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Evidence Brief

How do we provide support to children with psychosocial disabilities in school?

The question and the problem

It is estimated that approximately 10-20% of children, adolescents and young people (under the age of 18) worldwide have a disabling mental health condition. Approximately two-thirds of the global youth population goes to school for a significant proportion of the day. The idea of delivering mental health support in the setting has gained prominence as a way to increase the coverage and accessibility of mental health support for children. While there is a wealth of evidence around school mental health approaches in HIC, there is limited information with regards to their impact in low- and middle-income settings. This evidence brief explores what has worked for the delivery of school mental health initiatives in diverse settings, as well as evidence-based recommendations to strengthen them.

Recommendations

1. Ensure that school mental health approaches are tailored to the diverse needs of children at all ages
2. Incorporate multi-modal programming for mental health promotion, prevention and support for School-going children
3. Empower young people to actively participate in the design, development and delivery of school mental health approaches
4. Introduce more feasible approaches to sustain mental health support initiatives within low-resource education systems
5. Improve the readiness of school systems to adopt mental health as a key aspect of support provided to students

"School-based mental health services also have the potential for bridging the gap between need and utilisation by reaching disadvantaged children who would otherwise not have access to these services"

- Armbruster, Gerstein, & Fallon (1997)

Challenges

1. Inaction on emerging mental health concerns in children, adolescents and young people have long-lasting implications on disability in adulthood

- It is estimated that up to 50% of adult mental health conditions have their onset during childhood or adolescence, indicating the strong justification for early action to address mental health needs early and prevent the likelihood of developing more severe and often disabling mental health conditions in later life.
- There is a need to develop more accurate measures to identify the level of disability associated with child and adolescent mental health concerns as the use of disability-adjusted life years fails to account for the future impact of a mental health condition on health.

2. There exist limited resources and evidence-base on child and adolescent mental health research and approaches in schools from Low- and Middle- Income Countries

- Specialised mental health services for young people in LMICs are ill-equipped to deal with the high level of support and care needed. To address this resource gap, more inter-sectoral approaches to integrate mental health support within schools have been recommended as a way forward. It is important to note however, that many children living in informal settlements, slums and working children are a marginalised and vulnerable group who are unlikely to benefit from classroom based mental health programmes and such programmes need to additionally prioritise the identification of points of access to services for these groups.
- While there exists high-quality and promising evidence for school-based approaches, this largely comes from research done in HICs which have more resources allocated towards CAMH

3. A focus on prevention and promotion for mental health within schools has potential to limit future costs to an already burdened health system

- Lack of investment in preventive programs means that health systems may not reach a significant proportion of a vulnerable population; interventions need to include components of cost analysis and effectiveness in their methods in order to build a stronger case of investment and health policy relevance to their work.
- In HIC, there is evidence to suggest that multi-tiered and mixed-component prevention and promotion programmes i.e. incorporating both universal and targeted support (rather than vertical programming on distinct tiers of preventative programmes) provides more benefit when delivered in schools and classrooms

4. Lack of youth-led narrative and participation in the design, development and delivery of mental health approaches in schools

- School-based approaches need to be inclusive to the needs of young people in order to improve uptake and effectiveness of these approaches e.g. how to manage confidentiality in such settings, group-based approaches and the role of parental involvement as the evidence around the feasibility of these issues varies between HIC and LMIC contexts
- There is promising evidence from HIC to suggest that peer-facilitator delivered mental health approaches in school-settings strengthened social support and norms and are more likely to benefit from higher rates of engagement with marginalised populations

5. Poor readiness in LMIC educational systems to provide additional support in the way of mental health care

- Education systems in LMICs are already struggling with limited financial resources. Task-shifting for teachers has been identified as one way to incorporate mental health education and establish referral pathways in schools. However, teachers are often paid poor salaries, have competing priorities and have to manage crowded classrooms which may impact on the feasibility of this approach in LMIC school-settings.
- In both HIC and LMICs, interventions that harnessed culture-specific coping mechanisms and mind-body skills were found to be more effective at reducing symptomology and sustaining effects at 3 months and reduced burden to school systems by utilising local support systems

How did we find answers

We conducted a review of reviews, examining systematic, narrative, and other types of review evidence on the mental health approaches for children, adolescents and young people under the age of 18 in school-based or classroom-room based settings. All recommendations are based on reviews of literatures from low- and middle-income countries, as well as some reviews of literature from high-income countries where the recommendations made were transferable to low-resource settings. This evidence note is based on the findings of 8 reviews of low- and middle-income country evidence, 2 reviews concerning evidence from high-income countries and 2 reviews which summarised literature from both settings.

Evidence-informed Recommendations and Actions

Key Recommendations	Actions
Ensuring that school mental health approaches are tailored to children with diverse needs and ages	Evidence suggests that incorporating psychosocial interventions like cognitive-behavioural therapy is beneficial in reducing symptoms for depression and anxiety in older children and adolescents; building the foundations of mental health coping mechanisms like socio-emotional skills like self-management, self-esteem, social skills and emotional understanding is more effective when targeted towards younger children
Incorporate multi-modal programming for mental health promotion, prevention and support for School-going children	One package does not fit all when it comes to prevention, promotion and treatment approaches for school-going children. Developing multi-modal packages of care e.g. strengthening capacity of teachers to respond to mental health needs and referrals for students, involving parental support, psychoeducation and introducing psychosocial interventions (e.g. Classroom-based Interventions) for children at risk are all strategies that have proven efficacy and feasibility in some diverse school environments, including in conflict settings
Empowering young people to actively participate in the design, development and delivery of mental health approaches in schools	Programmes and researchers should make explicit the methods involved in assessing the needs of and consulting young people in the design, development and delivery of their school mental health approaches to ensure they are aligned to contextual and cultural needs e.g. training adolescents and young adults to be peer facilitators
Introduce more feasible approaches to sustain mental health support within low-resource education systems	In LMICs, school-based programmes can improve the scope and feasibility of their programmes by integrating materials into the existing curriculum (e.g. psycho-education, resilience-building and coping skills training) rather than developing new activities or hiring specialised staff members that require continual financial resources and may make sustaining the programme more challenges.
Improve the readiness of school systems to adopt mental health as a key aspect of support provided to students	Nurture supportive environments that promote professional development for staff involved in delivering school or classroom-based mental health support to children as a way to provide ethical and sustainable incentives and bring about change through a holistic whole-school approach

Policy priorities

The evidence reviewed in this brief makes a case for ministries of health and education to work together in order to invest in, develop, implement and evaluate prevention programmes in school-based settings to address the low coverage of specialised treatment services and high demand for mental health care in children, adolescents and young people in their countries. Prioritising preventative approaches like addressing causal factors and enabling environments to nurture protective factors for mental health conditions in early stages of development has the potential to reduce future costs incurred by the health system. A large majority of countries do not recognise the unique mental health needs of young people within national policies or programme plans of action. Governments and ministries should take multi-sectoral action to address this gap within their countries and along with youth representative organisations draft and develop inclusive, integrated and comprehensive child, adolescent and youth mental health policies and plans of action.

GAPS & RESEARCH NEEDS

High levels of variability in the types of population selection criteria, mental health conditions targeted, outcomes and measures for detection make it challenging to identify and recommend specific interventions and approaches. Researchers should employ methods to reduce heterogeneity among their findings, as well as explore the differential effects for gender reported across school based programmes. Many school-based approaches also incorporated short follow up periods and lacked reporting for quality assessment like blinding, allocation concealment and methods for randomised sequence which reduces the statistical power in estimating the long-term effects of the school-based approaches used in specific populations.

Conclusion

There is encouraging evidence to suggest that research-policy partnerships for school mental health programmes may encourage more feasible programme design and implementation along with supporting research teams with the resources and expertise to employ more rigorous evaluation methods. School-based programs have to consider the capacity limitations of managing the mental health needs of children in classroom-based settings and to address the potential added burden on school systems and staff who have limited opportunities for development when teaching in low-resource settings. While the burgeoning interest in developing and evaluating such approaches is promising, the number of studies evaluating school-based mental health approaches is fairly small despite the improved and relatively high rate of school enrolment in LMICs. This evidence-base needs to be strengthened to be able to draw conclusions on best-practice approaches in delivering mental health support in the school setting.

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