by PHE and researched, analysed and written by the Institute of Health Equity (IHE). There are related evidence reviews available in this series. There is a companion summary briefing note available on this and other related topics from the same series. This review is intended primarily for directors of public health, public health teams and local authorities. This review and the accompanying briefing are part of a series commissioned by PHE to describe and demonstrate effective, practical local action on a range of social determinants of health.

This evidence review was written for IHE by Matilda Allen.

We would like to thank all those on our advisory group who commented on the drafts of this briefing, with particular thanks to Bola Akinwale, Jessica Allen, Mel Bartley, Nicholas Beale, Fiona Brooks, David Buck, Ann Marie Connolly, Eustace DeSousa, Julie Dunning, Alex Godoy, Catherine Gregson, Catherine Johnson, Georgina Kyriacou, Michael Marmot, Claire Robson and Lesley White.

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PHE publications gateway number: 2014334
September 2014

Contents

Introduction	4
1. What is resilience?	5
2. Resilience and health inequalities	8
2.1: Resilience and health	8
Risky health behaviours	8
Qualifications and skills	8
Employment	8
Mental wellbeing	9
Recovery from illness	9
2.2: Social inequalities and resilience	9
3. Scale of the problem	12
4. What works to increase resilience	15
4.1: Who should act to build children's resilience, and why	16
The role of schools in building resilience	16
The role of local authorities in supporting and encouraging schools to take action	17
4.2: Focusing on individuals	18
Improving achievements	18
Supporting transitions	21
Healthy behaviours	23
4.3: Addressing interpersonal issues	25
Parents and carers	25
Teachers and other staff	28
Friends	30
4.4: School and community level action	31
Whole school approaches	31
The school as a community hub	33
4.5: Principles for implementation: proportionate universalism and prevention	37
5. Areas for further research	39
Conclusion	40
References	41

Key messages

1. Resilience is the capacity to 'bounce back' from adversity. Protective factors increase resilience, whereas risk factors increase vulnerability. Resilient individuals, families and communities are more able to deal with difficulties and adversities than those with less resilience.
2. Those who are resilient do well despite adversity, although it does not imply that those who are resilient are unharmed – they often have poorer outcomes than those who have low-risk background but less resilience. This applies to health outcomes and effects success in a range of areas of life across the life course. Evidence shows that resilience could contribute to healthy behaviours, higher qualifications and skills, better employment, better mental wellbeing, and a quicker or more successful recovery from illness.
3. Resilience is not an innate feature of some people's personalities. Resilience and adversity are distributed unequally across the population, and are related to broader socio-economic inequalities which have common causes – the inequities in power, money and resources that shape the conditions in which people live and their opportunities, experiences and relationships.
4. Those who face the most adversity are least likely to have the resources necessary to build resilience. This 'double burden' means that inequalities in resilience are likely to contribute to health inequalities.
5. Schools have a key opportunity to build resilience among children and young people, and there is a range of ways in which local authorities can support and encourage schools to take action.
6. Actions to increase resilience can be targeted at different levels – they can aim to increase achievements of pupils; to support them through transitions and encourage healthy behaviours; to promote better interpersonal relationships between people – particularly parents or carers and children; and to create more supportive, cohesive schools that support both pupils and the wider community.

Introduction

The Marmot Review recognised the important role of schools in building resilience, and recommended as a policy objective that, 'schools, families and communities work in partnership to reduce the gradient in health, wellbeing and resilience of children and young people'.¹

This review builds on that position and provides a summary of evidence about the effect of resilience on health, the unequal distribution of resilience and its contribution to levels of health inequalities. The review outlines the potential actions that can be taken in schools in order to build resilience for all children and young people and reduce inequalities in resilience. Throughout, a social determinants approach to resilience is taken. Children and young people's individual characteristics are seen as shaped by, and related to, inequities in power, money and resources, and the conditions in which they are born, grow, live, and in which they will work and age.² Family and community resilience are highly significant and similarly shaped by wider social and economic factors.

The focus is on children and young people aged five to 18, in primary and secondary school settings. There is good evidence about what works to build protective factors and reduce risk factors in schools in order to promote wellbeing, and some evidence specifically on building resilience. The purpose of this document is to show that taking action on resilience is possible and necessary – to build resilience as a goal in its own right, but also as an important way to improve public health and reduce inequalities in health and in other desirable outcomes.

This paper is part of a collection of evidence reviews commissioned by Public Health England (PHE) and written by the UCL Institute of Health Equity. It is intended to support directors of public health and their teams within local authorities, health and wellbeing boards, councillors, school staff, and others with an interest in health inequalities, education and wellbeing in their local area. A corresponding briefing on this topic area is also available, alongside the further evidence reviews. Of particular interest in relation to resilience are the evidence reviews on parenting programmes, the transition from home to school, and young people not in employment, education and training (NEET).

Throughout the paper, we have highlighted certain evidence and resources in boxes such as this one. These are labelled in the following ways:

Intervention – an example of a strategy, programme or initiative, taken by a local area, organisation or national government, that it is felt may contribute to reducing health inequalities by acting on the social determinants of health. It has either been evaluated and shown to be effective, or is considered to be an example of promising action.

Key Message(s) – summaries of the key findings or action proposed in this paper.

Key literature – summaries of academic studies or other reports which provide key information relevant to the chapter, often taking into account a range of different programmes or projects.

1. What is resilience?

Resilience is described as the capacity to 'bounce back' from adverse experiences, and succeed despite adversity. Adversity can be defined as a lack of positive circumstances or opportunities, partly brought about by physical, mental or social losses or deprivation³, or the experience of trauma. Resilience has been defined as the 'opposite' of vulnerability³⁻⁵. Some research characterises resilient individuals as having average or expected outcomes; others emphasise flourishing (i.e. doing better than average).^{3, 6, 7} In this paper we include both.

Resilience has been defined as an individual personality trait, and dependent on innate characteristics.^{8, 9} However, evidence summarised in this review demonstrates that the conditions in which people are born, grow, live, work and age shape their capacity to respond to external shocks or adversity without experiencing significant harm. In this way, the family, community, social, cultural, and economic environments in which we live, the opportunities available to us and our experiences across the life course all shape the outcomes we experience in the face of adversity.^{10, 11} Resilience interacts with, but is not 'created' by, characteristics of individuals. Rather, it is shaped and built by experiences, opportunities and relationships¹²⁻¹⁴ – what could be termed the 'social determinants' of resilience.

The impact of the environment, experiences and opportunities on people's resilience occurs through the development of either risk or protective factors. Risk factors are more likely to lead to vulnerability while protective factors are more likely to increase resilience. When we face adversity, vulnerability increases the chances of negative outcomes, whereas resilience can enable us to achieve positive outcomes, including good health. Therefore, building resilience requires action to maximise protective factors and minimise risk factors.¹⁵ These factors are described further in section 3.

This definition of resilience is also informed by a capabilities approach. 'Capabilities' are described by Sen and Nussbaum as the capacity of individuals to 'do and be that which they have reason to value'.¹⁶ Capabilities are shaped by the conditions in which people live, and their experiences and opportunities, similar to the social determinants approach which we outline above.

Capabilities, like resilience, enable us to be able to withstand adversity, shock or disadvantage. The concept of resilience is also similar to the idea of 'competence': competent people are defined as those who have the abilities "to generate and coordinate flexible, adaptive responses to demands and to generate and capitalize on opportunities in the environment".¹⁷

This paper refers not only to the resilience of individuals but also to the resilience of families and communities. For example, a local community that has good health compared to the national average or a similar community, without having significantly more wealth, might be seen as being resilient. Community resilience impacts on individuals' resilience: those who grow up in resilient communities are themselves likely to be more resilient.

Key literature: resilience in older ages

A growing body of research on resilience in older age (usually 65+) provides insight into the impacts that resilience has, what protects individuals and communities against the negative impacts of adversity, and what can be done at the start of life in order to ensure resilience is maintained across the life course. Interesting findings, particularly in the area of social protective factors, include the following:

- resilience is, in part, dependent on the level of adversity. More severe adversity results in vulnerable outcomes, despite protective resources.^{3, 5} This also applies to the number of adversities experienced^{6, 7}
- older people with resilient outcomes have been shown to have resources that stabilised life change by providing continuity (such as social roles and activities and close ongoing relationships)^{3, 5}
- integration into a community has been shown to be a protective factor that increases resilience among older adults⁶
- research using longitudinal data that examined 'bouncing back' after adversity among older adults found that the only variable that was consistently related to resilience was social support (having people who are trusted and can help in a crisis). The study did not find a psychological profile for having more or less resilience⁷

This social determinants approach to community and individual resilience involves four further features. Firstly, resilience is a dynamic process¹⁸⁻²⁰ and is developmental – it can accumulate and develop (or reduce) over time.¹⁴ Changes in resilience over the life course are likely to be related to the experiences of individuals, families, and communities and wider social, economic and political factors.

Secondly, resilient individuals and communities are not unharmed or invulnerable.¹³ They display better outcomes than those who are not so resilient, but they rarely achieve as good results as those who have not experienced similar adversity, stress or disadvantage.^{12, 21} For this reason, resilient children living in disadvantaged areas tend to have lower overall outcomes than children who lack resilience but live in low-risk environments.^{22, 23}

Thirdly, even highly resilient individuals cannot overcome all adversity. For example, evidence suggests that very few children manage to be resilient in the face of severe abuse and neglect, or multiple adversities such as having a parent with mental illness, while living in poverty and having little social support.^{22, 24-26}

Finally, since there are inequalities in the determinants of resilience, there are also likely to be inequalities in levels of resilience, which relate to broader socio-economic inequalities in power, money and resources. This is examined further in section 2.2.

2. Resilience and health inequalities

2.1: Resilience and health

Risky health behaviours

Risky health behaviours among young people include tobacco smoking, drinking alcohol, illicit drug use and unprotected sex. The evidence suggests that these behaviours tend to cluster together, and there is evidence of a social gradient, where those from more disadvantaged socio-economic groups are more likely to engage in risky behaviours and in multiple risky behaviours.²⁷ Engaging in risky behaviours has a direct impact on young people's health, and is also likely to affect performance and experience in schools. Risky health habits can also persist into adulthood, leading to lifelong negative effects on health.^{29, 30} For these reasons, reducing risky behaviour can have an immediate positive impact on educational attainment as well as longer-term positive impacts.

Building resilience in young people may help to protect against engaging in risky health behaviour, and improve health and health behaviours.¹² Resilience among young people can also help to delay 'transitions' such as parenthood,¹² which can help to avoid the potential negative health consequences of early pregnancy for both parents and babies.

Qualifications and skills

Academic attainment is linked to health as there is strong evidence that those who do well academically are more likely to be healthy, with longer life expectancy, than those who achieve less good results.^{1, 31, 32} For example, data shows that highly literate adults are at least twice as likely to earn more, have political efficacy, volunteer, trust others, be employed and be in good health, than those with lower literacy.³³ In the UK, those who have no qualifications are over two times as likely to have a limiting illness than those who achieved university level (or equivalent) education.¹ The effects of low academic achievement on mental health can occur before adulthood: almost half of young people with fewer than five GCSEs at A* to C said they 'always' or 'often' felt down or depressed compared with 30% of those who were more qualified.³⁴ There is also a clear gradient in educational attainment correlating with socio-economic position and deprivation.¹

There is literature to suggest that improving resilience may improve academic results,^{12, 35} and some evidence that resiliency-building programmes have increased academic attainment in certain subjects.³⁶ This is a two-way relationship, as better academic attainment can also act as a protective factor against adversity and therefore build resilience.

Employment

There is strong evidence that good quality employment is beneficial for physical and mental health (see the 'Employment' evidence review in this series for more details).^{1, 31, 32}

Resilience may improve an individual's performance in the labour market, reducing the chances of unemployment or low quality, low paid work. Research shows that those who have a high

level of 'non-cognitive skills' are more likely to have better employment outcomes. These skills include resilience and coping.³⁷ This partly occurs by leading on from better attainment at school. Resilience may also equip individuals with a greater capacity to find and keep good quality work.

Mental wellbeing

Mental wellbeing has an effect on physical and mental health outcomes³⁸ and overall levels of health inequalities. For this reason, where resilience-building increases mental wellbeing and mental health, this is likely to improve the health of individuals and communities. Hammond and Feinstein have reported on an association between 'flourishing' at secondary school and adult health outcomes, over and above the effect that could be explained by academic success.³⁹

Resilience can be thought of as an essential component of mental wellbeing – and programmes that increase mental wellbeing may do this partly through impacting on resilience. Similarly, good mental health shares common causes with resilience.

Recovery from illness

There is some evidence that resilience is associated with quicker and better recovery from illness,¹² in part through social relationships⁴⁰ or social capital.⁴¹ For example, emotional support has been shown to be independently related to lower risk of death after myocardial infarction in older people,⁴² and positive expectations tend to predict physical recovery after a heart transplant.⁴³ Those with adequate social relationships have been shown to have a 50% greater survival rate than those with poor social relationships.⁴⁴ There is more limited evidence available on young people specifically, but there is research to show that social support may help young people with depression.⁴⁵

2.2: Social inequalities and resilience

There is a lack of clear evidence that specifically shows inequalities, or a socio-economic gradient, in the distribution of resilience, partly because data on the prevalence of resilience has not been gathered on a large enough scale, and because measurement is complex. However, there are inequalities in adversity, and in protective resources.

Firstly, some people are more likely to face regular and significant adversity in their lives than others, thus requiring higher levels of resilience. Adversity is defined as damaging or negative environmental, social, economic or other factors, which are cumulative,²⁶ and tend to cluster.¹³ For example, children living in poverty often also experience family difficulties or unhealthy housing.^{13, 46} Studies show that children who are exposed to adverse childhood experiences tend to have a higher risk of unhealthy behaviours, poor mental wellbeing, and poor educational and employment outcomes.⁴⁷⁻⁴⁹ Exposure to these experiences is unequally distributed: one study found that those who experienced four or more adverse childhood experiences were significantly more likely to live in deprived areas.⁵⁰

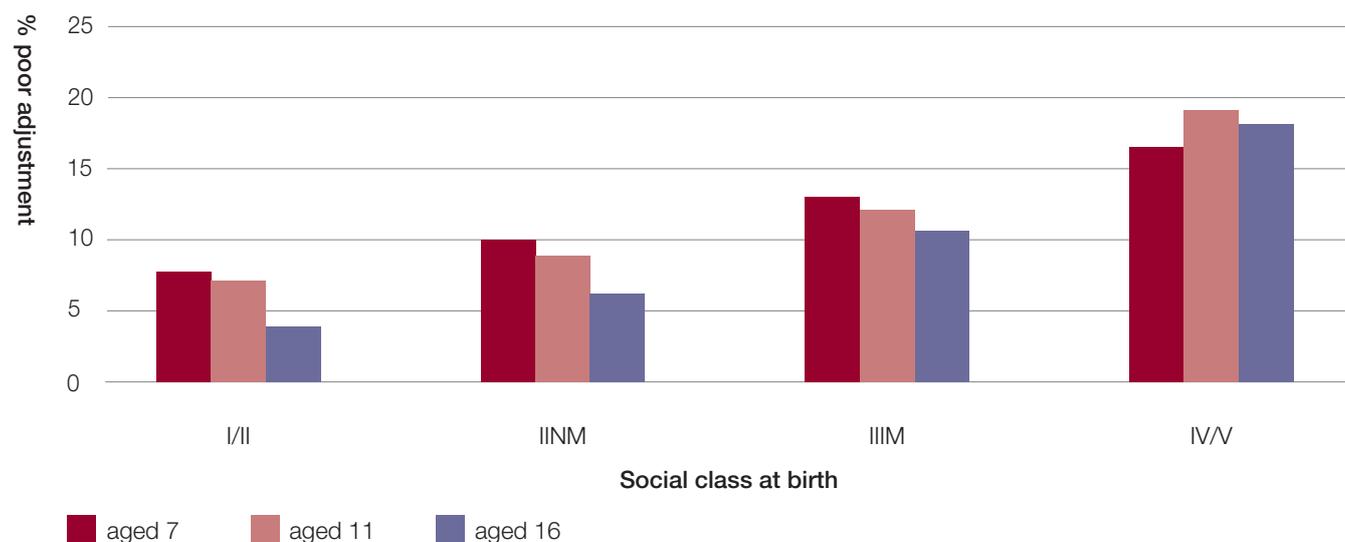
There are also inequalities in the distribution of risk or adversity in the environment: for example, areas of higher deprivation are more likely to have lower quality housing, or have higher levels of crime.¹ These factors are distributed along a social gradient: those who are at the bottom of the gradient (living with higher deprivation or in a lower socio-economic position) are more likely to experience more frequent and more severe adversity,¹ putting them in greater need of resilience than those further up the gradient.

Secondly, not everyone has the same opportunity to access and develop the resources that are necessary to build and strengthen resilience. Poverty is likely to limit the extent to which capabilities and resilience can be built and which have a positive impact on health.⁵¹ Many of those in greatest need of resilience find it hardest to access the resources required to build protective factors: resources such as education and employment opportunities, decent housing, sufficient income, and healthy local areas (as described in the Marmot Review).¹ For example, research shows that opportunities for participation in education and employment, particularly important for doing well in the face of adversity,¹⁴ are lesser in areas of deprivation or for those of low socio-economic status.

Considering this 'double burden' – a greater incidence of adversity and a lower level of resources and opportunities from which to build resilience – it is likely that there is a gradient in outcomes, and that children and young people from poorer, more disadvantaged backgrounds are more susceptible to worse health and other negative outcomes due to a lack of resilience and greater experience of adversity.

These inequalities in resilience may result in inequalities in social and emotional adjustment throughout childhood, as seen in figure 1:

Figure 1. Rates of poor social/emotional adjustment at ages 7, 11 and 16, by father's social class at birth, 1958 National Child Development Study



Source: (1)

Survey data also shows that children who are materially deprived have reported lower levels of choice and control and more negative feelings about the future. Children who experience deprivation are less likely to feel positive about the future.⁵² Longitudinal data has shown a linear relationship between factors such as poverty, parent conflict, separation and parent-child interaction, and the incidence of psychosocial problems at 15-16 years of age.^{4, 53} Finally, evidence shows that anxiety, aggression, confidence, emotional and cognitive development, concentration, and readiness for school are all graded by socio-economic status.¹² Inequalities in all of these areas are likely to reflect and contribute to inequalities in resilience, as the presence of damaging risk factors and the absence of protective factors increases vulnerability and reduces resilience.

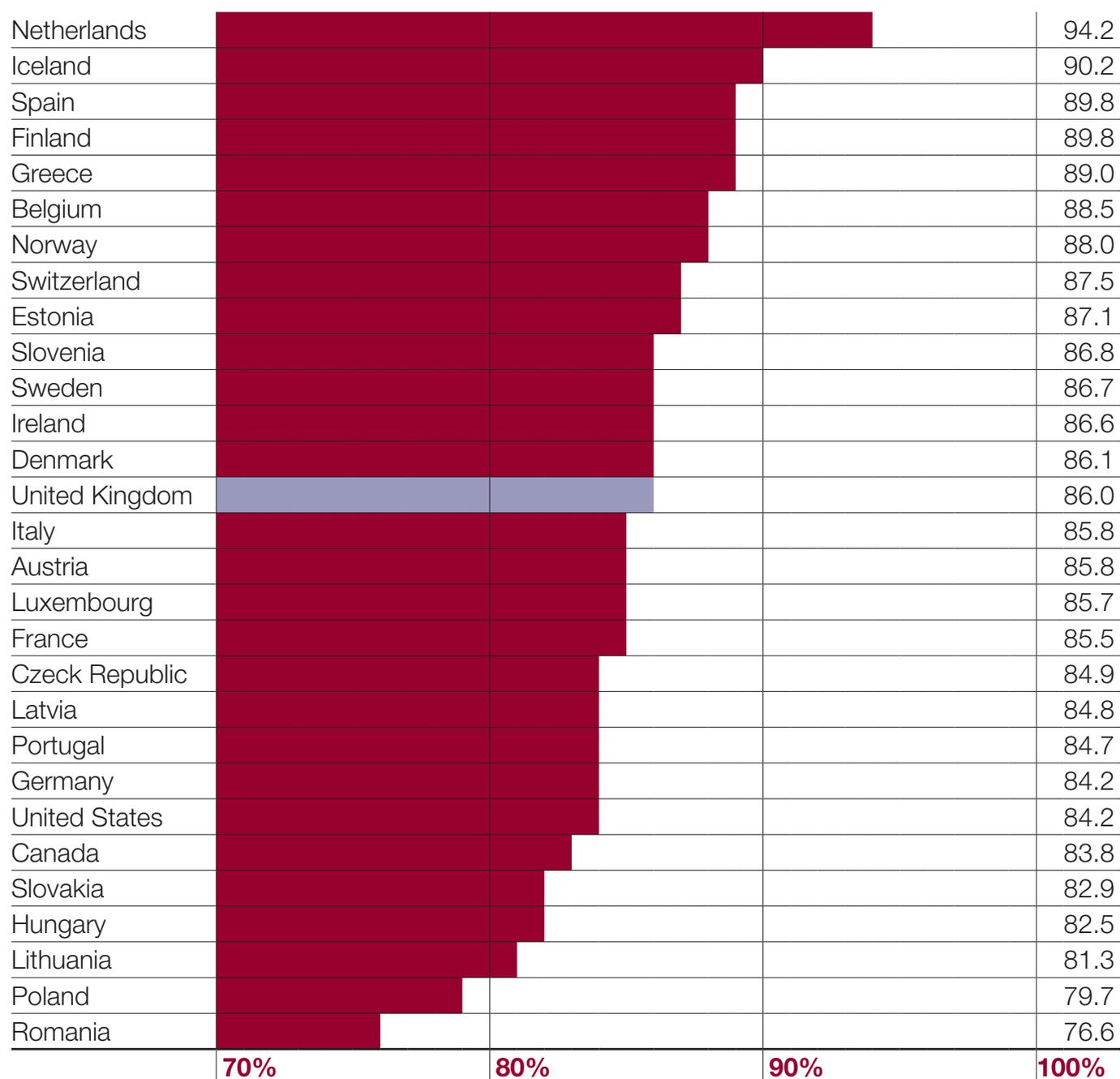
3. Scale of the problem

Measuring resilience is complex. A methodological review of resilience measurement scales found 15 measures of resilience, but no 'gold standard'.⁵⁴ The review reported favourably on the Connor-Davidson Resilience Scale, the Resilience Scale for Adults and the Brief Resilience Scale; however, none of these is applicable to children. There is an adaptation of the Connor-Davidson Resilience Scale for young adults, which could be informative.⁵⁵ Similarly, the 'Healthy Kids Survey' has a resilience and youth development module.⁵⁶ However, this did not score well in the review of resilience scales.⁵⁴

As explained in section 1, resilience depends in part on the levels of protective and risk factors. Measuring these can, therefore, give a good indication of the likely levels of resilience in the face of adversity.

Some of the studies mentioned throughout this document take this approach. In addition, outcome scales for young children can be informative. 'Measuring what matters: a guide for children's centres' sets out a suite of indicators to measure good early child development in the areas of children's health and development, parenting skills, the context of parenting, and later life outcomes.⁵⁷ Where children display positive outcomes in these areas, they are more likely to be exposed to the protective factors necessary for resilience building. Other protective factors include achievement and attainment at school, successful transitions, good relationships with parents, teachers and peers, a supportive school environment, and community social capital, resources, services and connectedness. At a wider level, protective factors include a lack of poverty and deprivation. The Centre for Mental Health lists protective factors for community resilience as being positive social networks, access to positive opportunities such as education, and participation in community activities.⁵⁸ Risk factors include the opposite of many of these features – for example, low achievement in school or neglectful or unsupportive family relationships. At a community level, factors such as socio-economic disadvantage and poor housing conditions can increase risk.⁵⁸ Measuring the incidence of these risk and protective factors can indicate likely levels of resilience and vulnerability.

Some data that relate to resilience are also gathered at national levels. For example, studies have measured resilience in terms of good mental health, functional capacity, and social competence,⁴ or quality of life.³ Survey data such as the Children's Society publication 'The good childhood report',⁵² or measures of social and emotional adjustment such as the National Child Development Study, can be instructive. Other national measures of relevance include UNICEF's 'child wellbeing' index, in which the UK is rated fourteenth out of 29 richest countries in terms of child wellbeing,⁵⁹ see figure 2.



% of children aged 11, 13 and 15 with scores above the middle of a life satisfaction scale

Figure 2. National variations in children's subjective wellbeing

Source: (52)

At a local level, there are a number of informative sources of data. The Child and Maternal Health Intelligence Network (CHIMAT)⁶⁰ provides figures on a range of wellbeing indicators for school-aged children and young people, by local authority area. They also provide a children and young person's mental health benchmarking tool, and links to a range of resources on emotional wellbeing for children and young people.⁶¹

Figure 3 is taken from the CHIMAT website, and provides the child wellbeing index average score from 2009, by upper tier local authority in England. The index compiles data from a number of domains that reflect risk and protective resources, including material wellbeing, health, education, crime, housing, environment and children in need.⁶² The darker the shade, the lower the level of wellbeing (white shading indicates that data was not available).

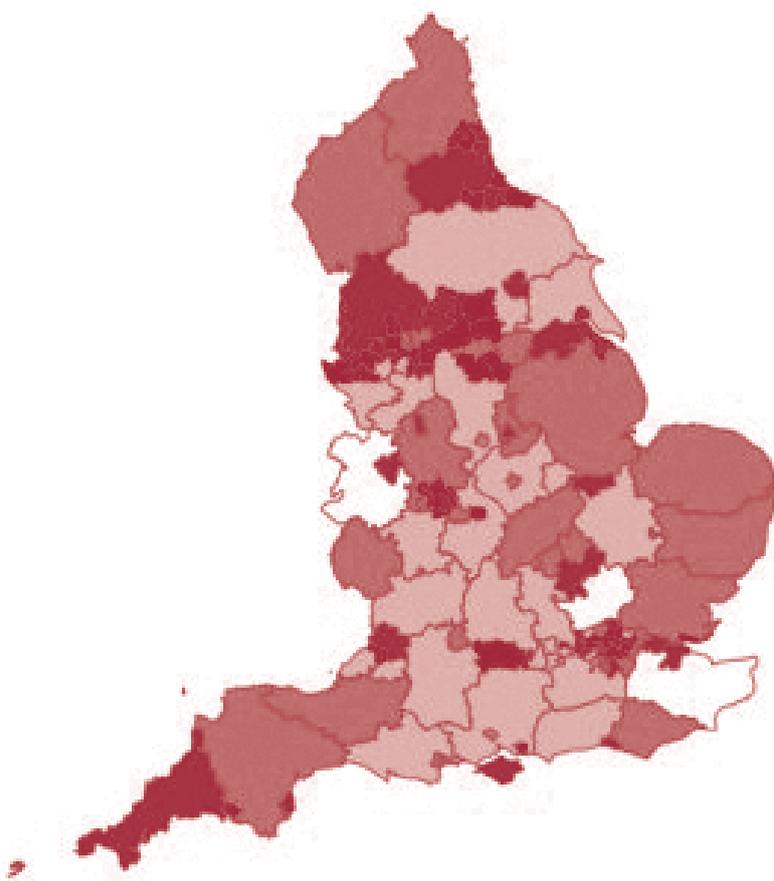


Figure 3. Child wellbeing index average score, upper-tier local authority, England, 2009

Source: (63)

There are also tools that schools can use, such as the strengths and difficulties questionnaire (SDQ).⁶⁴ The SDQ is widely used across the UK – for example, British local authorities are required to measure the mental health of looked after children using this tool.⁶⁵ The quality of other local health services can also be assessed using the Department of Health ‘You’re Welcome’ quality criteria.⁶⁶

The Office for Standards in Education, Children’s Services and Skills (Ofsted) publishes an indicator of whether ‘Children and young people’s views are listened to a ‘great deal/fair amount’.⁶⁷ The Office for National Statistics (ONS) is also conducting a large-scale analysis of wellbeing levels in the UK, down to a local level, including indicators such as “feeling that you can overcome your difficulties” but this is currently only gathered for those aged 16 and over.⁶⁸ In order to gather data on wellbeing from children and young people, specific tools and questionnaires are often necessary, as those designed for adults are not always wholly appropriate.

Schools and local authorities can work together to gather data on local children's outcomes, using the measures mentioned in this section, as well as other local sources of data. As well as measuring outcomes similar to resilience, such as emotional wellbeing, it is necessary to measure risk and protective factors that may enable children and young people to have a resilient response when faced with adversity in future. In some cases, schools opt out of the collection of non-mandatory local data, due to concerns about the time and cost involved. Greater encouragement and support may be needed to ensure that relevant and useful local data is collected where possible.

4. What works to increase resilience

In the first half of this report, we explained that resilience (and vulnerability), can be a feature of individuals, families, and communities. There are also different spheres in which action can take place – individual, interpersonal, and school and community. Within each of these areas, there is evidence to suggest that certain actions can increase resilience. These actions are split into the following areas:

Individual:

- improving achievements
- supporting transitions
- promoting healthy behaviours

Interpersonal:

- parents and carers
- teachers and other staff
- friends

School and community:

- whole school approach
- the school as a community hub

Relationships, experiences, opportunities and environments shape protective and risk factors. When children and young people experience adversity, the levels of risk and protective factors in their lives will influence the extent to which they are either vulnerable or resilient. Furthermore, responses to adversity later on in life are also, in part, dependent on risk and protective factors experienced in younger years. In order to achieve more positive outcomes, it is necessary to limit adversity, for example, through national efforts to reduce child poverty. However, for those who face adversity, maximising protective factors and minimising risk factors can build resilience and limit vulnerability. This reflects the finding that young people who have adequate resources, individually, within the family and within social contexts, have greater levels of resilience.⁴

Schools, as universal free services that play an important role in the development of children for at least 11 years of their lives, have an opportunity to increase the resilience of the students they teach, their families, and the wider community. This section outlines 'what works' to build resilience in five main domains. Each of these areas interacts, and tackling one area without considering the others is unlikely to be successful. A coherent and broad strategy, therefore, is needed.

Cost can be an issue, and operates as a barrier to action. However, there is much that can be done within the daily operation of schools, and taking action to improve resilience can reduce costs in other areas. For example, reducing truancy can produce a saving of £1,318 per year per child, and reducing exclusion can save £9,748 in public value benefits, 89% of which goes to local authorities.⁶⁹ Where action on resilience reduces later crime levels, large savings are also possible.⁶⁹

Throughout this section, interventions and case studies are presented. Some of these (such as the healthy schools programme), are no longer national strategies. However, they still inform understanding and activity, and many schools and local areas have chosen to continue commissioning or providing these services. Some interventions have not measured resilience specifically, but have noted outcomes in related areas such as capabilities, 'coping' strategies, self-efficacy and self-belief, and more general models such as positive mental health, wellbeing, mental capital, and emotional and social development.

4.1: Who should act to build children's resilience, and why

Actions to build resilience can be taken by a wide range of organisations including national and local government, public services, employers, community groups, the third sector, and employers. However, in this document we focus on those actions that can be taken in schools. In this section, we set out some of the reasons why schools should act, and a brief summary of the ways in which local authorities could support these actions.

The role of schools in building resilience

Schools have a statutory responsibility to promote the 'wellbeing' of students.³⁵ Resilience, or related concepts, is mentioned in many key documents. For example, an England-wide educational initiative on 'personal capabilities'⁷⁰ emphasises 'tenacity, self-motivation, problem solving and self-image'; Ofsted has stated that "children's wellbeing and happiness in school underpin their attainment and achievement"⁷¹; and the 2013 report from the Chief Medical Officer called for action to build emotional resilience in children.⁷²

Schools have great potential for action, and much of the literature recognises schools as a key factor in building resilience in the face of adversities such as poverty and family difficulties.^{4, 9, 73-75} For example, in a study of children exposed to community violence, school support seemed to be a strong predictor of behavioural, academic and emotional resilience.⁷⁶

Whereas risk factors and protective resources are unequally distributed throughout the population (see section 2.2), schools provide a universal service for all children. While individual schools have their own characteristics, evidence shows that, at least for children's wellbeing in primary schools, most of the variation exists within rather than between schools.⁷⁷ For this reason, actions taken in schools have an opportunity to address the gradient in wellbeing, and improve the experiences and results of those children who are performing less well than their peers. There is also good evidence that sound mental health and emotional wellbeing can lead to better academic attainment (78), leading to multiple positive outcomes for schools. Schools are also the location of important transitions (for example, from home to school, between schools, and leaving school), which creates both challenges and opportunities.²⁶

Many activities proposed in this section work best when applied to the whole-school setting, rather than in particular lessons. However, there is also an opportunity to integrate an awareness of resilience-building into PSHE (personal, social, health and economic education) classes. The new curriculum from September 2014, published by the Department for Education,⁷⁹ provides opportunities for building in resilience programmes, including in mandatory teaching of sex and relationship education. There is also guidance available on drug and alcohol education, and the Centre for the Analysis of Youth Transitions provides information on a range of programmes that improve outcomes for young people.⁸⁰

The role of local authorities in supporting and encouraging schools to take action

This evidence review describes interventions that predominantly take place in school settings, are commissioned by schools, or are led by school staff. The ability of local authorities to influence, work with, encourage, or enable schools to take any particular action varies by local area. In some areas, an increased number of academies and free schools, and consequent higher levels of autonomy, have limited formal influence and cooperative arrangements.⁸¹ Guidance from the Department for Education states that there are limited statutory requirements for formal relationships between local authorities and academies.⁸² However, there are still opportunities for action, even with academies and free schools.

Most local authorities have dedicated individuals or teams who have extensive knowledge and experience in this area and work very effectively with local schools and the education sector in general, as well as with their colleagues in public health. Actions depend on local context, experience, need and resources, and are often built on a long history of collaboration and jointly delivered programmes. Some effective local authority approaches have tended to include the following features, in addition to the responsibility for overseeing maintained schools:

- providing schools with data of levels of need within their local population, so that they are enabled and encouraged to tackle existent need. This can include health data or deprivation levels, or CHIMAT data, for example. More information on data can be found in section 3
- monitoring changes in health outcomes where relevant and appropriate, using national and local data and indicators, and feeding this information to schools
- relaying information on interventions that are evidence-based, and have been shown to have good outcomes, including through local school improvement services and/or local children and young people's partnerships (or equivalents) where these exist
- enabling and encouraging schools to work in partnership – with other schools, the local community, the voluntary sector, and local authority commissioned services and programmes. Working with other schools and sharing information can be facilitated through local clusters of schools
- working across governance frameworks – for example, local councillors or local authority staff can be involved with school governing boards, and head teachers or other school representatives can sit on local health and wellbeing boards
- facilitating connections between schools and clinical commissioning groups and commissioning development, which can help to ensure that local commissioning is responsive to the experiences and needs of children and young people. Local authorities can also help schools to commission services to ensure efficiency and cost-savings, where possible
- acting as a conduit for information and guidance about national and local policy to schools, including in the areas of resilience, health, wellbeing, and inequalities; and vice versa, feeding information from schools into local and national policy context
- training school staff on resilience-promoting programmes or similar

The transfer of public health to local government also gives potential for more weight to be given to preventative health and wellbeing work, including in schools. There are, for example, a number of areas where local authorities have direct commissioning responsibility – including children's public health, the healthy child programme for school-age children, the national child measurement programme, school nursing, some sexual health services including sexual health advice, prevention and promotion, mental health promotion, mental illness prevention and suicide prevention, some physical activity and obesity programmes, and alcohol, tobacco and drug programmes.⁸³

Acting on resilience could also help to improve performance on the public health outcomes framework indicators, including pupil absence, entrants into the youth justice system, young people not in employment, education or training (NEETs), under-18 conceptions, and a range of behaviour, health and wellbeing indicators at child and adult level.⁸⁴ This remit gives local authorities a responsibility and opportunity to build on existing work with schools on these areas, including through joint commissioning, information sharing, and joint delivery. The Public Services (Social Value Act) 2012 provisions could also be a potential lever in this area, as the Act requires public bodies to consider choosing providers based on the social value that could be created in an area, not on cost alone.

4.2: Focusing on individuals

Schools have an important opportunity to build resilience through action that focusses on individual pupils. Individual-level protective resources include personality traits, intelligence, communication skills, and sociability.⁴

In this paper, we have focussed on the wider protective and risk factors that contribute to resilience and vulnerability, and therefore not on the teaching of coping strategies such as problem-solving and self-efficacy. We take the position that while these strategies may be effective, they are insufficient on their own. Instead, we have focussed on universal strategies that take into account the dynamic and dependent nature of resilience, and seek to reduce risk factors and build protective factors. Within this scope, there are some actions in the individual sphere that can promote protective factors and potentially reduce inequalities, specifically: improving achievements, supporting transitions, and encouraging healthy behaviours.

Improving achievements

The evidence suggests that those who do well academically are more resilient in general.^{13, 85, 86} It seems that good results at school, and staying in education for as long as possible, are protective of exposure to risk, disadvantage and stress later on in life. However, it is not only academic success that builds resilience. Research shows that confidence in physical abilities (for boys) is also a resiliency factor⁸⁷ and, more generally, success in sport, music and art can all promote resilience, partly through contributing to a child's confidence in his or her abilities.⁸⁷

It is also important that children and young people are engaged in school, as evidence shows that engagement (beyond simply attendance) can help to overcome adversities and positive school experiences are important in building resilience.²⁶ There is some evidence that high-risk children who enjoyed primary school are more likely to have improvements in social and behavioural wellbeing than those who did not enjoy it.¹³ There is also evidence that play can increase resilience,⁸⁸ which is part of the reason that the Qualifications and Curriculum Development Agency's independent review of the primary curriculum proposed increasing the role of active, play-

based learning.⁸⁹ The Seattle social development project (see box) is just one strategy that shows the potential positive impact of increasing engagement in school and, while the example is from another country, it provides valuable evidence from a long-term cohort study.

Key literature: Seattle social development project

The Seattle social development project in Washington state, US, is a longitudinal study of behaviours in adolescents and young adults. The study has now followed participants up to age 33.⁹⁰

In 1981, the study assigned those in the first year of school into intervention and control groups, and implemented a range of policies for the intervention group including actively engaging children in learning, strengthening bonding to family and school, and encouraging positive behaviours. There has been a range of findings about the effectiveness of this intervention, and the development of unhealthy behaviours in general.⁹¹ For example, compared with the control group, those who received the intervention were less inclined to heavy drinking, had less history of multiple sexual partners at age 18, increased age of first sexual intercourse, and lower incidence of pregnancy and childbirth among women.²⁷ In addition, results at age 21 include higher use of contraception, lower involvement in a wide variety of crimes, and lower incidence of mental health disorders. Intervention students had also completed more education, and had more secure and higher quality employment outcomes.⁹²

The study has also found specific benefits among those from low-income families, including in academic achievement and some healthy behaviours.⁹²

The study finds that adolescent problems and unhealthy behaviours 'are influenced by multiple, often overlapping risk and protective factors that exist in individuals and in their social environments' and that the intervention was successful as it reduced risk factors and enhanced protective factors.⁹²

Schools already have many strategies to increase educational attainment, and there are many local and national programmes in this area. However, it is important, and widely recognised, that the role of a school is not only to get results and meet standards, but also to build on the strengths and interests of children,⁹³ including in areas such as sport, arts and music.⁸⁷

Schools can also promote engagement and involvement through the use of strategies that encourage 'dispositions for learning' through creating a positive 'learning architecture'.⁹⁴ An institution that recognises and values engagement, enjoyment and play, as well as academic success, is likely to be more successful in protecting and building the wellbeing of its students – including increased resilience.

Finally, there are a number of specific strategies that teach social and emotional skills as part of a wider strategy, which have shown some positive (although mixed) results; for example, social and emotional aspects of learning (SEAL) and a range of other social and emotional learning (SEL) programmes (see following boxes).

Intervention: SEAL (UK)

Resilience forms part of the social and emotional aspects of learning (SEAL) programme, implemented as a national strategy in 2005, which is defined as “a comprehensive, whole-school approach to promoting the social and emotional skills that underpin effective learning, positive behaviour, regular attendance, staff effectiveness and the emotional health and wellbeing of all who learn and work in schools”. It is implemented in 90% of primary schools and 70% of secondary schools in the UK.⁹⁵ Although funding for the programme was withdrawn by the coalition government, many local areas continue to use the materials and run the programme locally.⁹⁶

SEAL guidance for teachers emphasises that developing social and emotional skills will help children to become more resilient, and have academic benefits.

The national evaluation of SEAL in secondary schools published in 2010,⁹⁵ revealed that not all schools had adopted a ‘whole-school’ approach, although this may have been due to the short time scale. The authors suggest that the most crucial factor impacting on implementation may be staff “will and skill”, as well as time and resource allocation.

Results were mixed: from the start of the programme to the evaluation, there were significant reductions in pupils’ “trust and respect for teachers, liking for school, and feelings of supportiveness”. However, there was also significant increases in “pupils’ feelings of autonomy and influence”.

Based on these findings, the evaluation proposed the following recommendations for future programmes:

- they should “more accurately reflect the research literature about ‘what works’”, and monitor more effectively
- sufficient resources and time must be made available to staff
- greater engagement with parents and/or carers is essential
- initiatives should be trialled before national implementation
- there should be guidance for schools, focussed on the evidence base

Key literature: social and emotional learning programmes (US)

A meta-analysis of 213 universal (not targeted) social and emotional learning (SEL) programmes delivered to over 250,000 schools pupils in the US (mostly from 1997 to 2007) found that those who participated in these programmes, compared to control groups, showed significantly improved attitudes, behaviour, social and emotional skills, and higher levels of academic achievement equivalent to a 11% gain in results.⁹⁷ These programmes focussed on the development of social-emotional competencies. Goals of SEL programmes include building self-awareness, self-management, social awareness, relationship skills, and responsible decision making. Often, involvement and participation of students is a key component. The study found that universal, school-based interventions are effective, and (where measured), effects were still noted for some period of time after the end of the intervention. The analysis also found that programmes delivered by teachers in classrooms were most effective (compared with those delivered by non-school personnel).

Supporting transitions

Schools also have a particular opportunity as sites of transitions.^{98, 99} Transitions provide a key chance to build resilience and reduce vulnerability.²⁷ For example, the experiences of transition from primary to secondary school have been shown to affect health and wellbeing later on in life.¹⁰⁰ Transitions into school also offer a good opportunity to engage with and support parents¹⁰¹ (see section 4.3 below).

However, transitions (including from home to school, between schools, and from secondary school to further education or work), are also times of risk, during which children can suffer emotional distress, or a decline in progress and commitment to learning,¹⁰² which can also undermine resilience. Sharing information and working across organisational boundaries is particularly important in this area, so that schools understand the background and circumstances of children coming into their schools. The intervention in the box below describes a pilot to support transitions between schools in order to build resilience.

Intervention: building emotional resilience in schools in Denny, Scotland¹⁰³

This pilot ran from 2007–08, with the aim of developing an integrated, holistic approach to building emotional resilience and wellbeing. The programme had a specific focus on supporting the transition from primary to secondary schools, including through training teachers and working with parents.

The pilot was funded by the Scottish Government, Falkirk Council and HeadsUpScotland, and was delivered by YoungMinds and a group of eight schools in Denny.

The programme included four initiatives:

- building confidence and self-esteem among pupils, including through peer support, use of the Creating Confident Kids programme, and the Aiming for High programme, which is specifically designed to increase resilience in young people during times of transition
- promoting confidence and understanding among teachers and other staff, including through training on resilience and emotional wellbeing
- raising awareness of resilience and wellbeing among parents through workshops designed to increase support across the transition between schools
- enhancing the leadership skills of head teachers in the areas of resilience and wellbeing

An evaluation revealed the following key findings:

- pupils' self-esteem and resilient attitudes were enhanced, and worries about transition were reduced
- staff's own confidence in their ability to promote and facilitate discussion about resilience and emotional wellbeing increased
- parents felt more confident in their ability to support their child, and there were improvements in the parent–child relationship
- schools reported a greater focus on, and prioritisation of, resilience and emotional wellbeing

Schools are also a key part of the more general transition from childhood to adulthood. Research suggests that the impact of this transition is affected by social mobility, education, gender, neighbourhood deprivation and family support, as well as personal competence and resilience.¹⁰⁴ Schools have the potential to ensure that this transition is as smooth as possible.

Extra support may be necessary to support transitions for children who move between schools regularly, as they are likely to experience a higher degree of vulnerability as a result. Research has shown that only 27% of pupils who move secondary schools three or more times achieve five A* to C GCSEs, compared to a national average of 60%, and those who move schools are more likely to be from disadvantaged backgrounds.¹⁰⁵ Research by the RSA suggests this problem will affect more pupils in future due, in part, to more house moves caused by changes to housing benefit rules, larger numbers of young people in care, and larger pupil numbers.¹⁰⁵

Understanding and acting during times of transition is part of a life-course approach that recognises the cumulative impact on health and wellbeing over the course of an individual's life. We provide further evidence on this in our early years review (on the move from home to primary school), and NEETs review (on supporting the transition out of school).

Healthy behaviours

As set out in section 2, resilience and risky health behaviours are inter-related. Those who lack resilience are more likely to engage in unhealthy or risky behaviours. Similarly, engaging in these behaviours is likely to increase vulnerability and reduce resilience. Therefore, interventions or programmes that aim to reduce risky health behaviours may also increase resilience.

There is also some evidence of economic benefit of these programmes. For example, school-based community obesity prevention has a benefit to cost ratio of 7:1, when long-term improvements to economic productivity and individual health are included;¹⁰⁶ effective smoking prevention in American schools has been estimated to have a cost benefit ratio of over 15:1 over a lifetime, yielding net savings of \$619 million annually.¹⁰⁷

There is good evidence that schools can impact on behaviours, decreasing the likelihood of young people taking up smoking¹⁰⁸, drinking¹⁰⁹, taking drugs,¹¹⁰ eating unhealthily¹¹¹ or not exercising.¹¹² Research has found that the most promising programmes are those that “seek to increase resilience and promote positive parental/family influences and/or healthy school environments supportive of positive social and emotional development”.²⁷ There is good evidence in favour of whole-school interventions (discussed further below), particularly in relation to substance use.²⁷ For example, a study in Scotland found that variations in smoking rates between schools were primarily down to school-level characteristics such as caring and inclusiveness, after controlling for socio-economic factors.¹¹³

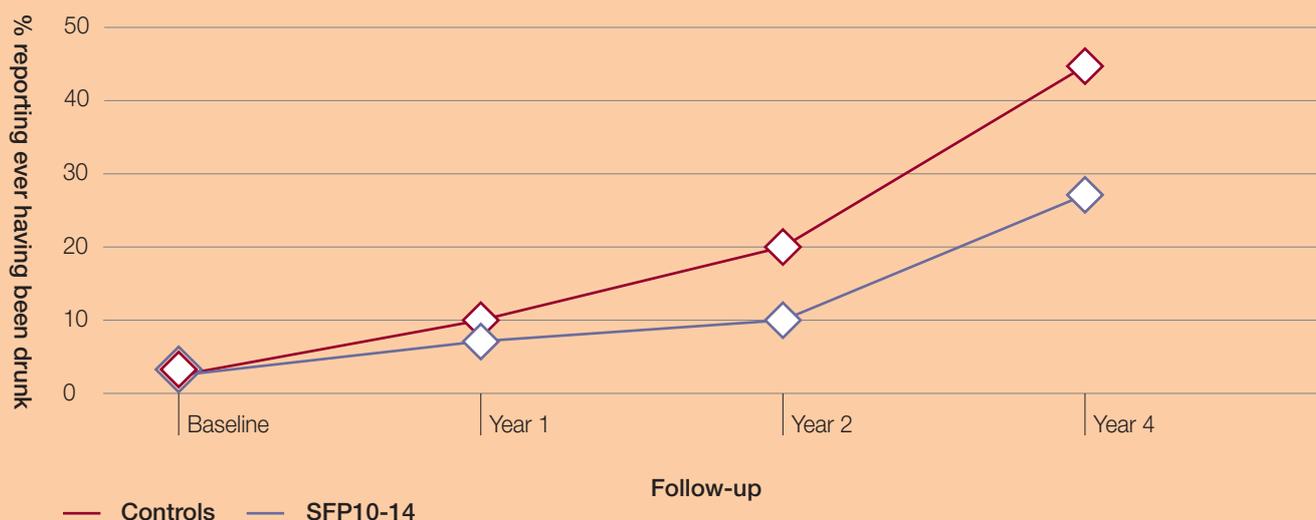
On an individual level, some interventions to promote behaviour change have features that increase resilience.¹⁰⁹ For example, school-based programmes to prevent smoking seem to be particularly effective when they focus on improving skills such as problem solving and self-esteem.¹⁰⁸ However, it also seems that there is very mixed evidence regarding social influence and life skills training interventions, which aim to change individual characteristics. Similarly, simply providing information to students appears to be necessary but insufficient.²⁷ There is some evidence to suggest that ‘multi-domain’ interventions that include school, family, individual and community elements have positive impacts on behaviours.²⁷ The strengthening families program (see box) works mainly with parents and carers in order to improve parenting skills, with the aim of reducing unhealthy behaviours.

Intervention: strengthening families program

The strengthening families program (SFP), which began in the US, involves working with students and parents in order to reduce alcohol and drug use among students by building protective factors and reducing risk factors. Sessions with parents and children focus on how to deal with stress, anger and peer pressure, and improving relationships and communication within families. The programme also aims to improve parental skills and interpersonal and personal competencies among children.

Schools can support the SFP by referring parents or families, and in some cases schools themselves deliver the program.

Research has shown that the programme is successful in encouraging long-term behaviour change in reducing alcohol consumption,¹¹⁴ reducing aggressive and hostile behaviour, improving parent-child interaction and increasing school attendance and engagement. Additionally, effects tend to increase over time, rather than deteriorate.¹¹⁵



Source: (116)

The graph below, from the SFP10-14 major longitudinal study, shows that alcohol use among participants of the SFP is lower than for control groups.

A literature review of a number of interventions designed to impact on behaviour found that the SFP was the most promising family intervention in terms of reducing smoking, alcohol, and illicit drug use after four years. The review also found that there was good reason to believe that the programme may impact on sexual health, although this has not been specifically evaluated.²⁷

Over 30 local authorities across the UK have received training from Oxford Brookes University and implemented a similar SFP in their localities.¹¹⁷ All of these local authorities are still running the programme, and most feed data to Oxford Brookes. Some aggregated selected results from the youth survey are presented below, which show improvement in a number of indicators after taking part in the programme.¹¹⁸

Youth survey questions	% of participants answering a 'good bit of the time' or 'most of the time'	
	Before	After
I know one step to take to reach one of my goals	15	35
I do things to make me feel better when I am under stress	13	27
I appreciate things my parents/caregivers do for me	22	42
If a friend suggests that we do something that can get us both in trouble, I am able to get out of doing it	17	31
I know how to tell when I am under stress	18	29
My parents/caregivers are calm when they discipline me	13	29
I feel truly loved and respected by my parents/caregivers	26	35

There is currently a four year randomised controlled trial of the SFP1014 programme taking place in Wales, which will also report on cost-effectiveness. Results will be available by early 2015.

4.3: Addressing interpersonal issues

The research consistently emphasises that, in nearly all cases, children cannot build resilience without love, support, and positive relationships, most crucially with their family.²⁶ In a broader arena, social support has a proven association with risk of mental illness.¹² For children and young people, interpersonal relationships with family, teachers and friends are an essential source of social support. It is also important that those who are supporting children, whether they are family, teachers or peers, are themselves supported in this role.

Parents and carers

Effective parenting and good parent–child relationships are likely to have a significant effect on resilience. Parent-child factors have been shown to be the most significant predictive factor in changes in wellbeing, with positive relationships linked to improvements in behavioural and social wellbeing.¹³ Furthermore, for those participants who were particularly 'high risk'ⁱ, parents' positive feelings about their child acted as a protective factor against declining wellbeing,¹³ and children from disadvantaged backgrounds who displayed resilience in another study were more likely to have stable and supportive family relationships.¹⁴ Further research has found that family support and connectedness can also increase protective factors against risky behaviours in adolescence.²⁷

Characteristics of 'home life' that tend to increase resilience are having parents who are interested in and supportive of education,^{14, 87, 119-121} and who have high aspirations and expectations of their children,⁸⁷ particularly where this increases self-esteem.¹² Research shows that parental support for education tends to increase the chances of boys staying on in school,⁸⁷ and can increase educational attainment.^{23, 120} It is also important that parents read to their children,¹⁴ and take them out for activities,¹⁴ as well as offering a high quality home learning environment.¹²

ⁱ 'High risk' children had three or more of the following risk factors: an exceptionally stressful event, household income in the lowest 25%, mother had depression, mother had alcohol problem, any special educational needs

Schools can play an important role in helping parents to engage with, take an interest in, and support their children with their education,¹²² partly by building links with families. Building these connections between home and school, and working with parents, can help not only to build communication between school staff and parents or carers, but also to provide opportunities to increase communication and interactions between parents and their children.¹⁴ There may also be opportunities for impacting on other children in the house, for example by encouraging breast feeding, which has a range of benefits for children's development¹²³ and may play a role in increasing resilience against psycho-social stress.¹²⁴ Home-school links can be designed to promote parental confidence and engagement.²⁶ The intervention outlined in the box below, FAST, shows how working with families can improve involvement in education and have a range of good results.

Intervention: Families and Schools Together (FAST)¹²⁵

FAST is an early intervention programme run and funded by Save the Children in partnership with Middlesex University and delivered in a school setting in areas of high deprivation. The trial was predominantly engaged with low-income families – 77% had annual incomes of under £20,000.

The programme works with families, supporting them to improve their children's skills in reading, writing and maths, and encouraging their good behaviour and positive attitude; facilitating parents to be involved in their children's education, including by supporting learning at home; and encouraging stronger bonds between parents and their children, the school, other parents, and the local community.

Results from the UK FAST programme:

- a reduction in family conflict (-16%), increase in total family relationships (+15%), and an improvement in parent-child relationships (+14%)
- a reduction in emotional symptoms (-25%), conduct problems (-24%), hyperactivity (-19%), peer problems (-16%), and total difficultiesⁱⁱ (-20%)
- an increase in parental social relationships with community (+8%), and involvement in education (+3%)
- an increase among parents in support provided to others (+25%) and received from others (+33%)
- 84% of parents reported that the FAST programme had empowered them, and 90% agreed they had more information and knowledge about their child's education

ⁱⁱ A component of the Strengths and Difficulties Questionnaire (SDQ) which corresponds to an increase in the risk of mental health disorder.

- teachers reported an increase in child academic competence, in parental involvement with school, and a reduction in impact of child difficulties (-29%)
- 18% of parents had made more visits to the GP or hospital, 27% reduced their alcohol and 24% reduced their tobacco consumption, 21% reduced their use of recreational drugs
- fewer FAST students needed special education services than those in a control group, suggesting that there may be cost-saving benefits to the programme

Schools can also play a part in building parenting skills.¹²² For example, research shows the importance of 'authoritative parenting', which is characterised by warmth, support, appropriate amounts of structure and consistent discipline.¹³ Schools can help to build these skills either by providing information or small, group-based programmes run by trained practitioners.^{35, 126} There is good evidence that parenting programmes can be effective in improving child behaviour and encouraging positive parenting, and that they can be a cost-effective intervention;¹²⁷ further evidence is available in this series' early years evidence review.

Finally, research shows that schools are in a particularly good position to take action in this area, as parents are more likely to speak to school staff than other professionals about concerns, stress, or problems their children or families are facing.¹⁰¹ This gives school staff an opportunity to identify those parents who would benefit from further provision.¹²⁸ The intervention described in the box below, Place2Be, shows how programmes to build children's resilience can also benefit parents who are themselves facing difficulties.

Intervention: Place2Be¹²⁹

Place2Be is a charity that is commissioned by primary and secondary schools nationally to provide emotional and therapeutic services, building children's resilience through talking, creative work and play. They currently reach 75,000 children, helping them to cope with wide-ranging and often complex social issues.

Place2Be also provides support for parents, teachers and other school staff. Parents come to counselling sessions, most commonly to discuss depression and divorce. Domestic violence was reported by 38% of parents.

Over four years of analysis,¹³⁰ consistent improvements in wellbeing have been reported by teachers, parents and children, the majority of whom (60-70% in 2011-12) reported lessened difficulties following the programme.

For children with the greatest difficulties – those in the 'abnormal' clinical category – rates of improvement were higher than for children as a whole: three-quarters of these children improved and half achieved clinical 'recovery' according to teachers. Parents' assessments of improvements were even higher.

The programme has also estimated that for every £1 spent on the counselling support services, there is a cost saving of £6. This includes reduced costs associated with social services, welfare benefits and the criminal justice system.¹³¹

Staff such as school family support workers can be encouraged to refer families not only to school-based provision but also to other local programmes. In turn, other local services can refer to school staff – for example, GPs can refer to school nurses or school support workers, such as parenting or educational workers.¹⁰¹ Integrated and comprehensive provision of family services, and extended home–school partnerships to include communities (see section 4.4), can also build the resilience of at-risk children.¹³² The local authority will need to ensure that information is available in order to facilitate this. In addition, schools themselves, particularly academies and free schools, have an increasing opportunity to commission their own services.¹⁰¹

Teachers and other staff

While the role of teachers and other school staff is rarely, if ever, as central to resilience-building as that of parents and family, it is still an important element. Evidence shows that teachers' support and guidance of pupils is key for children's development and in helping them to build resilience.^{14, 85, 133, 134} Interventions to modify the social school environment in order to build relationships between staff and pupils have also been shown to reduce violence and aggression.¹³⁵ Staff can also play a role in working with families, as discussed above.

The support offered by teachers and school staff is clearly open to influence by schools, creating an obvious opportunity for action. This is something for governing bodies to consider in partnership with senior leadership and teaching staff.

There is also some evidence that support from school staff is particularly beneficial for those from backgrounds of poverty or who are facing multiple adversities,^{13, 136} meaning that school strategies to improve relationships between staff and students could have a 'levelling-up' effect on the gradient, having proportionately more influence the higher the need. The YoungMinds programme trains teachers specifically to support the needs of pupils who have extra difficulties, in order to build wellbeing and resilience.

Intervention: YoungMinds in schools (137)

The organisation YoungMinds was funded by the Department for Education in 2011 to run a programme that aimed to improve outcomes in schools, particularly for those with behavioural, emotional or social difficulties. The programme provides a set of resources and training courses for educational professionals, which were designed to increase understanding of and impact on mental health and wellbeing in schools.

YoungMinds in schools includes support for schools on whole-school emotional wellbeing (including of parents and teachers as well as pupils), therapeutic story writing, mindfulness, and working with and supporting parents. This work is built on a conceptual base which recognises the impact of risk and resilience, the importance of successful transitions, and the role of attachment, particularly between parents and children.

The interventions used were based on evaluated programmes, including the story links intervention, which builds partnerships with parents in order to reduce the risk of pupil exclusion. An evaluation of the programme found that it resulted in a significant improvement in pupils' overall emotional stress, relationships with parents, teachers and peers, pupils' behaviour, and a decrease in exclusion. In addition, positive outcomes were seen in the home-school relationship, parental engagement, and engagement and confidence in reading.¹³⁸

The two-year government project-funding ended in March 2013, although the organisation continues to work with schools and local areas, some of whom are commissioning YoungMinds through their public health funding to work with schools in the local area (for example, the London Borough of Haringey). YoungMinds is also working with partners to create an Academic Resilience Toolkit, designed to support secondary schools in using a resilience approach.

Research recommends that schools promote healthy relationships between young people and staff, based on mutual respect and learning, including through measures to increase and improve inclusiveness and communication.³⁵ For example, guidance from the National Institute for Health and Care Excellence (NICE) for promoting social and emotional wellbeing at schools recommends building good and mutually trusting relationships with teachers at primary and secondary school level, and mentions the importance of having a committed mentor or other person from outside the family at secondary level.^{35, 126} The Skills for Life programme in Camden, London focussed on the importance of staff mentoring (see box).

Intervention: Skills for Life programme, Brookfield Primary School, Camden¹³⁹

Brookfield Primary School in Camden, London has been working with the Camden School improvement service (a service working in partnership with schools to improve outcomes, close gaps in performance and attainment, and support transitions¹⁴⁰ to implement a programme that aims to enhance learning outcomes for vulnerable children, identified as those who lacked resilience, had behaviour or motivation problems. The approach taken involves training staff to become mentors for vulnerable children. Weekly mentoring sessions are provided, alongside work with parents and carers, and a greater identification and celebration of success among pupils.

Outcomes for those children involved included:

- equal or better progress in reading and writing compared to the rest of the school
- a 45% reduction in the number of serious incidents
- good attendance and punctuality compared with the rest of the school
- better relationships between staff and pupils.

Staff training is also essential, including on managing behaviours and building relationships with pupils, how to link to other agencies, and how to identify and respond to need.^{35, 126} Teachers and other staff can also be trained to identify those students who are particularly at risk or who are showing signs of stress or anxiety.¹²⁶

Friends

The literature on the link between friendships and resilience is more limited than on other areas, although there is some evidence that peer contact can help to build resilience in children and young people.^{85, 141} Studies have found that friendships can support children's wellbeing¹³ and that interacting with others, including friends, matters to the development of resilience.⁵¹ On the other hand, and for obvious reasons, some peer contact such as bullying in schools can be a risk factor and undermine resilience.

For these reasons, schools may consider taking action to promote and facilitate supportive friendships and, additionally, to tackle bullying and victimisation. An awareness of both the benefits and potential negative impacts of online friendships and social networking is necessary. There are also more formal mechanisms of support such as peer mentors that can be encouraged³⁵ (see box).

Key literature: peer mentoring in schools¹⁴²

A UK review of evidence on the benefits of peer mentoring in schools found that:

- students and staff report that peer mentoring benefits both the mentees and the school overall
- pilot studies have found that peer mentoring has an impact on reducing bullying, promoting self-confidence and self esteem
- more formal programmes that include training, support and management of mentors show better results
- evaluations of American and British programmes have found that peer tutoring and mentoring can increase academic attainment, improve social integration, increase self-confidence, improve attendance, reduce disciplinary referrals, and improve attitudes towards school
- there tend to be mutually beneficial effects – for mentors and mentees
- an independent evaluation of an online mentoring programme (CyberMentors) found that those training to become CyberMentors showed more resilience and better emotional health. Participating schools reported reductions in violence and absence, and increases in confidence, good behaviour and pupil relationships with each other

4.4: School and community level action

Alongside actions in an individual sphere, and those that work to build interpersonal relationships and support, there is also a role for schools in a wider context. This includes a 'whole school approach', which modifies the school environment in order to be of best benefit to pupils, staff and families and the school as a community hub.

Whole school approaches

The Department for Education has defined whole school approaches as “cohesive, collective and collaborative action in and by a school community that has been strategically constructed to improve student learning, behaviour and wellbeing, and the conditions that support these”.¹⁴³

Various research has shown the effectiveness of a universal, whole-school approach.⁹⁹ Systematic reviews of the impact of school-based interventions on mental health indicate that the vast majority of interventions have taken a universal (whole-school) approach to achieve optimal impact.⁹⁶

Health-promoting schools are a type of whole school approach which has shown positive impacts, including on resilience (see box).

Key literature: systematic reviews of health-promoting schools

The health-promoting schools approach is a type of whole school approach that includes health education in the curriculum, changing the school's social and/or physical environment, and involving students' families and the local community.

A systematic review on the effectiveness of the health-promoting schools approach in promoting students' health and wellbeing found positive results in the areas of body mass index, physical activity, physical fitness, fruit and vegetable intake, tobacco use, and being bullied.¹⁴⁴

A systematic review has also been conducted on the specific impact of the health-promoting school approach on resilience among students internationally, using studies published from 2007-11.¹⁴⁵ This research showed some positive results – including high levels of parents and teachers reporting that the programme built resilience, highlighting of the importance of a parent-teacher collaborative approach, and increases in the participation of parents, the local community, and other service providers in resilience-promoting activities and general partnership. There is also evidence that students new to a school and students with special needs gained the most benefit, suggesting that health-promoting school activities could help to 'level up' the gradient in outcomes. Further evidence showed increased resilience scores among teachers in a number of different areas, including personal skills building, health policies, and school and community relations. Similarly, students' resilience scores improved, including in the areas of self-esteem, happiness, connectedness to family, teachers and community, autonomy, communication and cooperation.

The review concludes that although there are a limited number of studies, the current evidence suggests that “using the health-promoting schools approach to promote resilience is clearly promising”,¹⁴⁵ and in general, the programmes were effective. More research is needed, particularly in terms of the effect on parents, and on long-term impacts.

Evidence from Australian primary schools suggests that the whole school approach specifically increases resilience.¹⁴⁶ The National Healthy Schools Programme in the UK also took a whole school approach (see box).

Intervention: National Healthy Schools Programme (NHSP) (147)

NHSP was a government-led project, started in 1999, designed to improve health and wellbeing within schools. Action took place within the four areas of emotional health and wellbeing, physical activity, healthy eating, and personal, social and health education, the first of which is most relevant to resilience-building. Schools which were validated as achieving under all of the four criteria were awarded national healthy schools status.

The whole school approach was a key element of the healthy schools programme, as was the use of data and evidence-informed practice, with a toolkit available to help schools 'plan, do and review' the health and wellbeing improvements within their student population, and to encourage selection of interventions based on needs data and evidence.

Since the change in government in 2010, the programme is no longer monitored and implemented at a national level; however, resources (including case studies) are still available online in order to support the implementation of the approach,¹⁴⁷ and many local areas or regions have taken forward projects. For example, healthy schools London assists and awards schools in the same four areas listed above, and in community engagement. Their website¹⁴⁸ provides further resources and case studies.

NICE has modelled the cost-effectiveness of whole school approaches to preventing bullying and victimization, and found that where these interventions were successful, the cost would be £9,600 per quality-adjusted life year (QALY) – well below the £20,000 a year NICE threshold.ⁱⁱⁱ However, the same review found that there was a significant range in the level of efficacy of programmes.¹⁴⁹ Whole school approaches have also been shown to be more effective than targeted programmes in improving outcomes for those with additional needs or particular vulnerabilities.⁹⁹ If these groups are particularly benefited, the approach may be successful in reducing inequalities and levelling up outcomes.

In order to implement a whole school approach, it is necessary to consider not only all students, but staff and family as well. They are also characterised by their concern for multiple goals, not simply academic attainment.⁹³

There are ten elements to the whole school approach, listed below. Further information on each area can be found in the NHSP report.¹⁵⁰

1. Leadership, management and managing change.
2. Policy development.
3. Curriculum planning and resources, including working with outside agencies.
4. Learning and teaching.
5. School culture and environment.
6. Giving children and young people a voice.

ⁱⁱⁱ For more information on QALYs and other forms of measurement, please see the guide to economic impact review in this series.

7. Provision of support services for children and young people.
8. Staff professional development needs, health and welfare.
9. Partnerships with parents/carers and local communities.
10. Assessing, recording and reporting children and young people's development.

The school as a community hub

As well as supporting good relationships and building and recognising the achievements of pupils, there are ways in which the school can function as an institution that acts as a local hub, connecting individuals, groups and services to each other. In this way, and by working with the local population and reinforcing community networks, schools can help to build trust, cohesion, influence and cooperation within the community, thereby increasing social capital and community resilience, which can have positive effects on health and reduce inequalities.

A review of interventions found that those taken in schools to develop a stronger sense of community may reduce violence and aggression and build emotional health.¹⁵¹ There is also evidence that young people who were more likely to overcome the effects of socio-economic disadvantage (that is, display resilience), were those who participated in extracurricular activities,^{14, 35} were part of strong social networks,¹⁴ or took part in voluntary or part-time work.^{26, 35} Schools can offer these opportunities to their pupils, and in this way, contribute to lessening socio-economic, and related health, inequalities.

As part of working closely with the local community, schools can provide a hub for local services and agencies that have relevance for the wellbeing of children, families and communities.⁹³ This was the central idea of the full service extended schools initiative (see box).

Intervention: full service extended schools initiative (FSES)¹⁵²

The FSES initiative was a three-year project launched by the Department for Education and Skills (DfES) in 2003, with the aim of developing one or more FSES in each local authority (focussing particularly on areas of high deprivation). 'Extended' schools provide a range of services, including, health, adult learning, community activities, study support, and childcare from 8am-6pm. The programmes focussed on overcoming barriers to learning by acting on family and community problems.

In total, 138 schools were involved in the initiative, and results included:

- a positive impact on pupils' attainment, particularly for those facing difficulties
- increased engagement with learning, family stability and enhanced life chances
- more stable domestic environments
- improvements in the qualifications and employability of the local community
- a reduction in unhealthy behaviours and an increase in positive health-related outcomes
- a reduction in youth crime and disorder
- increased self-confidence and social skills

The authors of the evaluation conceptualise the positive outcomes as increases in capability, informed by Sen's approach.

A cost-benefit analysis showed high costs, ranging from £391 to £1,961 per pupil per year (predominantly financed by school funds). However, it also found equal or higher benefits in the outcomes listed above, including positive net present value. This resulted in the FSES being considered a good investment, particularly as benefits accrued disproportionately in favour of those facing the greatest difficulties. The evaluation stated that this resulted in a redistributive element of the FSES.

Following the three-year initiative, the DfES set out an intention to roll out a (more limited) extended schools approach on a national level, with the aim of all children having access to extended provision in their schools by 2010. This was renamed as an extended services approach, and has also shown positive results.¹⁵³

Schools are also able to commission external services – a systematic review found that locating social work in schools increased skills, problem solving, and relationships between peers. Most programmes in this review focussed on reducing risks and enhancing protective factors, thereby building resilience.¹⁵⁴ Local authorities have an obligation to secure provision of counselling for school-age children, which has been shown to have some positive results in improving the mental health and wellbeing of pupils, although there is room for improvement in terms of equality of access and outcome monitoring.¹⁵⁵ The Welsh school counselling service has also showed some positive results (see box below).

Intervention: school-based counselling in Wales¹⁵⁶

In 2010, the Welsh government commissioned an evaluation of its school-based counselling service, which had been in existence for three years. The counselling strategy, based on a review of UK-based counselling services,¹⁵⁷ used a whole school approach, with a central concern for children's wellbeing. The evaluation found that:

- counselling was associated with significant reductions in psychological distress in all the local authorities examined
- reductions in psychological distress were considerably greater compared with those pupils in a control group who did not receive counselling
- the overall mean reduction in psychological distress was large
- according to a client questionnaire, 85% of respondents felt more positive about going to school and more able to cope after counselling
- the strategy did not add to the workloads of school staff, and may have relieved the pressure on some teachers
- counsellors, link teachers and local authority leads all responded positively, reporting positive impacts, including, among pupils who received school counselling:
 - behaviour: 80% net improvement
 - attendance: 69% net improvement
 - attainment: 65% net improvement

Commissioning services are most likely to be successful when informed by local information and strategy. For example, the joint strategic needs assessment (JSNA) is an identification of children's needs using tools such as the common assessment framework.⁹³ and delivered in partnership with other local organisations, including other schools¹²² and in partnership with health and wellbeing boards. There are also good opportunities for schools to link with local organisations such as child and adolescent mental health services (CAMHS). Research indicates that schools with the best links to CAMHS show the greatest decline in behavioural difficulties among students.¹⁵⁸

Finally, schools can enhance their role in the community, and increase both community and individual resilience, by offering a wide range of all-age community activities, such as after-school clubs or further education courses.^{14, 26} Schools can become places where children and their families can access a wide range of support and services, and a hub where all members of the community can meet and interact.¹⁴ A community approach to increasing protective factors can be seen in the Communities that Care intervention (see box).

Intervention: Communities that Care (CTC)¹⁵⁹

CTC was originally an American intervention, which was then implemented in the UK. It uses a preventative model to improve public health by preventing violence, delinquency, school dropout and substance abuse among children and young people.

The programme uses a social development strategy to strengthen protective factors, increase resiliency, and enable positive development. This is based on data and surveys of adolescents that identify risks and strengths within a community, and works across different organisations (including schools) and community groups.

The American programme has been evaluated,¹⁶⁰ and results show that compared to control groups, youth within CTC areas are:

- 25% less likely to have initiated delinquent behaviour
- 32% less likely to have initiated the use of alcohol
- 33% less likely to have initiated cigarette use
- 25% less likely to engage in violent behaviour
- more likely to have improved academic performance

American evaluation also shows that for every dollar invested in CTC, there is a return of \$5.30, in the form of savings within the criminal justice system, lower health care costs, increased earnings and higher tax revenues.

The UK-based programme was trialled between 1998 and 2003 by the Joseph Rowntree Foundation, after which the charity Rainer (now called Catch22) ran the programme within local authorities from 2006 until 2008, when it ended. The programme was not continued due to a lack of funding from local authorities, who found that the long time-lag before benefits were seen made it difficult to justify in commissioning processes.¹⁶¹

Action at a community level also involves enabling and encouraging local procurement processes to consider how contracting decisions will impact on the local area. The Public Services (Social Value) Act 2012¹⁶² enables public service commissioners to incorporate a consideration of community benefits (social value) when awarding contracts and making procurement decisions. It also encourages local social enterprise by providing a 'community right to challenge', whereby communities or social enterprises can challenge public procurement decisions if they can demonstrate that they themselves could provide the service to greater social effect. Schools and local authorities can develop the implementation of school programmes to develop resilience and improve inequalities by drawing on the Social Value Act.

Acting for the benefit of families and communities means involving them in any strategy a school takes to improve resilience, capabilities and wellbeing. When a service or activity is made available, it is essential to ensure that all have the opportunity to access the service, particularly those who are most disadvantaged.^{12,35} For some, this may require a further level of support; for example, some families may need assistance with transport or extra childcare in order to make full use of services on offer.¹²⁶

Where schools are working with partners, including the local authority, it is helpful if all partners have a clear understanding of their role and obligations, and that protocols are set up to cover processes of assessment and referral,¹²⁶ as well as joint commissioning.³⁵

4.5: Principles for implementation: proportionate universalism and prevention

In section 3, we described inequalities in the prevalence of adversity and resilience. Proportionate universalism describes a way of delivering interventions so that they are universal (accessible to all), but targeted with an intensity proportionate to need. Where proportionate universalism is successful, it can 'level up' outcomes, so that those who are at the bottom of the social gradient see the most improvement.¹

This approach may be of use in building resilience among children and young people, some of whom will need targeted resources – for example, interventions to increase completion of secondary school among gypsy and traveller communities. In addition, schools in areas of deprivation serve populations who are likely to experience greater levels of adversity, and are therefore more in need of programmes to support and build resilience.

However, it is also important that interventions are accessible to all. This is necessary for four reasons:

1. Adversity is not a case of 'have and have not' – it occurs along a gradient. Even those who are not facing severe adversity will benefit from a higher level of resilience.
2. A higher level of resilience, when maintained, may be necessary for an individual at a later point in life. Future adversity or shock is not always possible to predict, and we therefore have a responsibility to ensure that all children and young people are equipped with the resources necessary to cope with these circumstances, should they arise later on in the life course.
3. Approaches that are only targeted at the most 'at risk' children or young adults run the risk of stigmatising these pupils,²⁷ and thereby reducing protective factors such as peer support.
4. Targeted approaches can be vulnerable to short-term funding cuts. Interventions that do not benefit the whole population may well lack universal public support and are more easily decommissioned than universal services that enjoy universal use and support.

Research on resilience has emphasised the importance of a combined universal and targeted approach,²⁷ and throughout this document we have highlighted where interventions or strategies have the potential to 'level up' outcomes.

5. The second principle for implementation is the value of prevention. Interventions and research findings have shown that it is possible, and desirable, to build resilience before the onset of adversity.^{5, 7} This may, in fact, have a greater impact than acting later on in the life course.²⁷ For example, the Seattle social development project (see above), implemented in the early years of primary school, has been shown to have a positive impact on the prevention of unhealthy behaviours in adolescence. Having said this, research also shows that although early intervention is desirable,⁹³ effective programmes can have an effect even on older children or extensive problems.¹⁶³

5. Areas for further research

There are a number of areas that this paper has not addressed fully. These include the experiences, needs and actions that can be taken for particular groups of children – including those with social and emotional needs, gypsy and traveller children, looked after children, and those who are educated at home or in private schools, where the role of local authorities is less clear. Further research is needed on what can be done to build resilience for these groups. Nor does this paper address how actions should be adapted according to the age of the child, the family or local context. This is both an area for further research and a task for local areas or schools as they implement programmes.

Community resilience is an important factor in building individual resilience, and can increase opportunities, impact on experiences, and improve the conditions in which young people live. It is likely that building community resilience is a key way to build individual resilience, which was briefly discussed in the 'school as a community hub' section, above. However, this area does need further research, particularly in terms of effective interventions and measuring outcomes.

As has been made clear in this paper, there is a lack of clear measurement of resilience, and this can hamper efforts to gather data both on how resilient children and young people are, and also on what works to increase resilience and reduce risk. More effective and standardised monitoring and indicators may help us to increase knowledge in these areas.

There is also more research needed on the long-term impacts and costs of programmes that increase resilience, particularly since the outcomes are often likely to be seen across a range of areas (such as health, crime, and employment).

NICE has identified a number of areas where further research is needed in specific relation to social and emotional wellbeing.³⁵ These include:

- the differential impact of different professional groups
- cost-effectiveness of organisation-wide interventions
- the links between social and emotional wellbeing of children and young people and later health outcomes
- the impact of interventions on educational attainment and crime rates
- a method for valuing the costs and benefits of interventions that involve different sectors

Conclusion

Resilience is the capacity to 'bounce back' despite adversity, and achieve good outcomes, including in health. Supportive relationships, positive experiences and constructive opportunities are all protective factors that are necessary in order to build resilience. Meanwhile, risk factors can increase vulnerability and reduce the capacity for resilient outcomes. Therefore, the development of resilience depends on the conditions in which people are born, grow, live, work and age.

Because resilience depends on these conditions, wider inequalities in power, money and resources are reflected in inequalities in resilience according to disadvantage – those who need it most tend to have it least. Furthermore, adversity follows a social gradient, creating a double burden of greater need and lower resilience. Resilience has an impact on health outcomes through effects on health behaviours, qualifications and skills, employment, mental wellbeing, and recovery from illness. Therefore, inequalities in resilience can reinforce or contribute to inequalities in health.

Schools have an opportunity to ensure that children and young people are supported and enabled to build resilience. Local authorities can encourage and help schools achieve this aim. There is good evidence on what works to promote wellbeing in schools, and some evidence specifically on building resilience. This evidence, including results of interventions, suggests that schools can build resilience by improving achievements, supporting transitions, promoting healthy behaviours, and working with parents to improve family relationships and support, as well as encouraging support from teachers and peers. Additionally, resilience can also be built by schools acting as a community hub and working with and for the local community, and adopting a whole school approach. Where interventions are successful, they may help local areas to improve the lives of children, their families, and the community. Successful action can contribute to tackling health inequalities and 'levelling-up' the social gradient in health.

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