*The*BlueD⊕t

DESIGNING

A HEALTHY ECOSYSTEM

TO PROMOTE

Mental Health

*The*BlueD⊛t

THE BLUE DOT features articles showcasing UNESCO MGIEP's activities and areas of interest. The magazine's overarching theme is the relationship between education, peace, sustainable development and global citizenship. THE BLUE DOT's role is to engage with readers on these issues in a fun and interactive manner. The magazine is designed to address audiences across generations and walks of life, thereby taking the discourse on education for peace, sustainable development and global citizenship beyond academia, civil society organisations and governments, to the actual stakeholders.

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**"Look again at that dot.
That's here. That's home. That's us.**

On it, everyone you love,
everyone you know, everyone you ever heard of,
every human being who ever was,
lived out their lives.
The aggregate of our joy and suffering
thousands of confident religions,
ideologies, and economic doctrines,
every hunter and forager, every hero and coward,
every creator and destroyer of civilization,
every king and peasant, every young couple in love,
every mother and father, hopeful child,
inventor and explorer, every teacher of morals,
every corrupt politician, every superstar,
every supreme leader, every saint
and sinner in the history of our species lived there-
on a mote of dust suspended in a sunbeam."

CARL SAGAN
PALE BLUE DOT: A VISION OF THE HUMAN FUTURE IN SPACE

https://mgiep.unesco.org/the-bluedot

Mental Health: *Building the defenses*

Depression is now recognized as one of the leading causes of disability with the World Health organization (WHO) reporting that suicide is the fourth leading cause of death among 15-29 year old's. In India, a WHO report from 2015 reported that about 25% of children between the ages of 12-15 suffered some form of depression.

These numbers are - to put it bluntly - morally unacceptable in today's day and age. Moreover, there is increasingly acknowledgement of the key role mental health plays in achieving the Sustainable Development Goals. How can we expect individuals to adopt sustainable practices and pay attention to global problems such as climate change if they are suffering from depression, anxiety, and a sense of hopelessness among others? But we are also caught in a chicken and egg situation whereby these drivers are also responsible for causing poor mental health and if untreated, leading to mental illness. A recent survey of youth across the world found that many are anxious, frustrated and depressed at the state of the world and the uncertainties climate change will bring to their lives.

The Center for Disease Control in the United States defines mental health as "Our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices".[1]Mental health is important at every stage of life, from childhood and adolescence through adulthood.

There is increasing evidence as well as knowledge that the state of mental health is a spectrum ranging from good mental health to poor mental health and mental illness at the far end of the spectrum. Movements across this spectrum is dynamic and runs both ways. It is only natural to move across the spectrum but moving into a permanent state of mental illness can be dangerous for the individual and for society at large. No stone must be unturned to fight mental illness.

The common sense thing to do is to build the defenses of each individual to ensure that one can maintain good mental health and to provide the capability of individuals to regain good mental health if circumstances force a person to suffer bouts of depression and or anxiety. The objective is to provide the defenses so that an individual can get back into their "zone" when distressed and not allow poor mental health to deteriorate to mental illness.

This issue of The Blue DOT focuses on building these defenses and I am very pleased to see such an enthusiastic response by many of the experts from a diverse set of countries writing for this edition. I am confident that what they have to say would be useful in pushing our knowledge base on this topic and offer solutions to this pressing need of the hour.

As always, we look forward to your feedback and suggestions on how we can improve the Blue DOT and make it relevant to the contemporary problems we face today.

[1]https://www.cdc.gov/mentalhealth/learn/index.htm

ANANTHA KUMAR DURAIAPPAH

FOREWORD

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YOUTH PIECE

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COVER STORY

INTERVIEW[2,3]

YOUTH VOICE

The Blue Dot:
Foreword

Alan Winde is a former businessman, now Premir, and since 2019, Premier of the Western Cape, Province of South Africa

Before he began his career in politics, he started and successfully operated 10 businesses in his hometown of Knysna. Determined to contribute positively to his town, he then became a councilor, and later, became a member of the provincial parliament.

In 2009, following the DA's victory in the provincial election, he became the Provincial Minister of Finance, Economic Development and Tourism, with a firm focus on growth and jobs.

It was this same focus that drove his campaign for the premiership, which was centred on improving economic and household prosperity by getting the basics right, such as education and healthcare, and improving safety and public transport for all the residents of our province. He further committed to improving the efficiency of government service delivery through innovation, new technology and culture change.

Since becoming Premier, he has implemented several programmes to achieve these goals, including rolling out lifestyle audits for his cabinet and launching a billion rand safety plan through which over 1000 officers have been deployed to high crime areas. He also oversaw the province's response to Covid-19, building an 862-bed hospital in a record 6 weeks. In Februrary 2022, he announced a major focus on infrastructure to help recover the province's economy post-covid, which includes a new emphasis on a dedicated mobility department to improve public transport.

The COVID-19 pandemic has exacerbated the existing drivers of poor mental health, including social isolation, domestic violence, traumatic events, poverty, financial insecurity, bereavement, unemployment, and drug and alcohol misuse. Even before the pandemic, the WHO reported that globally there was a 13% rise in mental health conditions and substance use disorders between 2007 – 2017 and that approximately 20% of the world's children and adolescents have a mental health condition[1]. This has become much worse since COVID-19. In 2020, South Africa was one of the countries (out of the 204 surveyed) with the highest increase (more than 36,4%) in prevalence of depressive and anxiety disorders[2]. Local data confirms consistently higher rates of depressive symptoms reported since the onset of COVID-19, with the risk of screening positive for depressive symptoms having increased from 21% in 2017 to 29% in 2021[3]. This is particularly the case for young people – in 2020, 72% of young South Africans (ages 18 – 35) interviewed were classified as having depressive symptoms and at risk of having depression, up from 12% in a similar study in 2017[4]. In the Western Cape, the number of suicides has increased by just under 27% compared to pre-pandemic years[5].

As South Africa's youth unemployment increases, this triggers hopelessness and depression among

[1] https://www.who.int/health-topics/mental-health#tab=tab_2

[2] COVID-19 Mental Disorders Collaborators (2021) Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 Pandemic. Lancet 398: 1700-1712

[3] Hunt, H., Breet, E., Stein, D., & Tomlinson, M. 2021. The COVID-19 Pandemic, Hunger and Depressed Mood Among South Africans

[4] Mudiriza, G. and De Lannoy, A., 2020. Youth emotional well-being during the COVID-19-related lockdown in South Africa

[5] Western Cape Forensic Pathology Services, 2022.

youth. The link between hunger and mental health conditions is also well-established. We know from both local and international research that food insecurity has worsened since the onset of the pandemic, compounding the mental health burden.

As the Western Cape Government (WCG), we have been on a journey to better understand and respond to this challenge. We know that a purely clinical response is insufficient and instead have chosen a Whole of Society Approach (WoSA), as this enables us to tackle mental health and well-being holistically.

One of the pillars of our holistic approach is our early life course programme. Support is provided to mothers and children in the first thousand days of life (0-2 years old) and access to early childhood development programmes has been improved. Once children reach primary school, we offer after-school programmes, where children can take part in sports and recreation activities and social and emotional learning programmes. At high school, learners take part in Cognitive Behavioural Therapy-inspired violence prevention initiatives.

Many young people struggle to find their next opportunity once they leave school. We provide stepping-stone youth development internships and professional development opportunities. One such example is a three-month, residential life

skills and outdoor education programme. For adults, we offer mental health care and counselling services, substance abuse services and healthy lifestyle initiatives. We recognise that this is not enough, given the scale of the challenges since COVID. We have therefore established a platform for mental wellbeing amongst government departments, non-profit organisations, and academia. From this collaboration has emerged a Theory of Change, which has subsequently informed our strategy: map mental health services and improve the relationships between public and public benefit service providers, upscale communications campaigns that de-stigmatise mental illness and tell people where they can access services, and assess and upscale training interventions for public officials, non-government providers, and religious leaders alike.

The mapping meetings have been powerful. All service providers in a district – whether public or non-governmental - have met to share their experiences and to listen to their colleagues' experiences. This has strengthened relationships between mental health care providers and has enabled the identification of shared resources and possible solutions – solutions that will be pursued together. The mapping processes have also highlighted the specific training and communication needs that will be implemented transversally throughout the Province.

One constant theme that runs through all of our programmes is a focus on mental wellbeing rather than mental illness. By strengthening the factors that support mental wellbeing, we are on course to improve the overall wellbeing and prosperity of the people of the Western Cape, South Africa.

Editorial Note

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The Global Burden of Disease (GBD) Study estimated that the COVID-19 pandemic has led to a 27.6% increase in cases of major depressive disorder and a 25.6% increase in cases of anxiety disorders worldwide in 2020[1]. The data provides clear evidence about the rise of mental health problems, and COVID-19 has undoubtedly further exacerbated these concerns.

There is a lack of consensus on the general definition of mental health and often gets conflated with mental illness. The World Health Organization defines it as a "state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"[2] highlighting that mere absence of mental illness is not enough

[1] World Health Organization. (2022). Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022. In Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022.
[2] World Health Organization. (2004). Promoting mental health: Concepts, emerging evidence, practice: Summary report. World Health Organization.

to define mental health and broaden the focus to also include relationships with others and society.

Mental health can also be defined as a continuum emphasizing that it is not static, and we can move from one end of the spectrum (incomplete mental health as languishing) to the other end (complete mental health as flourishing) (Keyes, 2022). In our everyday lives, we are all subjected to many stressors that may cause an emotional disequilibrium and we are left unable to take any action to stabilize ourselves. Mental health as a continuum implies that suffering from mental illness is not absence of mental health; it merely means that the person, at present, lies at the negative end of the continuum, and can bounce back with evidence-based interventions provided by professionals.

Defining mental health as a continuum also highlights the benefits of preventive and promotive measures in young people like equipping them with skills, attitudes and mindsets where they are able to better regulate and manage themselves. This can be developed by fostering the growth of social, emotional, and cognitive competencies (SEC) and creating learning environments that are centered on positive and supportive relationships. Cultivating Social and Emotional Learning (SEL) involves developing competences and/or attitudes necessary to recognize and control emotions, develop caring for others, form positive relationships, make responsible decisions, and deal with challenging situations (Payton et al., 2000; Greenberg et al., 2003; Weissberg

et al., 2015). Accumulating evidence from various fields such as psychology, neuroscience, and physiology indicate that SEL outcomes have helped young people attain the insight, equilibrium and judgment necessary to lead functional lives that thrive (Frydenberg et al., 2017) and also show improvements in academic outcomes (Durlak et al., 2011) and psychological well-being (Hymel et al., 2018). However, when young people are already suffering from mental health issues and depending on where they are on the continuum, they may need evidence-based interventions provided by clinical professionals that can reduce their symptoms and improve the functional quality of their lives.

Despite opportunities to prevent and promote mental health, the reality is that one in seven 10-19-year-olds experiences a mental disorder, and suicide is the fourth leading cause of death among 15–19-year-olds (GBD Study, 2019). A focus group study with adolescents across 13 diverse countries on important emotional behavioral challenges faced by young people calls attention to the increasing prevalence of depression, anxiety, suicide and self-harm, drug and alcohol use, violence and aggression, eating disorders and how Covid 19 increased isolation, feelings of emotional distress, and risky behaviors (John Hopkins and UNICEF, 2022). When considering behavioral strategies for preventive and promotive interventions there are several lessons that can be learnt from other health domains, specially when targeted at adolescents. These behavioral considerations while designing programs are creating an

enabling environment, establishing positive social norms in peer groups, promoting feelings of empathy and prosocial motivation, engaging young people, building young people's confidence in their ability to protect themselves, and facilitating social connections (WHO, 2021).

Adolescence marks a transition to enormous somatic and psychological changes. Unsurprisingly it is also characterized by increasing susceptibility to mental disorders than during other times of life. The susceptibility to mental disorders can be attributed to increased vulnerability of the brain since it is undergoing a lot of reorganization (Konrad et.al, 2013; Patel, V, et.al, 2011) along with increasing social pressures and expectations. This reorganization of the adolescent brain also makes it highly malleable because of its neural plasticity, making it a great time to teach various social, emotional, and cognitive competencies to buffer against adverse experiences.

Research on the developmental changes of cognition and brain maturation during adolescence link neurodevelopmental trajectories of social and emotional learning with the prefrontal cortex. The changes of social, emotional and cognitive neurodevelopment show functional correspondence with the emergence of social and emotional competencies. The learning of social and emotional skills and knowledge that accompanies growth and learning contributes to the development of social and emotional competencies that is life long. The social and emotional fulfillment from

the positive social influence of fulfilling social relationships contributes to the enrichment of social and emotional learning.

The changes of cognitive and neural plasticity demonstrate the malleability of cortical mechanisms to experience and learning. The neurodevelopment of social and emotional capacities coincides with the changes of cognition and neural plasticity that are linked to social and emotional regulation. The development of social and emotional knowledge contributes to the understanding of the importance of control and regulation of social and emotional cognition. The malleability of cortical plasticity to experience and learning illustrates the role of cognition and brain function on social and emotional regulation.

Many mental health problems manifest during early and late adolescence, but support for developing social, emotional, and cognitive competencies needs to start early. Emerging[3] research suggests that there is a developmental progression for how SECs should be taught and how they are particularly important during transitions, elementary to middle school or middle school to high school. Schools and community-based organizations, second only to families, can play a major role in providing a safe and supported environment characterized by healthy and positive relationships. Comprehensive attention to school health that promotes both physical and mental health and wellbeing helps to also create inclusive learning environments devoid of bullying, discrimination, violence, isolation, etc. Research shows that higher social emotional competence

and prosocial behavior significantly enhance academic motivation, learning engagement, and academic performance even in preschool (Martinsone et al., 2021). Promoting mental health at schools needs a whole community approach that includes building capacity of teachers, social workers, parents, care givers, community-based organizations using evidence-based approaches to SEL.

The development of programs of social and emotional health of schools and community-based organizations builds on the evidence-based approaches on the neuroscience of social and emotional learning. The promotion of mental health that is focused on social and emotional learning contribute to the sharing of educational and scientific knowledge of the importance of social, emotional and cognitive competencies. The understanding of the importance of positive social relationships and the sharing of social and emotional knowledge contributes to the promotion of health and well-being. The recognition of the importance of positive social influences on social and emotional learning enriches the youth development of learning environments.

Scientific knowledge of the neuroscience of social and emotional learning contributes to the educational and scientific resources of school- and community-based programs on social and emotional health. The promotion of the social and emotional health programs of school- and community-based partnerships builds the resources that are beneficial to community and social development. The building of public awareness of the importance

[3] Eccles, 1999; Eccles et al., 1993; Conley, 2015

of the impact of social and emotional learning on human development promotes health and well-being. The involvement of schools and communities in mental health promotion programs on social and emotional health benefits the advancement of the public understanding of health and human development.

WITH THIS BACKGROUND, THE CURRENT ISSUE OF THE BLUE DOT WILL FOCUS ON INVESTIGATING THE FOLLOWING:

The links between the neuroscience perspective on brain maturation, neural networks, and mental health

Promoting preventive and promotive features during early childhood and beyond using an "all young people" vs "at risk" narrative.

Voices from the field- researchers, policy makers, not-for-profit founders, international organizations and psychologists who provide a context setting, age-appropriate conversation about mental health, and the importance of removing the stigma around mental health.

A call for an integrated whole school, whole community approach and practical ways of achieving this.

Practical examples of programmes that have worked in developed and developing countries; and an analysis of why they have worked.

Voice of the youth on their challenges, uncertainties and methods of coping

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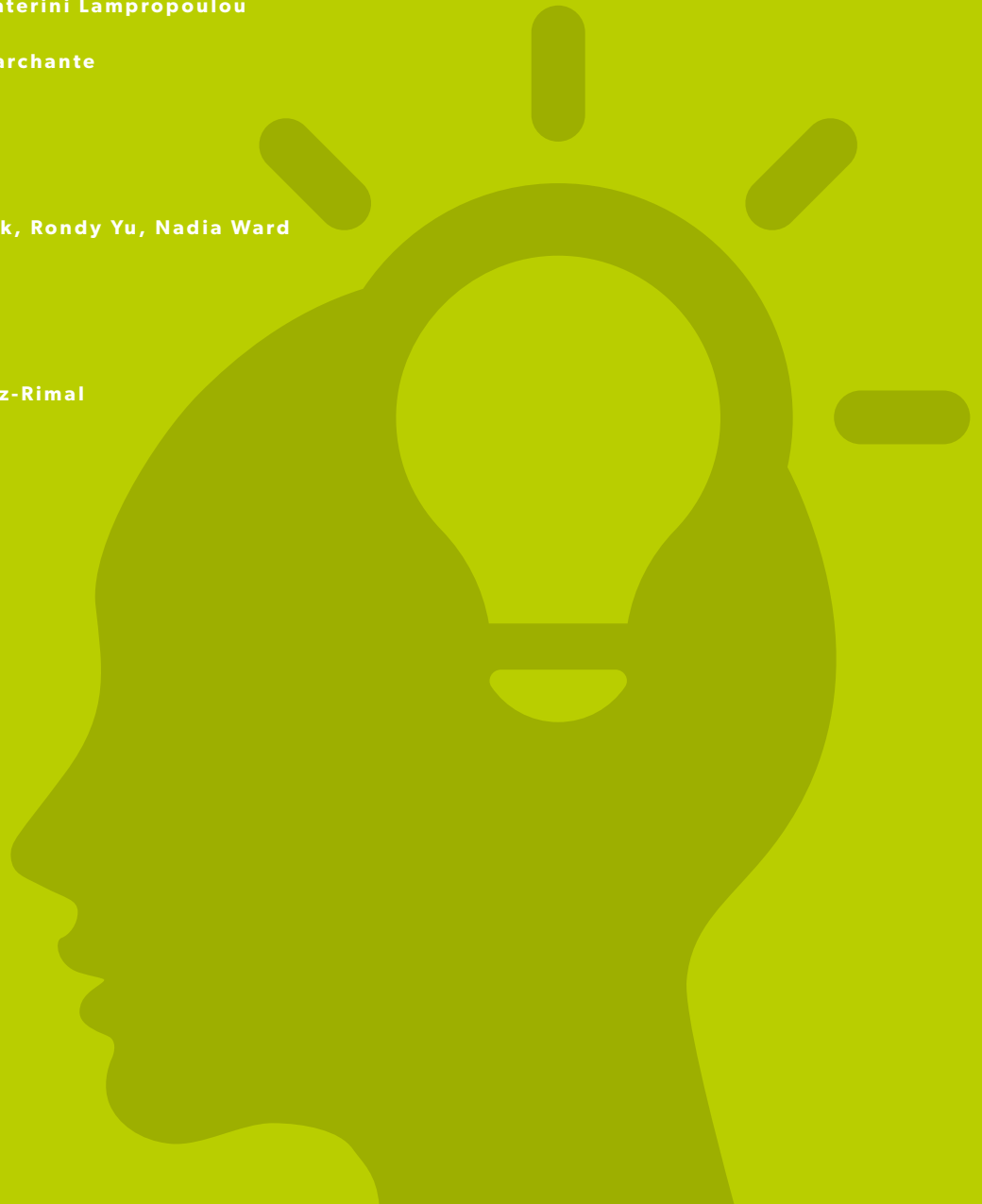
OPINION

Promoting mental health through social and emotional learning in early childhood education

Promoting preventive and promotive features during early childhood and beyond using an "all young people" vs "at risk" narrative, especially focused on the early childhood 0-4 years.

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He has been involved in a cross-cultural
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interventions. He is currently involved
in two European project (E+KA2):
SLIDE, to promote digital learning
and GREEN SESAME, to promote
sustainable behaviors in adolescents.

In recent years, a growing number of studies have investigated the importance of children's non-cognitive traits in predicting health and well-being in adulthood. Non-cognitive processes such as empathy, emotion regulation and self-control are predictors of behaviors in adulthood, such as the likelihood of committing crimes or substance use (Jones et al 2015). *Inadequate functioning on a social and emotional level can have significant consequences on the level of public health, even if the interaction between cognitive and non-cognitive characteristics in development must be considered. Scholastic success requires both intellectual skills and motivation and self-regulation Skills (ibidem).* Another aspect to consider is that noncognitive skills are more malleable than cognitive ones and therefore lend themselves more to being a target for prevention actions (ibidem).

The social emotional competence of children is therefore of fundamental importance from the earliest stages of development. Many recent programs have emphasized the importance of socio-emotional learning. The CASEL (Collaborative for Academic, Social and Emotional Learning) framework identifies five key skills: self-awareness, self-management, social awareness, relationship skills, and responsible decision making (CASEL, 2020). CASEL has also contributed to developing resources at different levels: classrooms, schools, families and communities (see the website: https://casel.org/).

A meta-analysis by Durlak et al (2011) examined 213 school-based social and emotional learning (SEL) programs, involving 270,034 students from

The results showed a greater improvement in social and emotional skills, attitudes, behavior and academic performance in the SEL participants than in the control groups...

kindergarten through high school. The results showed a greater improvement in social and emotional skills, attitudes, behavior and academic performance in the SEL participants than in the control groups; with a gain of 11 percentile points in the results. As predicted, two variables moderated positive student outcomes: SAFE practices (sequenced, active, focused, and explicit) and implementation problems, SAFE practices involve the use of connected and coordinated training activities to achieve specific objectives (Sequenced), based on active learning (Active), aimed at achieving personal or social skills (Focused), and at developing specific SEL skills (Explicit). Implementation problems can occur, for example, when parts of the intervention are not carried out, or the occurrence of unexpected events determines an alteration of the intervention implemented.

Overall the results highlight the importance of adequate planning - both in the preparation of SAFE activities and by trying to prevent problems that could compromise an adequate implementation of the program.

Martinsone et al (2022) investigated the relationship between emotional social competence and emotional and behavioral problems in the learning outcomes of preschool children based on parental and teacher assessments. The sample consisted of 507 preschool children and their parents and teachers. The results show, through teacher assessments of learners, that higher levels of social emotional competence and lower levels of social, emotional and behavioral difficulties are associated with higher academic achievement.

As reported by Blewitt et al (2021), research has shown that SEL programs in Early Childhood Education and Care (ECEC) can have a significant positive impact on children's mental health. Most of the research has focused on the classroom level, with less attention to school and community levels. Blewitt et al (2021) emphasize the need to consider how individual, interpersonal, organizational and community factors work together in promoting the socio-emotional functioning of children and helping to reduce the negative outcomes of mental illness and physical health. They propose considering SEL intervention in early childhood under a "public health model". As part of a public health model, proximal, distal and sociopolitical risk and protection factors must be examined, focusing on health at the population level. To this end, the use of a multi tier intervention system on three levels is proposed, which involves: a) universal prevention strategies (Tier 1), aimed at the entire population; b) targeted or selective strategies (Tier 2) aimed at groups at greatest risk; and c) intensive or indicated (Tier 3) strategies for groups that have been exposed to a health problem (Blewitt et al 2021).

Much research on the effectiveness of SEL programs in Early Childhood Education and Care (ECEC) has so far been based on interventions of a universal nature (tier 1). A systematic review by Blewitt et al (2019) of targeted interventions (tier 2) shows only partial confirmation of the efficacy of SEL programs. SEL targeted programs aimed at preschool children generally concern externalizing behaviors, while few studies investigated problems related to internalizing behaviors. The results of the studies examined do not allow to demonstrate the effectiveness of targeted interventions for emotional competence, and the authors note the importance of using longitudinal approaches and evaluating the differential impact of universal and targeted components using a variety of outcome measures.

In the face of so many studies that have shown how experiences made in the early years affect health in adulthood, there is still a lack of developmental and preventive orientation in mental health services. *Mental health professionals are often only approached when problems are well established, and opportunities for change have diminished (Buka et al 2021). Instead, it would be important to work on building a system that provides support for the family from the early years of development.* In this regard, Buka et al (2021) propose an integrated system of mental health services and social services in the context of pediatric primary care, providing for the use of telemedicine and emergency management strategies. In this context, primary prevention strategies should also be developed to reduce the impact of racial and socioeconomic inequalities on health.

An encouraging study on the possibility of successfully implementing SEL programs in Early Childhood Education (ECE) in the context of universal prevention (tier 1) was carried out by Moazami-Goodarzi et al (2021). This study is based on a SEL program called "Roundies". The program was subjected to an experimental group and a control group of children of about 5 years.The results, based on the teachers' feedback, showed satisfactory results, with an increase in prosocial behaviors and a reduction in difficulties, assessed with the SDQ questionnaire.

Decades of research have allowed us to demonstrate the impact that participation in early childhood education programs for example, Head Start (Deming, 2009) have on different dimensions of wellbeing; highlighting significant financial investment. On the other hand, SEL studies conducted so far in early childhood have involved small-scale interventions related to specific skills. In this sense, Mondi et al (2021) highlight the importance

of reflecting on strategies that allow SEL programs to be applied on a large scale. To do this, SEL must be defined and measured in a consistent, developmentally appropriate, and culturally sensitive manner. To do this, interdisciplinary collaboration involving a variety of stakeholders, such as parents, researchers and policymakers (ibidem), is required. Efforts must therefore be invested to support different ecological levels. Work at home and at school must be integrated with public policies that support the development of health (ibidem).

The conclusion we can draw from what has been said so far is that Intervention programs based on the SEL framework have a solid foundation of research that supports their effectiveness. Much remains to be done to promote their application in the early stages of development. Furthermore, the importance of giving more resources especially for the universal level of intervention (tier 1), the one that gives greater results and returns on investment for public health, should be emphasized.

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Acknowledging The Behaviours We Want: Promoting Positive Mental Health in Schools

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Universally, it is expected that school teachers manage their classrooms so that productive learning can occur for all children. More is now demanded from classroom teachers and at the same time student behavior has become increasingly concerning and challenging. To restore order, tired and stressed educators can resort to various forms of punishment, exclusion and other reactionary practices. This is despite the increased likelihood of antisocial behaviour and decrease in the quality of student mental

health associated with such approaches (Barker et al., 2022; Herman et al., 2022; Hemphill & Towl 2020). Further, *challenging student behaviour can be a sign of adverse mental health and can in turn affect the mental health of others.*

In consideration of inconsistent and unproductive responses to poor student behaviour, *thousands of schools in many countries are now implementing School Wide Positive Behavioural Supports (SWPBS) as an organisational framework for their classrooms and school communities more broadly* (Lloyd et al. 2020).

School Wide Positive Behavioural Support is defined as a framework for enhancing the adoption and implementation of a continuum of evidence-based interventions to achieve academically and behaviourally important outcomes for all students (Sugai and Simonsen, 2012).

Initially established in the 1980's in the US to disseminate evidence-based positive interventions for students with severe disabilities, more recently the program has shifted focus to become a behaviour support for all students and has an emphasis on tiered implementation practices and systems.

SWPBS frameworks place supports along a continuum or tiers that match the intensity of student need, and work to acknowledge positive behaviours and prevent behaviours of concern.

The three-tiered approach defines, teaches, and reinforces positive behaviours for all students through the establishment of processes, procedures, and programs. (National Technical Assistance Center on Positive Behavioral Interventions and Support (PBIS), New South Wales Government Department of Education, Victorian Government Department of Education)

Primary prevention (tier 1): Practices and systems establish a foundation of regular, proactive support while preventing unwanted behaviours. Schools provide these universal supports to all students.

Secondary prevention (tier 2): additional specialised group systems for students who are at risk for developing more serious problems before those behaviours start. These supports help students develop the skills they need to benefit from core programs at the school.

Tertiary prevention (tier 3): specialised, individualised systems for students with high-risk behaviour, provided in addition to primary and secondary prevention. At Tier 3, schools rely on formal assessments to determine a

TIER 3
INTENSIVE SUPPORT FOR A FEW STUDENTS

TIER 2
TARGETED SUPPORT FOR SOME STUDENTS

TIER 1
GENERAL SUPPORT FOR ALL STUDENTS

1
EXPECTATIONS
SET CLEAR BOUNDARIES

2
MODELLING
MODEL POSITIVE BEHAVIOUR

3
CONSISTENCY
BE CONSISTENT

4
ACKNOWLEDGEMENT
ACKNOWLEDGE POSITIVE EFFORTS

5
EVALUATION
EVALUATE SUCCESS
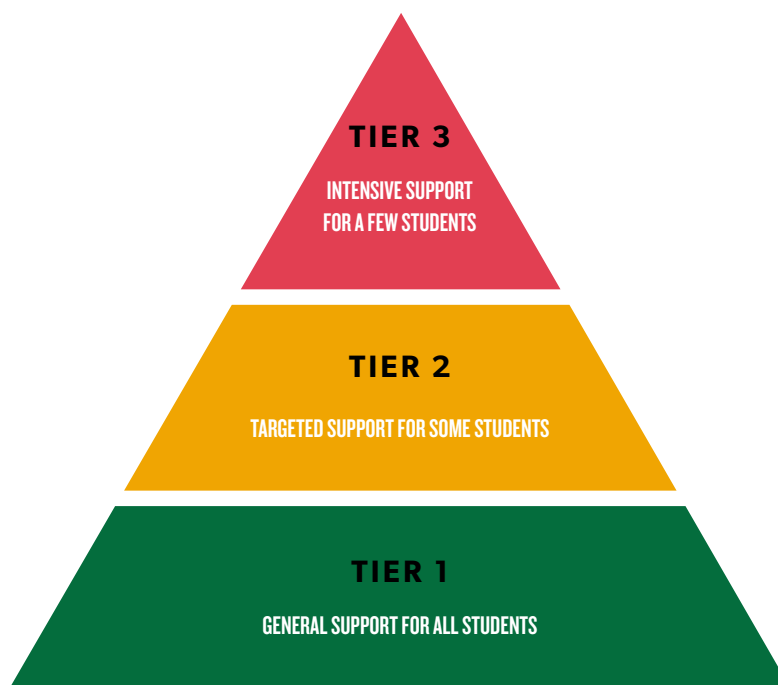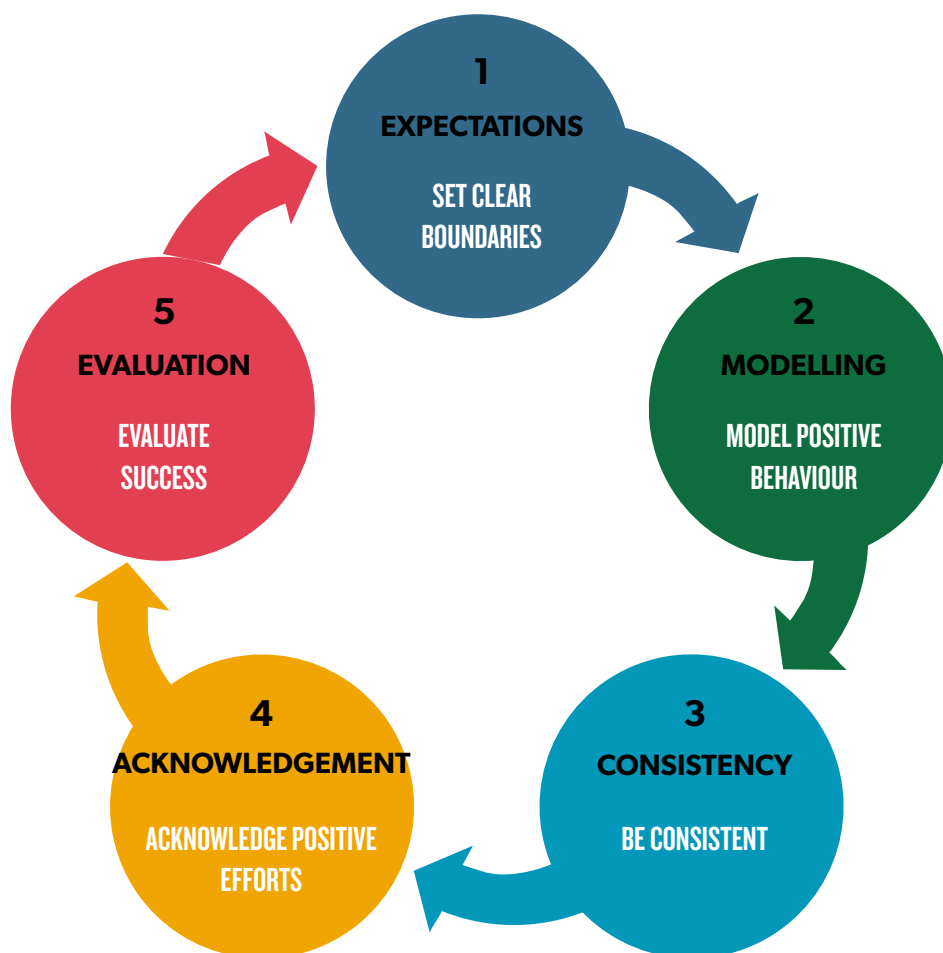
student's need and to improve their behavioural and academic outcomes.

The success of the program requires leadership structures within a school to manage executive functions including stakeholder buy-in, staff capacity, and implementation functions including training, coaching and evaluation (Pearce et al., 2019) Each tier of support is implemented using a cyclical process as outlined above by researchers at Monash University's Faculty of Education.

1. **Expectations** – setting clear expectations eliminates doubt and sets targets.

2. **Modelling** – educators should model positive behaviours, illustrating what the behaviour looks and feels like (PBS is not just for students).

3. **Consistency** – maintain consistency so that students know what to expect with follow through.

4. **Acknowledgement** – positively acknowledge attempts that students make toward their target behaviours.

5. **Evaluation** – Evaluate the merit of each strategy regularly to ensure that it is working the way it should be Monash University Faculty of Education

The SWPBS framework backed by the Victorian Education Department, gave both a strategy and tools for positive change.

In summary, the program is a research-based framework that focuses on the whole school, not just certain children, classrooms, or teachers. It relies on ongoing monitoring and evaluation, and a deeply engaged school leadership and community. It builds robust systems and skills that promote, teach, and reinforce explicit positive behaviours to ensure that all students receive the support they need to thrive at school. It is possible that such positive and non-punitive approaches can indirectly contribute to the promotion of mental health in schools.

Since 2018, informed by an expanding and impressive evidence base, that includes culturally and geographically diverse demonstration sites and international best practice (Barker et al 2022). The Victorian Education Department in Australia has invested in introducing school-wide positive behavioural supports into its schools.

Seventeen area based SWPBS coaches work with school teams to clarify a school's needs and provide the necessary professional learning, supported by coaching, for teams to embed essential SWPBS features. The coaches ongoing availability helps overcome any barriers to initial and ongoing implementation.

Debney Meadows Primary School is an inner-city school located in Melbourne Victoria. Ringed by public housing towers, the school is one of the state's most disadvantaged. Its children face multiple challenges and at times harsh barriers to learning. 85 % of its students are from African descent, the majority being refugees from conflict and war-torn Somalia. More is now demanded from classroom teachers and at the same time student behavior has become increasingly concerning and challenging. To restore order, tired and stressed educators can resort to various forms of punishment, exclusion, and other reactionary practices.

Hakka, Amharic, Vietnamese, Arabic, Turkish, Urdu, Oromo, Nuer, Tigrinya, and Spanish are other languages spoken at home.

In early 2021, the Victorian Education Department appointed co-author and Liaison Principal Ms Kerri Simpson to lead the school until a new principal was in place.

In interview with the interim principal, students consistently expressed their total disregard for all things to do with schooling and were unwilling to be involved in any learning that was new or challenging. Commonly they were disrespectful and behaved aggressively to staff and fellow students and taking advantage of situations to be disruptive.

Stressed, exhausted, and each day a chore, the focus for staff was survival, not student learning. Staff absences were frequent and at times prolonged.

Home life for many students, was a continual challenge as parents continued to hope for better lives for their children, knowing that success at school would be central to realising this hope.

It was clear that the school urgently needed to redirect efforts and commence building a safe and positive environment for learning to occur. The SWPBS framework backed by the Victorian Education Department, gave both a strategy and tools for positive change. Through a series of planned consultations and conversations involving staff, students, and the community, two matrixes of expected behaviours and acknowledgements were developed.

The staff outlined their expectations of student behaviour across various school contexts. These expectations were kept simple and clear. The students were then consulted on their expectations. These were drafted and redrafted until agreement and a Behaviour Matrix could be developed.

The Behaviour Matrix encourages students to focus on explicit positive expectations. It is clear what is required, and what will be enforced to ensure a safe and orderly environment. See Appendix 1

The successful application of the Behaviour Matrix at the school is reliant on an investment in building understanding of the underlying factors influencing problematic behaviour and its likely triggers. Staff members are encouraged and supported to build positive and trusted relationships with their students. This enables a non-judgmental response to inappropriate behaviours consistent with the child's condition. Potential precipitating factors are then identified and addressed. The school considers, explores, and implements positive and non-punitive interventions to support student behaviour before considering disciplinary measures such as withdrawal of privileges or withdrawal from class.

Supporting the Behaviour Matrix is a positive recognition structure negotiated with the student body that focuses on acknowledgment of positive behaviours. See Appendix 2.

The co-author visited the school approximately twelve months after her introduction of the SWPBS framework and observed encouraging signs of change. Although still marked by significant disadvantage, the school community appeared focused on fostering and supporting student wellbeing and engagement. Students who were previously disengaged and aggressive, now expressed pride in their progress, and were managing and controlling their feelings and behaviours both inside and out of the classroom. Families noted the change and were greatly appreciative and supportive of the school's efforts in progressing their children's education.

The observations of the liaison principal are consistent with the positive trends in data collected by a Student Survey and the National Testing program. *The School Wide Positive Behavioural Supports enabled by the Victorian Education system and in place at this school, are providing a positive result for students' well-being and their families.*

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Victorian Government, Department of Education https://www2.education.vic.gov.au/pal/behaviour-students/guidance/5-school-wide-positive-behaviour-support-swpbs-framework#multi-tiered-systems-of-support

Debney Meadows Primary School	SWPBS Positive Behaviour Matrix		
	Inside	**Outside**	**Always**
Be a Learner	I display whole body listening I share my ideas, listen and encourage others I am curious, accept challenges and take risks I use the internet as a learning resource I charge all devices and accessories ready for learning	I have a go at new games and new skills I have a go at leading when playing I have a go at learning new roles in a game I cooperate with students to play fairly	I am kind and accept others and their differences I use a growth mindset I show respect with my voice, my body and my words I regulate my emotions and my behaviour I take responsibility for my actions
Be Respectful	I am calm and quiet when I enter and exit the classroom I put my hand up and wait for my turn I let teachers teach and students learn I handle devices with care	I attempt to include others in my games I listen for the whistle and stop when I hear it I learn the rules and follow them I return play equipment after the breaks	I follow the digital citizenship agreement I use toilets in the right way at the right time I take turns and collaborate with others I ask for help and help others I think before I act and move safely
Be Safe	I move calmly, quietly and safely through all school spaces I ask permission to enter or leave a learning area I stay with my class and teachers I keep my feet, hands and objects to myself I only use teacher-approved apps and websites	I stay inside the school boundaries I choose appropriate play equipment and activities I make good choices about who I play with and where I play I am SunSmart	I do what I am asked the first time I take care of property and ask before I touch things I keep all school areas clean and use the correct bin I have high expectations of myself and others

Appendix 02

Debney Meadows Primary School	SWPBS Positive Behaviour Acknowledgement	
Positives Earned	**F-2**	**3-6**
50	• Reward Time – 15 min • Borrow a fidget spinner • Sit on the teacher's chair for a session	• Reward Time – 15 min • Borrow a fidget spinner • Sit on the teacher's chair for a session
100	• Craft or Lego activities (30 minutes) • Be the line leader for a week • Sit next to a friend for one double session	•Device reward time (20 minutes) •First choice of classroom job •Sit next to a friend for one double session
150	• Couch potato during mini lessons • GP room or Garden activity • Sit with a friend for two sessions	• Couch potato during mini lessons • GP room or Garden activity • Sit with a friend for two sessions
200	• Outside game with a friend • Work in the library with a friend • Pick something to watch at eating time	• Listen to music during independent learning • Work in the library with a friend • Work in the office for a session
250	• Work in your buddy class for a session • Spend a session in another class • Work in the office for a session	• Be a teacher assistant in another class • Spend a session in another class • Lead the juniors during LOL
300	• Plan a game for your class to play • Watch a movie with a friend at playtime • Join another class in specialist (one session)	• Plan a game for your class to play •Watch a movie with your friend at play time • Join another class in specialist (one session)
350	• Sit on the teacher's chair all day • Work in the classroom library for the day • Eat lunch with your buddy / sibling for a week	• Sit on the teacher's chair all day • Work in the classroom library for the day • Eat lunch with your buddy / sibling for a week
400	• Plan a picnic with your class outside • Lunch with your teacher (our treat) • Choose a movie for your class – Week 10	• Plan a picnic with your class outside • Lunch with your teacher (our treat) • Choose a movie for your class – Week 10
500	• Principal for the Day • Organize a class party • GP Multi Pack – 5 x 30-minute sessions with friends in the GP room with ES • LOL Multi Pack – 5 x 30 minute sessions with friends in LOL with ES Library Multi Pack – 5 x 30 minute sessions with friends in the Library with ES	

The pivotal role in promoting well-being and resilience in times of adversity

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During the last decades the need to promote school communities' resilience and well-being due to crises situations has grown dramatically. School communities globally have been affected by significant events such as the economic recession, the refugee influx and more recently the COVID-19 pandemic. Consequently, the need for interventions that promote resilience and well-being at an individual and system level and that focus on vulnerable groups, based on social justice principles and children's rights, has been increased (Hatzichristou, Lianos et al., 2019; Hatzichristou et al., 2021; Shriberg & Clinton, 2016).
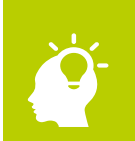
Social and emotional learning (SEL) is inextricably linked with the promotion of positive adjustment, resilience and well-being of school community members. It is defined as "the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions, achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions" (CASEL/ https://casel.org/fundamentals-of-sel). Most of the characteristics that have been used to describe schools that are resilient, effective, or caring communities refer to emotions and relationships among the members of the school community (Doll et al., 2014).

The recent emphasis on resilience and social emotional learning are reflected in changes in school psychological practices and service delivery globally (Hatzichristou, 2011; 2015; Hatzichristou & Elias, 2016). Several SEL intervention programs are implemented in schools across the world focusing on the promotion of psychosocial competence and adjustment facilitation for students in various settings.

Social and emotional learning constitutes a basic component of a conceptual model developed by Hatzichristou, *Lampropoulou et al. (2019) for promoting resilience and well-being, which includes a school community well-being approach within the framework of social justice principles and children's rights. The model, apart from the systemic approach and the emphasis on positive psychology, incorporates the latest theoretical approaches and practice models from resilience, effective schools, schools as caring communities and social-emotional learning literature (Hatzichristou & Lianos, 2016).* By integrating these theoretical components in system-level interventions, schools can enhance resilience and promote a positive school climate.

The evolution of the model, following the difficult periods affecting school communities at a national and international level, led to an increased focus on promoting resilience at an individual and system level, taking into consideration the needs of vulnerable groups. Throughout the past two decades, the Laboratory of School Psychology (LSP) (former Center for Research and Practice of School Psychology) at the Department

The most recent effort of the LSP includes the activities developed for supporting school communities during the COVID 19 pandemic. In particular, LSP has developed a multilevel approach that included research, training, resources' development and interventions based on students', teachers' and parents' psychosocial needs (Hatzichristou et al., 2021).

of Psychology, National and Kapodistrian University of Athens has developed, implemented and evaluated several programs. *The developed interventions focused on helping students build their resilience and strengthen their coping skills against several adversities, by incorporating social and emotional elements which were framed by social justice principles, strength-based approach and trauma-informed practices (Hatzichristou, Lampropoulou et al., 2019).*

The LSP's journey on SEL programs started with the development of the "Program for the Promotion of Mental Health and Learning", which constitutes the onset and the core of LSP's interventions. It is a prevention program implemented at a universal level aiming at strengthening all children in schools. The program addresses the basic theoretic concepts of social and emotional learning in promoting resilience, well-being, academic achievement and positive climate in the school setting including educational materials for three age groups (preschool, elementary and secondary school education) (Hatzichristou, 2011a,b,c; Hatzichristou & Lianos, 2016).

A number of other SEL based interventions were also implemented at a universal and selective level with the empirical evidence showing the effectiveness and the importance of their implementation (Hatzichristou, Lianos et al., 2019). Among the most prominent ones were the interventions developed

for supporting culturally diverse students (Roma, immigrant and refugee children), school communities after natural disasters and school communities during the economic recession in Greece (Hatzichristou & Lianos, 2016; Hatzichristou, Lampropoulou, Lianos et al., 2022; Hatzichristou, Lianos et al., 2021).

The most recent effort of the LSP includes the activities developed for supporting school communities during the COVID 19 pandemic. In particular, LSP has developed a multilevel approach that included research, training, resources' development and interventions based on students', teachers' and parents' psychosocial needs (Hatzichristou et al., 2021). One of the domains of this approach included the development and provision of a series of informative resources, including guidelines and activities to support schools and families/children's facilities throughout different stages of the pandemic. Specifically, 14 documents have been developed, during the different stages of the pandemic. The resources include useful advice for the psychosocial support of families, children, adolescents, parents and teachers/schools, as well as activities for teachers and parents (Hatzichristou et al., 2021). Several of these documents were translated into English, German and French to facilitate accessibility and equity (http://www.centerschoolpsych.psych.uoa.gr/index.php/2020-03-27-17-58-59).

Further, a booklet for families was created in collaboration with the Greek section of the Doctors of the World, to respond to the needs of migrant/refugees and vulnerable groups, available in Greek, English, Arabic and Farsi. The resources were circulated through the website of the LSP and through social media platforms -receiving great public engagement (over 495.000 readings).They were also shared with the Ministry of Education, which disseminated them to all schools across Greece and with various organizations, educational agencies within Greece and Greek schools abroad.
A special characteristic of the resources was that an effort was made to (a) provide appropriately adopted knowledge and information regarding the theoretical components of resilience, (b) provide guidelines based on crisis-management and trauma-informed practices, (c) develop activities for teachers and parents/care givers that incorporated SEL elements, resilience components and a strength-based approach and (c) infuse a holistic social justice perspective that would promote equity, respect and that would respond to the needs of all members of school communities, especially the vulnerable ones (Hatzichristou, 2022; Hatzichristou, Lampropoulou, Georgakakou-Koutsonikou et al., 2022).

The International Project: School wellbeing entitled Feeling CARED in school: A Journey Around the World (organized by the LSP in collaboration with the ISPA School Psychology Trainers Task Force and the ISPA Student Organizing Committee) was a recent international program that aimed

at connecting students around the globe highlighting the role of schools as protective environments. The project included an in-class discussion based on specific guidelines related to class/school characteristics that make students feel cared and accepted and the creation of a relevant poster. The project allowed for student voices to be heard while children's artwork, posters, and projects from different countries are presented at an online exhibition (https://international-schoolproject.space/s/posters/page/welcome) and video (https://www.youtube.com/watch?v=WeuTOZPpHcO).

Social and emotional learning is fundamental in the development and implementation of intervention programs. The flexibility and versatility of SEL is highlighted in the above described efforts which catered for the needs of school communities at a universal and selective level and responded to the emerging demands related with contextual factors. The empirical evidence of the intervention programs implemented by LSP support the important role of SEL and the significance of integrating it in schools' curricula. Universities can also play a significant role by providing the relevant knowledge to future professionals and by linking theory, research, training and practice in order to enhance competence and support school communities especially during difficult times.

5th Junior High School of Alimos, Greece

Marasleio Primary School, Greece

Wellington School, UK

Westside Village Magnet School, USA

American International School of Cyprus

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Project Positive Attitude:
Lessons from 18 years in the field

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1. *What is Social and Emotional Learning?*

Social and Emotional Learning (SEL) has been defined by the Collaborative for Academic, Social, and Emotional Learning (CASEL, 2022) emotional learning as "...the process through which children and adults understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions". This approach to the development of social and emotional competencies has thrived in the last 20 years, in part due to its strong emphasis upon assessment program effectiveness and its advocacy for the dissemination of results (Durlak et al., 2011; Taylor et al., 2017), and in part because of the diversity in the portfolio of interventions that have emerged under the banner of CASEL's framework.

This diversity of interventions is well displayed in CASEL's SEL framework (2022), which identifies four key settings where students live and grow: classrooms, schools, families and caregivers and communities. Different providers of SEL intervention focus on one or more key settings. However, most reported effectiveness trials detail interventions for which the setting was the classroom (see Taylor et al., 2017), and most of these analyzed how evidence-based programs promoted SEL.

2. *Why Studying Differential Effectiveness of Social and Emotional Learning Programs Matter?*

Although the effectiveness of SEL programs has been strongly supported in an extensive number of studies, including several meta-analyses (Durlak et al., 2011; Sande et al., 2019; Taylor et al., 2017), there are however gaps and imbalances in the current literature regarding SEL worldwide. *According to Elias (2019), one of the most noticeable imbalances is that most published reports (87%) detail effectiveness-based trials that have been conducted in the United States of America.* Furthermore, there is also a lack of literature regarding the effectiveness of SEL programs in developing countries, and it unwise to draw universal conclusions based upon homogeneous and culture specific samples of students living primarily in Western contexts, because such conclusions may not be replicated in other settings. Therefore, the current paper is an effort to contribute to balance this situation, by analyzing some lessons we have learned in the field, based on analysis of the results emanated from effectiveness-based trials of the three Positive Attitude SEL programs (Elementary; Low Middle School; and Upper Middle School) that have been implemented in Portugal during the last 18 years.

On the other hand, one of the most commonly reported gaps in SEL programs' literature has been the lack of analysis regarding the substantial variability in these programs' effectiveness (Coelho & Sousa, 2018; Domitrovich et al., 2019; Wigelsworth et al., 2016). Many researchers consider that one of the main challenges today in this field is understanding who benefits from universal school programs (Coelho & Sousa, 2018; Wigelsworth et al., 2016; Yeager et al., 2019). Similarly, other authors concluded that some interventions are most effective with certain groups or under certain conditions (Carroll et al., 2020; Sande et al., 2019). As a result, authors have increasingly focused on the differential effectiveness of SEL programs, i.e., what works for whom? In Project Positive Attitude, the main focus of our research since 2014 has been precisely Differential Effectiveness.

In Project Positive Attitude, throughout these 18 years, we have focused and analyzing 4 dimensions of implementation quality: implementation fidelity, dosage, implementers experience, and participant responsiveness

3. *Project Attitude Positive: What Have we Learned by Analyzing Differential Effectiveness*

Regarding student characteristics, to fully accomplish the aim of understanding who benefits from universal SEL classroom-based interventions, we need to capture heterogeneity, at both the student and classroom level
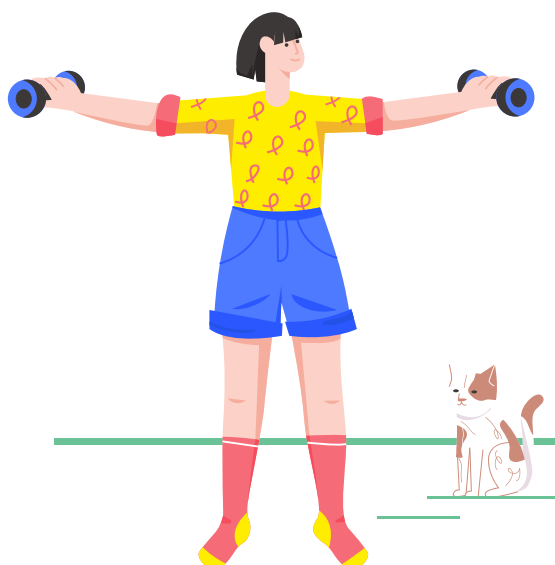
As explained by Greenberg and Abenavoli (2017), establishing what works for whom is especially relevant to universal school interventions, because they involve all students in a classroom or a school, but sometimes they only benefit a subset of students. Because Project Positive Attitude is an intervention led by practitioners, our main goal is to continuously improve our services to students and schools. Furthermore, the project is also the focus of a research unit. The combination of these two facets makes Project Positive Attitude keenly interested in analyzing the differential effectiveness of its programs. For us, it is crucial to understand who benefits more from our universal programs, and who does not, so that we can guide program development to better serve a wider range of students, as suggested by Jiang et al. (2018).

Traditionally, there are two identifiable trends in previous studies regarding differential effectiveness. A large group of these studies focus on implementation quality, whereas another group (Carroll et al., 2020; Coelho et al, 2015; Jiang et al., 2018) is focused on analyzing how students' characteristics (such as gender, age, socioeconomic status, or baseline levels of competences) help explain who benefited from interventions.

Regarding implementation quality, strong evidence supports that it moderates program success (Domitrovich et al., 2019; Durlak et al., 2011), and that high implementation quality is strongly associated with positive program outcomes (Durlak, 2015). *However, there is still debate regarding which aspects of program implementation are more likely to influence SEL programs' effectiveness.* In Project Positive Attitude, throughout these 18 years, we have focused and analyzing 4 dimensions of implementation quality: implementation fidelity, dosage, implementers experience, and participant responsiveness (through the assessment of students' satisfaction with the SEL program that they participated in).

Regarding student characteristics, to fully accomplish the aim of understanding who benefits from universal SEL classroom-based interventions, we need to capture heterogeneity, at both the student and classroom level, and understand how relevant variables influence how students interact with and learn from such interventions. Some researchers (Greenberg & Abenavoli, 2017; Yeager et al., 2019) suggested that study variation in treatment effects across students and classrooms should be further analyzed, because average treatment effects (i.e.,

effects of an intervention for the average student) could hide the variation in benefits across students and classrooms.

Given the emphasis on differential effectiveness of the research developed by the Project Positive Attitude team since 2014, we have produced several findings that have been (or will be reported) on peer assessed scientific journals. Below we will provide a short summary of the findings so far.

Implementation Quality. Evans et al. (2015) warned that sporadic and inconsistent implementation remained a significant challenge for SEL interventions. Because we have been very aware of such warnings, all Positive Attitudes SEL programs have been implemented with high implementation fidelity and have yielded high levels of student satisfaction; specially the elementary SEL program, during the 18 years of implementation this program as always received student evaluations of more than 4.2 (out of 5), and over 90% of students want it to participate again in similar programs. Therefore, there has been little variance in several key dimensions of implementation quality. For instance, in implementation fidelity, even when the upper middle school program was disseminated nationwide, in the Gulbenkian Academies of Knowledge (GAK) initiative, 83% implementation groups were delivered with over 90% of fidelity.

Gender. There are no clear results regarding gender differences from participating in the Positive Attitude SEL programs. In the Elementary Positive Attitude SEL program, girls benefited more than boys in self-esteem from participation (Coelho, Sousa et al., 2016). In the Positive Attitude Low Middle School SEL program, boys benefited more than girls in social awareness (Coelho & Sousa, 2017). As for the Positive Attitude Upper Middle School (PAUMS) SEL program, several effectiveness studies yield different results regarding gender; Coelho et al. (2015) reported that girls gained more in terms of self-control and social awareness after participation in the program, even though girls had higher initial levels for those competencies. However, later studies, with an updated version of the program found that girls, when compared with boys, showed greater gains in social awareness (Coelho et al., 2017; Coelho & Sousa, 2018).

Age and Development Stage. The Positive Attitude SEL programs have been consistently more effective for

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The results we have obtained over the last 18 years recommend the adoption of the Positive Attitude programs with maximum fidelity.

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younger students. This has been consistently reported in published journal articles (Coelho, Marchante et al, 2016), but even more so in our yearly reports to the municipality where the Elementary SEL programs usually yields statistically significant results in more social and emotional competencies.

Initial Levels of Competences. The results of the initial efficacy study of the PAUMS SEL program showed that the intervention group students with lower social awareness pretest scores profited than the others (Coelho et al., 2017), while the results after initial effectiveness study of the same program identified that the students with the lower levels of competences benefited more in every competence (Coelho et al., 2015)

Format. Because the Positive Attitudes Lower Middle School SEL program was not yielding as many statistically significant results as the two other SEL programs in the project, we conducted a study (Coelho et al., 2017) comparing two program delivery formats for the program implementation: curriculum (a semi-structured format) and pre-packaged (fixed structure). "\ The curriculum format started with an initial assessment that led to the choice of two modules, focusing on two social and emotional competences, that better suited the profile emanated from the initial assessment, whereas the prepackaged format allowed for the delivery of content that focused on each of the five social and emotional competencies identified by CASEL. So, there was less time and less activities per competency in the pre-packaged format and therefore all groups had the same activities. The pre-packaged format led to better results, particularly in self-esteem and, therefore, we adopted this format since.

Setting. Curriculum restructure is common in the Portuguese Educational System. One such restructure led half of the schools where the PAUMS SEL program was implemented to switch its implementation to an

after-school schedule. Because the other half of the schools where the program was implemented did not make this change we had the opportunity to compare the effectiveness of the program between the two different settings: within school and after-school hours, Multilevel analyses identified more positive intervention results in on self-esteem, self-control, and social awareness for students within the school schedule groups (Coelho & Sousa, 2018).

PROJECT POSITIVE ATTITUDE: LESSONS LEARNED FROM 18 YEARS IN THE FIELD

Therefore, there are several lessons regarding why the Positive Attitude SEL programs have mostly been effective over the last 18 years that can be drawn:

Maintain High Levels of Implementation Quality. In the literature, researchers' seldomly debate whether new interventions should be implemented with maximum fidelity, or rather if adaptation should be permitted or encouraged to suit local needs and preferences (Backer, 2002). The results we have obtained over the last 18 years recommend the adoption of the Positive Attitude programs with maximum fidelity.

Integration Between the Programs. Although CASEL (2013) recommends that effective SEL programming should begin in preschool and continue through high school, few published studies have reported upon the cumulative effects of participating in several SEL programs. Cumulative results from participation in Positive Attitude SEL programs seem to support the notion that social emotional competencies development is enhanced when students participate in SEL programs throughout their schooling (Coelho, 2021).

Assessment Tools. Although currently there are several assessment tools developed and validated for the assessment of SEL programs, when we started to assess our programs most of the assessment tools used in the field did not actually focus on social emotional competencies, but rather on mental health or social problems or difficulties. In that context, the development of specific tools was crucial to properly develop the positive attitude SEL programs.

Use of Multi-Informants. The use of multi-informants, specifically self-reports and teacher reports has been essential to fully understand the results of the Positive Attitude SEL programs. The results reported the conclusions of Achenbach et al. (2008), that each informant may reliably and validly report different aspects of children's functioning. The difference in results obtained (in studies such as Coelho et al., 2015) has been pivotal in guiding program development.

Stability of the Implementer Team. Throughout the Positive Attitude Project it has been possible to maintain a high level of stability of the team who implements the program. Currently, most of the team that is responsible for implementing the positive attitude SEL programs has over 10 years of experience in implementation. This level of experience has helped and facilitated program development and dissemination, because implementer experience has been associated with higher quality of implementation and also higher effectiveness of the Positive Attitude programs (Coelho et al., 2021).

Ongoing Assessment of Differential Effectiveness. Throughout the project's existence there has been an effort to conduct ongoing assessment of the programs' effectiveness. This option has rendered several benefits for the programs' development. In fact, it is probably one of the key factors why the program has lasted so long. However, there is still a need to increase the literacy of all agents (political decision makers, private funders, school principals, teachers, parents) involved in this area regarding this issue, as there are usually several sources of resistance to the need for ongoing assessment of the programs' effectiveness. For instance, after being considered a blueprint program and elected to be replicated in the GAK initiative, the academies that were implementing the PAUMS SEL program were asked not to create control groups by the initiative's main sponsor, because, as a blueprint program, the program had already established its effectiveness. It was possible to overcome this objection, because in the Projects' previous experience some social and emotional competencies fluctuate negatively and positively throughout even without any intervention, and we can overcome this limitation through the use of control groups. Otherwise, we might overestimate or understimate program results. Altogether, we can conclude that the use of control groups rendered valuable information to the positive results achieved during the nationwide dissemination of the PAUMS SEL program.

Implementation by psychologists. Since 2004 the Positive Attitude SEL programs have been implemented in schools by psychologists as external mental health consultants. Since 2019, the upper middle school SEL program has also been implemented by the school psychologist in some settings, during the nationwide dissemination of this program. Both formats have yielded positive results (Coelho et al., 2021).

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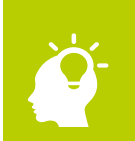
"*You are not alone*":
Tackling Bullying Together

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*B*ullying, until recently, has often been wrongly perceived by many as a rite of passage or a "normal" part of growing up. It has been identified by the WHO (Currie et al, 2012) as a major and preventable health issue and we now recognise the consequences and damage it does to our children, our schools and our communities (see Armitage, 2021; Nazir, 2018; Wolke and Lereya, 2015).

Bullying is defined as a deliberate, repeated pattern of aggressive behaviour intended to cause hurt and often, bullying is an imbalance of power or strength between the victim, and the bully (Wong, 2017). There are physical, verbal, emotional, social and cyber forms of bullying, all of which can be direct, indirect or passive depending on circumstances.

and destruction of property like cutting up belonging.

• Verbal bullying can range from name-calling, taunting, insults, spreading rumours to threats of physical violence and can happen in person and/ or through social media.

• Examples of emotional bullying are embarrassing, criticising and making negative comments about someone to make them feel bad about themselves, and humiliating or making fun of someone repeatedly in the presence of others.

• Social bullying is designed to harm someone's reputation, cause humiliation and is often carried out behind the victim's back which includes lying and spreading rumours, mimicking unkindly, encouraging others to socially reject, isolate or exclude someone and damaging someone's reputation.

• With Internet and easy access to mobile phones, computers, and other electronic devices, bullying can now be carried out online or in cyberspace. Cyber bullying can happen at any time, in public or in private and it includes posting hurtful comments to a social-network platform, sending hurtful pictures, texts, emails or videos online, creating webpage intended to hurt the victim, and deliberately excluding others online.

No matter, what form the bullying takes, it is a serious problem among school-age children and adolescents. Based on my experience as a teacher, educational psychologist, school counsellor and parent, one bullying case is still one too many.

Regardless, if it is the victim, the bully, the bully-victim (the individual who is bullied and bullies others), or the bystander (the individual who was witness to and present during the bullying event), there are both short-term and long-term effects which have serious and sometimes, lasting negative impacts on children's and adolescents' physical, mental, emotional health as well as overall wellbeing.

It is important to recognise some of the ways that these forms of bullying could be happening.

• Physical bullying can include hitting, pinching, slapping, pushing, tripping, kicking, damaging property like making marks on books,

Bullying can damage one's self-image and self-esteem, as well as bring about feelings of rejection, isolation, helplessness and loneliness. Some can develop health and mental health issues such as depression, anxiety, psychosomatic problems such as headache, stomach ache, insomnia, tiredness and sleep problems like nightmares and night terrors (Wolke and Lereya, 2015). For some, it can further develop into Acute Stress Disorder or Post Traumatic Stress Disorder (Warner, 2021). Being a victim of bullying can also lead to reactive aggression, substance abuse, self-harm, suicidal thoughts and attempts, and potential future delinquent and aggressive behaviour. In addition, academic achievement can be affected, resulting in poorer academic functioning, poor school adjustment and increase in school absenteeism as well as having poor social functioning and difficulty in forming friendships and relationships.

During the formative years, children are forming their identities and developing their personalities. Therefore, *when one is bullied at a young age, it can affect the individual with lifelong psychological damage such as having trust issues, issues with self-esteem and self-image, and anger issues towards self or others.* For example, one may blame oneself for being bullied, becomes angry with self and has negative self-thoughts. With being bullied, there is also a range of emotions that are present and may linger on such as anger, fear, distress, anger, irritability, helplessness, guilt, shame and despair (Vie, Glasø, and Einarsen, 2012).

Bullying causes physical, emotional, mental and/ or psychological harm and discomfort to all involved. In any bullying incident, it is crucial to recognise and acknowledge that there are always five persons involved: The victim, the bully, the bystander, the teacher, and the parent. Each has a role in managing and preventing bullying in schools and online.

Children and adolescents can be proactive in responding to bullying. Usually, they are at risk of being a victim of bullying because of various reasons - physical appearance, illness, disability, personal characteristics like being introverted, or even low or high academic performance. In all cases, victims need support from peers, teachers, parents/ caregivers or other trusted adults. They

when one is bullied at a young age, it can affect the individual with lifelong psychological damage such as having trust issues, issues with self-esteem and self-image, and anger issues towards self or others.

need to learn how to respond to bullying and manage the anxiety and stress resulting from the bullying which can include learning to avoid situations where they are alone, acquiring social skills, building their self-esteem, and learning to recognise and report bullying when it happens. They can also learn stress management skills and techniques like relaxation exercises, positive self-talk, practise self-affirmations, take a break from stressful situations, build network of friends for support, develop assertiveness skills, learn practical coping skills, improve physical health through exercises and healthy lifestyle, and make time for fun and relaxation.

Nobody aspires to be a bully. There are often underlying reasons resulting in children becoming one. Often bullies are insecure and bullying is a means to gain control of their lives, for example, parents' divorce which is out of their control. Sometimes, bullying is a learned behaviour from significant adults in the family. It is important to comprehend the reason(s) why a child bullies while tackling the bullying behaviour; otherwise, any action taken will only suppress the bullying temporarily before it resurfaces (Wong, 2015). We need to help the bullies change their behaviour and face the challenges that are shaping their bullying behaviour.

Often, bullies rely on the bystanders being afraid or indifferent to stop them. Bullies tend to back off when they are called out by their peers. *We need to develop in our children and adolescents empathy, compassion, moral courage, problem-solving strategies, and the life skills necessary to become proactive and helpful bystanders.* They need to understand that as bystanders, they are answerable and are responsible for stopping bullying when they see it happening. By being apathetic, they are actually condoning and encouraging the bullying. If they feel helpless to stop it, they can report to a teacher, a

trusted adult or a family member as soon as possible. Teachers are responsible in creating a safe, supportive, bully-free environment for students. When students feel safe, they are more inclined to report bullying. It is crucial for teachers to be familiar with their school's policies and actions towards bullying and discipline and to be trained on how to recognise and handle bullying and other traumas. Teachers need to be observant, firm and consistent in intervening and enforcing action(s) needed to tackle bullying which can include addressing bullying behaviour, emotional hurt and relational strains that can arise from bullying. The school counsellor is also important in supporting teachers to address bullying and to help rebuild positive relationships between the bully and the victim. Working with teachers and parents/ caregivers, counsellors can help to resolve the underlying problems and prevent bullying from happening again.

As a teacher and counsellor, I have seen different reactions from parents/ caregivers when they found out their child was a bully, ranging from denial to apologies to indifference.

As parents/ caregivers, we must be aware of our biases towards our children. We need to recognise the warning signs that our children could be involved in bullying - be it as a victim, bully or bystander. We need to have regular and open communications with our children. We can teach our children how to solve problems without resorting to violence, give positive feedback when they behave well to build their self-esteem and confidence, and encourage our children to be compassionate, to help others in need. We should also mind our own behaviour and language because our children learn from us in how they behave and respond to others. If our child reports a case of bullying, we have to take it seriously and never ignore or downplay the bullying and it is important that we keep calm and validate the facts of the incident (Wong, 2017). Parents/ caregivers, teachers and counsellor working in partnership is necessary to address bullying and drive home the message to our children and adolescents that a school is a safe and supportive environment and a calm collective approach to a peaceful resolution is far better than force.

When it comes to bullying, everyone matters. *Tackling bullying requires a holistic approach and the commitment, effort and participation from every member of society.* Bullying need not be a problem and we have the power to stop it.

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Beyond dichotomy– *The role of multidimensionionality and context specificity in overcoming the duality of prevention and promotion duality* of prevention and promotion

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School age is a decisive period marked by a significant development of the self, cognitive, motivational, and socio-emotional characteristics. In this period, individuals should, for instance, develop concepts necessary for everyday life as well as fundamental skills in reading, writing, and calculating, achieve personal and emotional independence of parents and other adults, develop conscience, morality, a scale of values, and achieve mature relations with age-mates of various genders (see Havighurst, 1976). High levels of well-being are supposed to enable young people to better deal with these developmental tasks and foster a healthy transition to adulthood (Pyhältö, Soini and Pietarinen, 2010). Accordingly, numerous empirical findings underline the special relevance of child and adolescent well-being for healthy functioning as well as important prerequisites for educational success (e.g., Suldo, Thalji and Ferron, 2011; Hoyt et al., 2012; Holzer et al., 2021). In conclusion, there is broad scientific consensus that promoting well-being at school age is an important investment in young people's future.

Against this background, the question arises as to where to start in sustaining and promoting well-being at school age. To this end, we first need to be clear about what we mean by school agers' well-being. Almost as diverse as the individual needs and backgrounds of young people are the various approaches to conceptualise well-being. They generally fall into two traditions: Hedonic well-being (i.e., positive affect, absence of negative affect), which refers to well-being as an outcome, and eudaemonic well-being (i.e., living life in a satisfying way, actualizing one's potentials), which refers to well-being as a process (Deci

and Ryan, 2008). While it was not uncommon until recently to operationalize well-being one-dimensionally (i.e., in terms of positive emotions only), there is now growing consensus that well-being is a multi-facetted construct, consisting of both hedonic and eudaemonic aspects (e.g., Huta and Waterman, 2014). Another difference between conceptualizations concerns the focus on the absence of pathological features (i.e., ill-being) versus the presence of resources (i.e., well-being) (Olsson et al., 2013). This reveals an area of tension with respect to approaching interventions: the debate about the relationship between the prevention of mental ill-being on the one hand, and the promotion of mental health and well-being on the other.

Traditionally, we differentiate between primary, secondary, and tertiary prevention. *While primary prevention refers to interventions aimed at preventing the incidence of mental health problems and disorders, secondary prevention refers to interventions aimed at reducing the severity of mental health problems and disorders or eliminating them – that is, not preventing their incidence but their increase.* Finally, tertiary prevention deals with the avoidance or

mitigation of undesirable consequences of mental health problems and disorders that cannot be reversed, for example the incidence of secondary diseases (Caplan, 1964). This distinction is, however, not without criticism. Particularly, following a salutogenetic approach, i.e., focusing on the origins of health and well-being) drawing clear lines between healthy and ill is no longer state-of-the-art. This is also referred to by the WHO that expresses that mental health represents more than the absence of mental illness but is a complex continuum experienced differently from one person to the next (World Health Organization, 2022). The adoption of a more differentiated perspective on mental health thus corresponds to the approach of understanding well-being as a multifaceted construct, which consists of different components that may vary in their expressions (e.g., Holzer et al., 2022). Multidimensional concepts of well-being have so far primarily been proposed from the field of positive psychology (Seligman and Csikszentmihalyi, 2000; Seligman, 2011). One of the most known multidimensional models of well-being is PERMA as proposed by Seligman (2011), consisting of the pillars positive emotions, engagement, relationships, meaning,

However, when conditions at home are less favourable, e.g., in terms of a less stimulating environment due to families' socio-economic disadvantages, school has the capacity to compensate for certain risk factors to some extent.

and accomplishment. Applying the PERMA model to the school age led to the development of the EPOCH model (Kern et al., 2016). It consists of the domains engagement, perseverance, optimism, connectedness, and happiness and has so far been validated for the age group of 10 to 18 years. Engagement refers to the capacity to become absorbed and focused on what one is doing, involvement and interest in tasks and activities, following the concept of flow (Csikszentmihalyi, 1997). Perseverance describes the continued pursuit of one's goals even in the face of obstacles. Optimism is associated with hopefulness and confidence about the future, a favourable view of things, and evaluating negative events as temporary, external, and specific to the situation. Connectedness refers to the sense that one has satisfying relationships with others, feeling valued, esteemed, and cared for as well as providing friendship or support to others. Happiness describes steady states of positive mood and feeling content with one's life, rather than momentary emotion (Kern et al., 2016). Hence, EPOCH unites both hedonic and eudaemonic aspects and draws attention to emotional as well as social and behavioural characteristics within a consistent framework. Moreover, the merit of a multidimensional model such as EPOCH is that strengths and weaknesses in children and adolescents' well-being profiles can be directly assessed along the five factors. This enables conclusions regarding starting points for sustaining and promoting well-being according to individual needs. By recognising that these profiles can be configured in different ways, the dichotomy between focus on resources vs. weaknesses is considerably reduced.

While this makes the EPOCH a very practical and helpful model overall, one downside for its application

is that it addresses general rather than context-specific well-being. As well-being is integrally shaped by the everyday contexts in which young people grow and develop (Žukauskien, 2014), conceptualisations and measures of well-being to locate resources as well as specific needs for intervention within youths' most significant settings are required. Between entering school and the completion of formal schooling, young people spend more time in school than in any other place outside their home (Eccles and Roeser, 2011). Ideally, the parental home and school complement each other and jointly contribute to the promotion of a healthy development (e.g., Cole, 2007). However, when conditions at home are less favourable, e.g., in terms of a less stimulating environment due to families' socio-economic disadvantages, school has the capacity to compensate for certain risk factors to some extent. On the one hand, in the face of psycho-social challenges, it is usually institutional schooling that provides first response, i.e., by means of counselling, psychological services, or special education. And complementarily, schooling has immense potential to promote resources in the sense of well-being. It thus integrally combines prevention as well as promotion of mental health, overcoming the prevention vs. promotion duality. Accordingly, some potentials of schools to promote well-being in terms of a multidimensional conceptualisation are as follows: Schools are the place where young people can engage and unfold their potentials, develop the ability to persevere and remain optimistic in the face of challenges, feel a sense of belonging and finally, where joy and laughter have a place (happiness). The notion that well-being in the school context is substantially shaped by the components of EPOCH as adapted to the school context was confirmed by conducting participatory qualitative research with samples of students and teachers themselves (Holzer, Bürger, et al., 2021).

In conclusion, drawing clear lines between prevention and promotion, illness and well-being is no longer compatible with a contemporary understanding of mental health. Holistic approaches to overcoming these dichotomies already exist. Accordingly, the application of coherent multidimensional frameworks that correspond to the multidimensionality of school agers' mental health is essential. Finally, *it is key to emphasise the importance of the school context in both developing and promoting well-being at school age.*

Multidimensional context-specific conceptualisations of school well-being seem an appropriate angle from which to proceed to equip practitioners with meaningful tools to promote well-being and provide scholars with solid theory to conduct systematic research and further differentiate knowledge about the effects of youth well-being in the long term.

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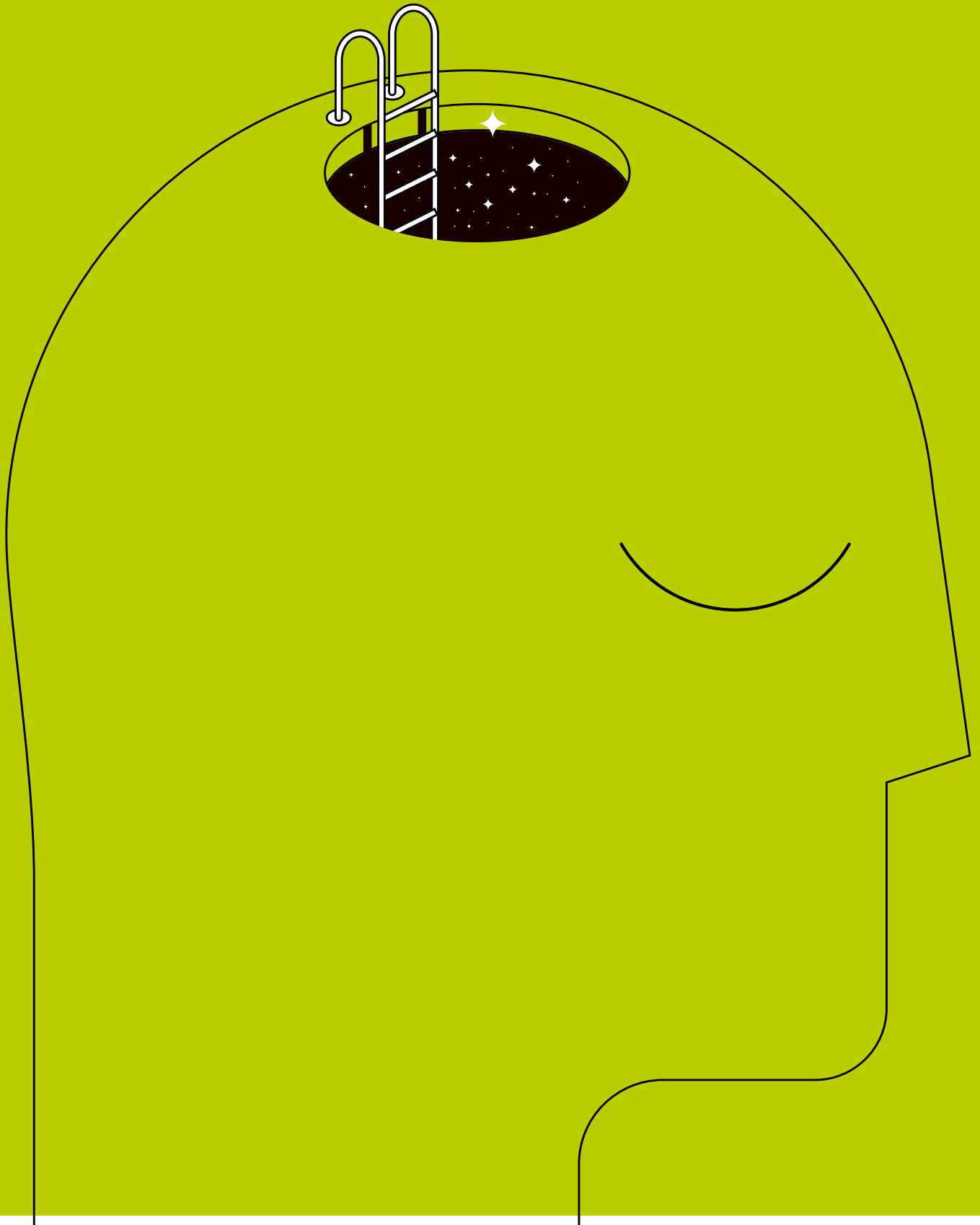
An Integrated Whole Community
Approach to Promote SEL and Mental Health

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ABSTRACT

Recognizing the imperative of promoting the social, emotional, behavioral, cognitive, and mental health of children and adolescents in promoting healthy development and well-being, we highlight the importance of embracing and implementing a public health approach, including multi-tiered systems of support (MTSS). We articulate and advocate a comprehensive and coordinated continuum of evidence-based MTSS within and across school and community systems, including a brief description of practical ways to accomplish this.

The need for further actions to promote mental health in schools and communities around the world is indisputable and urgent

"Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."
- World Health Organization, 2022a

The need for further actions to promote mental health in schools and communities around the world is indisputable and urgent (WHO, 2022b). More than 166 million youth (13%) aged 10–19 live with a diagnosed mental disorder, as defined by the WHO (UNICEF, 2021a). Compounding the problem is the fact that most youth experiencing mental health concerns go unidentified and, even when diagnosed, often do not receive any professional help (Merikangas et al., 2011). UNICEF (2021a, p. 35) highlights that around the world, "mental health conditions – and the lack of caring responses remain the cause of significant suffering for children and young people and top cause of death, disease and disability, especially for older adolescents."

Following the onset of COVID-19, the incidence, prevalence, and impacts of mental disorders among youth has increased (Johns Hopkins Bloomberg School of Public Health and United Nations Children's Fund, 2022). *Whereas COVID-19 has impacted all youth, it has compounded disparities in learning and achievement rooted in racial and socioeconomic inequality* (Dorn, Hancock, Sarakatsannis, & Viruleg, 2021; Lewis, Kuhfeld, Ruzek, & McEachin, 2021). Unprecedented numbers of students are disengaging from school and struggling to recoup lost learning in addition to experiencing mental health challenges (Dorn et al., 2021; Kwai & Peltier, 2021). As noted by Herman and colleagues (2021), many of the most significant risks for mental disorders results from the interplay of factors across the home, community, and school settings in cultural contexts that influence how these risks will be realized (Reinke & Herman, 2002).

Evidence is unequivocal that psychological health and social-emotional adjustment is the foundation for academic performance, as well-being and achievement outcomes are inextricably linked (Murray-Harvey, 2010, Opertti, 2022). Students with higher levels of assets exhibit better school attendance, academic self-perceptions, academic-related goals, social support, reading achievement, and fewer behavioral problems than peers with comparatively lower assets (Suldo & Shaffer, 2008). Fostering students' social-emotional development is a powerful and effective approach to increasing resiliency, reducing risk, and facilitating students' optimal academic performance (Benard, 2004).

A public health approach, emphasizing comprehensive and coordinated multi-tiered systems of support (MTSS) and culturally relevant care across school and community systems, is important to promoting youth mental health and well-being around the world. Professionally, we have each experienced the benefits of MTSS to support the social, emotional, behavioral, cognitive, and mental health development of youth, and the confluence of empirical evidence reveals the benefits (Herman et al, 2021; Reinke et al., 2021; Stephan, Sugai, Lever, & Connors, 2015). The following provides a brief description of core components of evidence-based strategies to illustrate implementation of a public health approach to promote

integrated supports across school and community systems.

Core Components of an Integrated Whole School / Whole Community Approach

Comprehensive Mental Health Supports

Appreciating the profound importance of the environment for child development, comprehensive school mental health systems (CSMHS) are founded on effective partnerships between schools, communities, and families. CSMHS improve access to care for all students (e.g., Gopalan, et al., 2010) and provide a full continuum of services and supports organized around the promotion of mental health, and the prevention, early identification, and treatment of mental health problems (Hoover et al., 2019). When implemented with fidelity, CSMHS drive more positive outcomes, including improvements in students' psychosocial and academic outcomes (e.g., Durlak et al., 2011; Flannery, Fenning, Kato, & McIntosh, 2014; Taylor, Oberle, Durlak, & Weissberg, 2017), early identification and intervention (e.g., Essex et al., 2009), school climate and safety (e.g., Thapa, Cohen, Guffey, & Higgins-D'Alessandro, A., 2013), and engagement for all stakeholders (e.g., Cappella et al., 2012). Effective implementation of CSMHS has several core features, including: well-trained educators and specialized instructional support personnel; family-school-community collaboration and teaming; needs assessment and resource mapping; multi-tiered systems of support; mental health screening; evidence-based and emerging best practices; data-based decision making and continuous improvement; and

funding (Hoover et al., 2019).

Collaborative partnerships among students, families, as well as mental health and educational professionals at the school and in the community with support from administrators, policymakers, and funders are critical (Blackburn Franke, Paton, & Weist, 2021; Cashman, Linehan, & Rosser, 2013). Technology-enabled services and digital platforms (e.g., apps, web-based electronic health records) that support coordination, communication, referral, and data sharing among all stakeholders can help integrate the system of providers across school and community and make service delivery and workflows more efficient and effective (e.g., Bruns et al., 2018).

Comprehensive and Coordinated MTSS Across School and Community Systems

Optimally, the continuum of mental health services shifts from providers at school to providers in the community as the level of need increases across Tier 1 (universal services and supports), Tier 2 (targeted services and supports), and Tier 3 (intensive services and supports). The following provides a brief description of several supports at each of these levels, see Figure 1 for a graphic summary of multi-tiered systems of support that are integrated across school- and community-based services.
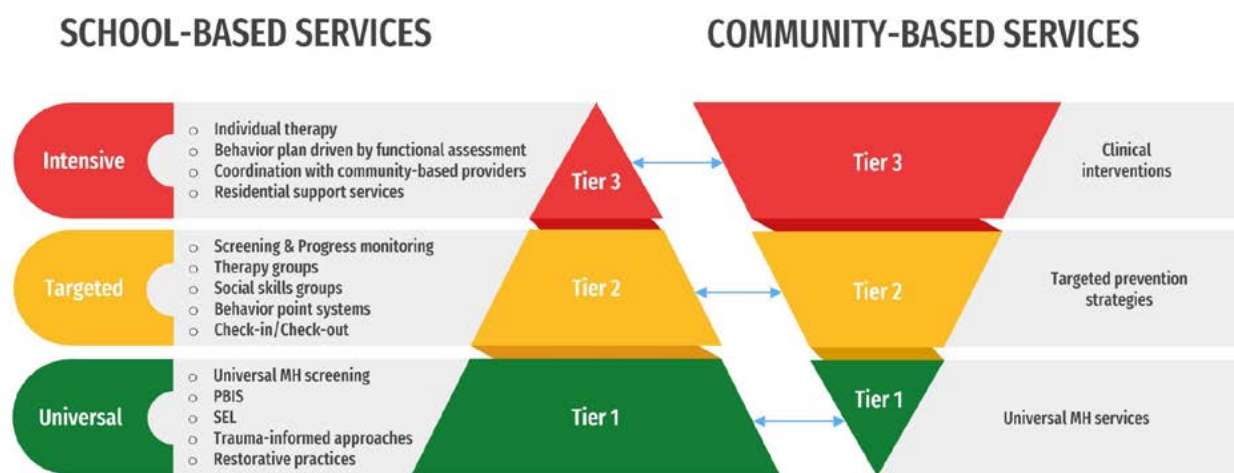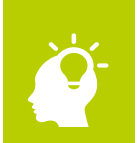

Figure 1. The integration of school and community services to promote SEL and mental health, across multi-tiered systems of support.

The Collaborative for Academic, Social, and Emotional Learning (CASEL) defines SEL as "the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions"

Tier 1

At **Tier 1**, schools employ evidence-based mental health promotion practices that support and benefit all students. Examples include positive behavioral interventions and supports (PBIS), social and emotional learning (SEL), trauma-sensitive classrooms, and restorative practices.

Positive Behavioral Interventions and Supports (PBIS). *PBIS is a schoolwide framework for organizing learning environments in a manner conducive to the adoption of research-based behavioral interventions for all students, particularly those that present with significant behavioral challenges* (Sugai & Horner, 2009). The framework calls for teachers and other school staff to explicitly teach all students a set of locally developed behavioral expectations for the classroom and other areas on-site used by students (e.g., hallways, cafeteria, playground). To encourage students to meet these expectations, school leadership teams design and implement systems that acknowledge and reward students for their adherence. These systems are context-specific, establish procedures for responding to desired and problem behavior, and provide a continuum of behavioral supports that are delivered based on assessed levels of need. Since its inception in the mid-1990s, researchers have amassed a significant amount of evidence in support of the use of PBIS (Sugai & Horner, 2020). Recent studies show that PBIS is linked to improved academic achievement (Kim, McIntosh, Mercer, & Nese, 2018; Lee & Gage, 2020) and school organizational health (Bradshaw, Koth, Thornton, & Leaf, 2009), and lower rates of suspension (Lee & Gage, 2020).

Social and Emotional Learning (SEL). *The Collaborative for Academic, Social, and Emotional Learning (CASEL) defines SEL as "the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions"* (CASEL, 2022). These five SEL core competencies are interrelated; can be explicitly taught, learned, and practiced; and include other important skills and attitudes that foster healthy and productive lives, such as positive coping skills, effective collaboration and problem solving, conflict resolution, perspective taking and advocacy, and ethical reasoning and behavior. Students develop SEL competencies through their daily experiences and interactions with others at school and home and in their communities (Nucci, 2001). Schools

and communities can foster youth's social and emotional competence through practices that create supportive, positive, and equitable classrooms and communities that foster a sense of belonging and emotional safety (Watson, 2018). Moreover, programs advancing equity-elaborated social and emotional competencies via approaches and practices like cultural integration, community-building, and positive ethnic-racial identity can promote positive school climate and reduce racial and socioeconomic learning inequities (Edyburn et al., 2022; Jagers, Rivas-Drake, & Williams, 2019; McCall et al., 2022). *Across the classroom, home, and community, key strategies for fostering SEL include creating positive and supportive environments for all youth, providing explicit instruction in SEL, integrating SEL into instruction and activities, forming healthy relationships between youth and adults, engaging families as partners in the promotion of SEL, modeling SEL competencies, aligning SEL efforts across school and community, and providing opportunities for youth to practice and reflect on SEL skills.*
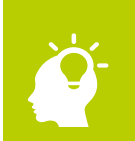
Trauma-informed Approach. *School- and community-wide efforts aligned with trauma-informed care recognize, understand, and are responsive to the impact of adverse childhood experiences and social determinants of health on youth development* (Nickerson, Reeves, Brock, & Jimerson, 2009). A trauma-informed approach uses the recognition that certain behaviors are related to traumatic experience to drive a new set of practices that are responsive to the needs of youth impacted by trauma (National Child Traumatic Stress Network, 2022). Any organized,

Across the classroom, home, and community, key strategies for fostering SEL include creating positive and supportive environments for all youth, providing explicit instruction in SEL, integrating SEL into instruction and activities, forming healthy relationships between youth and adults, engaging families as partners in the promotion of SEL, modeling SEL competencies, aligning SEL efforts across school and community, and providing opportunities for youth to practice and reflect on SEL skills.

structured, ongoing, and intentional effort to provide these youth with the support and care they need instead of punishing behaviors that are simply symptoms of these needs is aligned with trauma-informed care. For example, SEL, PBIS, restorative practices, mindfulness practices (Klingbeil et al., 2017), cognitive behavioral intervention for trauma in schools (CBITS), and school health or wellness centers are all aligned with a trauma-informed approach. Examples of trauma-informed practices include engaging in Collaborative & Proactive Solutions (CPS) (Greene & Haynes, 2021; Greene & Winkler, 2019); helping youth de-escalate; cultivating community, belonging, and positive classroom climate (Watson, 2018); fostering caring and responsive youth-adult relationships; and refraining from excluding students from school.

Restorative practices are "practices focused on building community through healing together after an incident of wrongdoing" and aim to "[create] resolutions for all parties, including the offender" (NASP, 2020). As delineated by Anfara, Evans, and Lester (2013), *Restorative practices are guided by seven core principles: meeting needs, providing accountability and support, making things right, viewing the conflict as a learning opportunity, building healthy learning communities, restoring relationships, and addressing power imbalances.* Restorative practices are a welcomed alternative to traditional retributive interventions, and there is a growing body of research linking their adoption with improved school climate and increases in students' social, emotional, and behavioral skills (Zakszeski & Rutherford, 2021).

Tier 2

At Tier 2, school and community professionals provide early intervention mental health support and services to students focused on preventing risk factors or nascent problems from progressing. Optimally, youth are identified for support and services through self-, teacher-, or parent-referral, mental health screening, or needs assessments. Tier 2 supports and services include therapy and social skills groups for youth experiencing similar concerns, behavior points systems, brief interventions, mentoring, and classroom-based accommodations and support (e.g., check-in/check-out, daily report card).

Tier 3

At Tier 3, school and community professionals deliver interventions to support students for whom Tier 1 and Tier 2 supports have been found to be insufficient for addressing their mental health needs. Tier 3 interventions are individualized and more intensive. Examples include individual or family therapy services, behavior support plans based on functional assessment results, and coordination with community-based service providers (Bradshaw et al., 2021; Cho et al., 2021; DiGirolamo et al., 2021; Thompson et al., 2021).
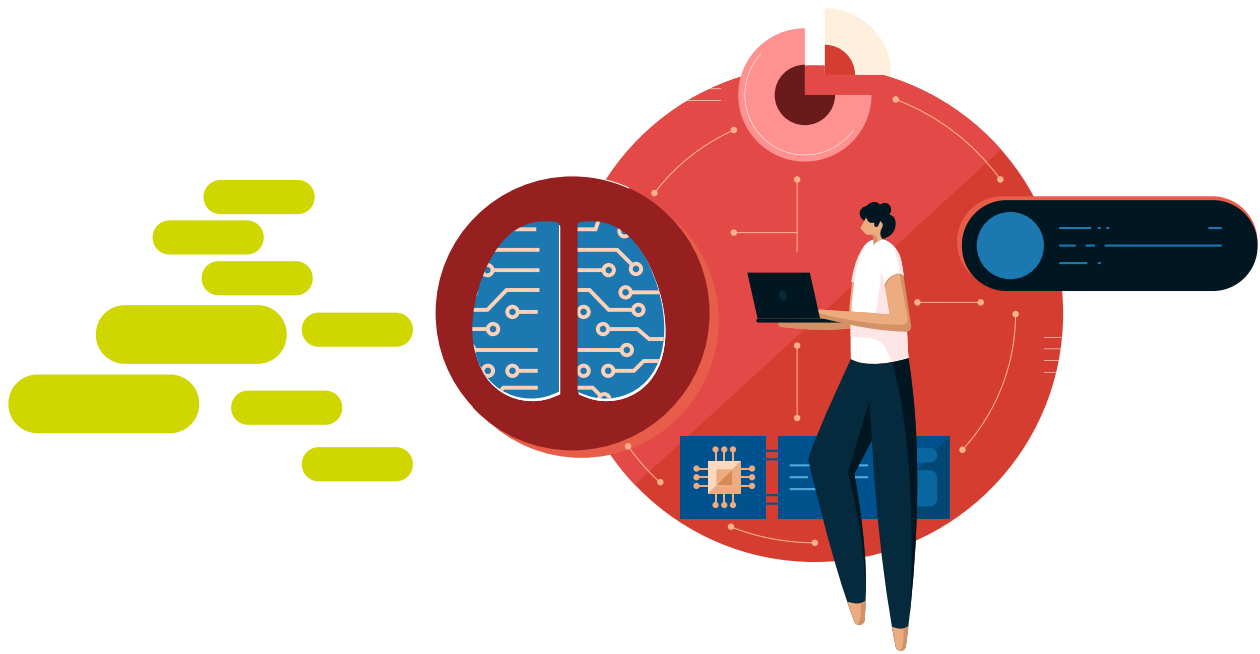
Individual therapy. Individual therapy involves "therapeutic conversations and interactions between a therapist and a child or family" that can help children, adolescents, and their families "understand and resolve problems, modify behavior, and make positive changes in their lives" (AACAP, 2019). Although there is evidence to suggest that behavior therapy and cognitive-behavior therapy are more likely to reduce symptoms of mental health challenges experienced by children and adolescents, there are a range of therapeutic approaches that may be effective for different types of problems (CDC, 2022).

Behavior plan driven by FBA. A functional behavior assessment (FBA), which involves gathering information about a problem behavior and relevant environmental variables to develop a hypothesis about its function(s), is used to inform the development of a behavior intervention plan that includes function-based strategies for affecting behavior change. The development of a behavior plan informed by an FBA to address problem behavior is an evidence-based practice supported by over half a century of behavior analytic research (von Ravensberg & Blakely, 2014) and is the most common response to severe student behavior challenges (Blood & Neel, 2007).

Coordination with community-based providers. Involving and collaborating with community-based providers is often necessary to provide effective and comprehensive mental health supports for students struggling with mental health challenges (Villarreal & Castro-Villarreal, 2016). Coordination with community-based providers is endorsed as best practice in the literature and can take place through the wraparound process, which is a strengths-based planning process that involves students, their families, school staff, and community-based providers in a team-driven process to establish networks of support and coordinate services for addressing complex social, emotional, and behavioral difficulties (Yu, Haddock, & Womack, 2020). The process comprises four phases: engagement, planning, implementation, and transition (Miles et al., 2019).

Conclusion

Supporting and promoting youth mental health is paramount. Integrated school and community multi-tiered systems of support (MTSS) services focused on social, emotional, behavioral, cognitive, and mental health of children and adolescents are essential in facilitating healthy development and well-being. An integrated whole school / whole community public health approach for SEL and mental health support requires the collaboration of interdisciplinary professionals to implement a comprehensive, coordinated, and culturally-sensitive continuum of evidence-based MTSS within and across school and community systems.

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Recent Applications of **Behavioral Sciences to Mental Health**

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*T*he demand for mental health services has steadily increased in the past few years. Studies based in the UK, US and Canada have shown an upward trend in the amount of people who seek mental health services and the amount of people who report depression, anxiety, and other risk behaviours[1,2,3]. This may be an indication of two things: an increase in the incidence of mental health conditions and a positive indication that access to mental health services has become less stigmatized. Whether the spike in serious cases of self-harm or suicide has prompted wider access, albeit centered in harm reduction, or whether the wider access has resulted in more cases reported to healthcare professionals is a matter that requires more research. However, evidence does highlight the alarming reality of the prevalence of mental illness; the WHO reported in 2019 that around 970 million people worldwide live with a mental health condition, which is one in every eight people[4]. For those aged 10-19, it is one out of seven, accounting for 13% of the global burden of disease for this age group[5]. This number, still a rough estimate considering underreporting, is likely to have increased after 2020, centering mental health in national and international public health agendas, with a special focus on early detection targeting children and young adults.

The impact of financial crises on mental health has been well researched[6]. Economic instability, catalyzed by the pandemic, the war in Ukraine and the effects of inflation felt worldwide can have long-lasting and inconspicuous

effects that manifest as depression, self-harm, substance abuse, etc. Often, these are diagnosed too late or go completely undiagnosed[7,8]. This is particularly relevant among young people, who are at a greater risk of social exclusion and are less able to access quality support and services[9]. Low-income countries tend to experience a magnified version of these crises: they are less equipped to provide poverty relief, they were less able to overcome the many challenges posed by COVID19 and they are also less prepared to tend to a more severely afflicted population[7]. In fact, the WHO estimates that the rate of mental health workers can be as low as 2 per 100,000 people in developing countries[10]. The need for mental health services may even be more urgent when populations suffer from collective trauma: in conflict-stricken Afghanistan, one in two people suffer from psychological distress[9]. In Lebanon, political turmoil and hyperinflation steadily raised suicide rates from 2011 until now[11,11] adding to that the effects of the pandemic and the Beirut explosion[12]. A post-explosion UNICEF survey conducted in Lebanon found that around 100,000 of surveyed children have been directly impacted by the explosion, with over 50 percent of respondents demonstrating signs of trauma.[13]

The COVID-19 outbreak was a crisis of many sorts; mandated confinement and the fear of the virus itself put unprecedented stress on people by disrupting their livelihoods with an uncertain future. Global intermittent or extended lockdowns resulted in unemployment and income loss. The effects of what was first seen as a medical emergency lingered as depression, anxiety, PTSD, etc. If anything, COVID-19 led individuals and institutions to rethink mental health and kickstart important conversations, yielding efforts and initiatives centered around facilitating access to services. To do

this, a deep dive into behavioral factors is necessary, not only to gather data about people's practices, but also their knowledge, concerns and attitudes towards theses services. In the case of youth, this is all the more important in increasing success of relevant initiatives. While young people's cognitive decision-making processes are similar to those of adults in many ways, there are aspects that are specific to youth that should be considered when designing interventions, in particular regarding their risk perceptions, as they tend to be more risk seeking. Examples of considerations in that regard include establishing positive social norms in peer groups, engaging young people in communicating risk-prevention messages, and facilitating safe social connections to reduce negative impacts on mental health.[14]

Behavioral science tools such as social norms have been instrumental in advancing both accessibility and uptake, especially when stigma continues to represent one of the main reasons why people hesitate to access services, even if available and easy to use. For example, in Qatar, even if 89% of the surveyed population in 2020 agreed that people with mental health conditions deserved compassion and support, fear of being known as a person with a mental illness, fear of discrimination and shame were reported as major barriers preventing people from seeking professional help[15]. For youth, schools are important platforms for promoting mental health and emotional wellbeing. Schools can play a particularly important role in early detection and prevention of mental health problems, especially given that most mental health issues begin earlier in life with around 50% of all mental illness appearing before the age of 14.[16]

[1] Hamm, N (2019). Mental Healthcare Needs Are Increasing. Managed Healthcare Executive.

[2] New mental health website to help address increased demand for services. HospitalNews.

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[9] https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-healthlockdown in South Africa

[10] https://oecd-development-matters.org/2020/08/04/mental-health-and-covid-19-in-developing-countries/

[9] Idem

[11] https://blogs.lse.ac.uk/mec/2020/01/28/lebanons-economy-and-its-effect-on-mental-health/

[11] http://timep.org/commentary/analysis/the-beirut-explosions-impact-on-mental-health/

[12] Idem

[13] https://timep.org/commentary/analysis/the-beirut-explosions-impact-on-mental-health/

[14] Young people and COVID-19: behavioural considerations for promoting safe behaviours. Policy brief; file:///C:/Users/f.makki/Documents/FM%20fin%20and%20admin%20SC/Affiliations-boards-committees-WHO/Youth/Youth%20and%20BI%20considerations%209789240028319-eng.pdf

[15] Qatar Mental Health Strategy Awareness and Attitudes Measure, 2020

[16] https://sehanafsia.moph.gov.qa/English/MHConditions/Pages/HealthChildren.aspx

Drawing lessons from such interventions will be crucial at a time when the WHO foresees a tsunami of mental health particularly affecting the youth. Suicide was found to be the second leading cause of death among 15–29-year-olds[17] causing health policy to prioritize mental health, particularly early detection. In this regard, the role of behavioral insights is medullar in designing and implementing such programs. This can look like behaviorally informing corporate welfare programs to promote work-life balance or conducting interventions to increase parental engagement to reduce risk seeking behaviors among the youth. It can also look like behaviorally informing efforts to promote help-seeking behaviors, (i.e., designing interventions that prompt individuals to seek help when they need it). Some relevant early intervention programs such as Unplugged, rolled out in schools in various European countries engages children aged 12-14 to develop critical thinking, effective communication, interpersonal relationship skills as well as self-awareness, emotional regulation and empathy. The program was associated with significantly lower levels of self-reported use of cigarettes, alcohol, and cannabis[18]. Other programs such as the Utrecht Coping Power Programme, rolled out in the US, Italy and Netherlands, targeted children as young as 8 and their parents in a 23 weeklong intervention aimed at fostering emotional development and social problem solving. The effects of the program in tackling behavioral disorders and substance use were detected even four years after the program had concluded[19], highlighting the importance of early detection and active parenthood in mitigating the drivers of mental health conditions.

There is valuable research in behavioral science that explores the effect of social norms on health outcomes[20,21,22,17,23] . For instance, a recent survey conducted before the COVID-19 vaccine was available, revealed that respondents' willingness to get vaccinated was positively correlated with their perceptions of others getting vaccinated[24]. Additionally, research has found that often stigmatized beliefs rise from erroneous perceptions of social norms, and further reveals that updating these norms can have a significant impact in promoting a desirable behavior. This was seen in a famous experiment in Saudi Arabia, where young married men (26 years old on average) were asked about their perceptions of other men's level of approval of women working outside the home and asked about their own level of approval. Researchers found that overall, actual levels of approval were significantly higher than what participants thought they were. Upon informing participants that other men viewed their wives working outside the home quite favorably, researchers found that these men were more likely to register their wives to find a job outside the home[25].

Expanding on the case of Qatar, in 2020, a randomized survey experiment was conducted between B4Development and the Ministry of Public Health to test the impact of a dynamic social norms statement on levels of trust on mental health services. This study was motivated by anecdotal accounts of MoPH professionals revealing that, despite efforts to launch a remote mental health service hotline during the pandemic, uptake remained suboptimal. The intervention consisted of informing people of the increasing trend in mental health

[17]WHO (2021) Mental health. Online: https://www.who.int/health-topics/mental-health#tab=tab_3

[18]https://www.emcdda.europa.eu/best-practice/xchange/unplugged_en

[19]https://www.emcdda.europa.eu/best-practice/xchange/coping-powerutrecht-coping-power_en

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[24]Graupensperger, S., Abdallah, D. A., & Lee, C. M. (2021). Social norms and vaccine uptake: College students' COVID vaccination intentions, attitudes, and estimated peer norms and comparisons with influenza vaccine. Vaccine, 39(15), 2060–2067. https://doi.org/10.1016/j.vaccine.2021.03.018

[25]Bursztyn, L, A L González and D Yanagizawa-Drott (2018), "Misperceived social norms: Female labor force participation in Saudi Arabia", NBER Working Paper 24736.

consultations and was embedded in a larger COVID-19 KAP survey. First, respondents were asked whether they had previously consulted a specialist or used the mental health helpline during the pandemic. Then, the treatment group[26] was exposed to the statement: "During the COVID-19 pandemic, more and more people have consulted mental health services". Finally, all respondents were asked about their level of trust in remote mental health services, measure on a 1-7 scale. Results for the sample of non-Qatari respondents[27] showed that respondents in the treatment group were 37% more likely to report higher levels of trust (5-7) versus lower levels (1-4).

Some tools could behaviorally inform the communication, e.g., making salient some of the facts around trends or positively framing certain information or available services. Other tools could be choice-architecture based, such as using default screening mechanisms for early detection, or making it easy to seek help. Behavioral insights have also been used to address some of the root causes of depression, such as commitment devices to increase physical activity or the use of ego or feedback to curb harmful behaviors such as excessive drinking[28, 29].

In view of the upcoming massive wave of mental health cases, focus should be on using behavioral insights at the entire health continuum[30]: from destigmatizing conversations about mental health using social norms or effective messengers, to promoting a healthy lifestyle through physical activity, healthy eating, work-life balance and positive social interactions, to simplifying access to resources like therapy or psychiatric intervention, all the

This study was motivated by anecdotal accounts of MoPH professionals revealing that, despite efforts to launch a remote mental health service hotline during the pandemic, uptake remained suboptimal.

way to promoting adherence to treatment, making it easier for professionals to follow up with their patients and aiding them in tracking their mood, making appointments or reaching out to helplines.

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[26]All respondents were randomly allocated to either a control or treatment condition, and only those in the treatment group received the social norms statement.

[27]The population in Qatar is made up of roughly 90% foreigners and 10% Qataris, so the survey collected representative data from both demographics and conducted separate analysis

[28]Woodend A, Schölmerich V, Denktaş Ş. "Nudges" to Prevent Behavioral Risk Factors Associated With Major Depressive Disorder. Am J Public Health. 2015 Nov;105(11):2318-21. doi: 10.2105/AJPH.2015.302820. Epub 2015 Sep 17. PMID:

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The importance of removing the stigma around mental health

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*M*ental health disorders affect a significant number of children and adolescents, with the 15% of the prevalence globally. Half of the mental health disorders begin by the age of 14 and 75% by the age of 24 (Bruha et al., 2018) which gives an important sign that early prevention is more than necessary, with a special emphasis on resilience and coping skills. There is a very poor situation in the field of mental health of young people, which is reflected in increasing cases of suicides, emotional distress, behavioural problems, calling for urgent prevention interventions at all levels and to remove the stigma which is present in our society, of the situation among those affected.

From birth, all individuals go through a phase of socialization, in which we adopt language, culture, values, rules, and along the way we are co-shaped by the interplay of both protective and risk factors and all agents that influence these factors in one direction or another. Adults and society in general, play an important role in strengthening the protection and reducing the influence of risk factors, which contributes to the resilient development of children. Therefore, understanding the factors that promote mental health in children and adolescents and considering these in interventions when talking about academic success and wellbeing are critical for the future. High expectations set by professionals, peers and caregivers are linked to self-esteem and academic motivation of children (Schiff & Tatar, 2003). Furthermore, high expectations impact children's expectations of themselves, their self-perception and academic ambitions (Rubie-Davis, 2006).
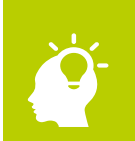
However, we live in a rapidly changing world wherever-increasing demands and expectations come to the fore. Social pressures, expectations and ideals, which in many cases are too high result in behaviours and situations which represent a great burden for the entire society. Higher expectations and pressures are set and observed in the field of education. Higher academic standards are moving back to the earlier years when children are still in kindergarten.

In today's society, many ideals and expectations represent a great burden to the individuals. There are quite unrealistic pressures and expectations regarding academic success. Everyone is expected to finish school and get a well-paid job. Happiness, healthy lifestyle and body image have emerged in recent years as a major preoccupation of our time. Many times, parents aspire and expect their children to finish university. But their aspirations are not always matching their children's expectations. Parents sometimes have much higher expectations and aspirations for their children than children had for themselves (Lindberg et al., 2019). In addition to that, societal conditioning that idealizes unrealistic body types also creates a vicious cycle of self-hatred, which can have negative individual and collective consequences. A large proportion of young people are dissatisfied with the appearance. And more individuals internalize cultural stereotypes about their appearances, the more likely they are to perpetuate them (Cornelissen et al., 2022).

Families as primary setting where the process of socialization starts, present an environment where important resources such as parental support, authoritative child-raising, and good family climate or cohesion are present. All of those are important resources for healthy and safe development of children (Darling, 1999). Many studies have shown a significant association between positive resources, such as supportive relationships with parents, and youth's wellbeing and life satisfaction. Regardless of level of risk, caring, supportive

families in fostering all children's social and emotional wellbeing were found to have positive effects. And on the other hand, poor family support and relationships have been associated with increased risk of child abuse and neglect, which predicts poorer outcomes across the life course, including mental health problems (Butler, 2022).

Just like society in general, the family as a microenvironment goes through important changes, which also results in the way children are raised. Career opportunities for women, adoption, remarriage, the cultural environment, economy are just some of them. Many parents often have limited experience with young children and are often confused or uncertain about parenting and are coping with parenting helplessness. On the one hand, we have parents who have unrealistic expectations of their children, and on the other hand, parents who are overprotective. Exaggerating about children's achievements, taking responsibility instead of children, preventing even smallest frustration in their children which eventually leads to the impoverishment of children in terms of skills and experiences. Children from overprotective parents are more prone to worry and anxiety (Spada et al., 2011). Also, children raised with overprotective parenting tend to have less competent social skills. They are more likely to suffer from social anxiety or social phobia which is usually accompanied by an excessive preoccupation with fears of rejection, criticism, or embarrassment (Spokas & Heimberg, 2008).

The period of adolescence is stressful due to rapid changes that take place during this time, both psychologically and physically. Adolescence is also a period in which reorganization of adolescent's brain is taking place. Quick changes that take place in this period itself and increasingly demanding expectations, pressures, and socially constructed ideals that young people follow in today's world put them in a higher risk for developing different risky behaviours.

I touched various factors in various environments very briefly and superficially. In interaction with various agents, those have a significant impact on the prevention of mental health-related problems or can accelerate them. The challenge for people who are facing mental health problems in general, and their families is the recognition of mental health problems. This can have liberating feeling but viewing oneself as such can be self-limiting.

Stigma is strongly present in our society. It prevents people from seeking professional help in times when they need a lot of support, encouragement, and love. Untreated mental health distress on the other hand has many negative consequences. It reduces quality of life, and it also has huge impact on productivity in private life.

When looking at the statistics, adolescents appear relatively healthy, if we limit our view of health to physical illness. But as we expand the parameters of the health and when we include psychological, social and environmental health, significant unmet health needs emerge for this age group. Therefore, the entry into adolescence has been the target of numerous health-focused preventive interventions which is not based on current health per se, but on the critical aspects of development that occur as children become adolescents. Subsequent mortality in adulthood is often viewed as the outcome of behavioural choices of adolescents and young adults therefore the need for prevention interventions in this period should be priority.

To conclude, stigma leads to social isolation and discrimination. It impacts individual's ability to finish the school, find a job, get the support, be part of the community and recover from mental health related problems. Globally, people living with such conditions are frequently excluded from society and have difficulties in different areas of life. The periods before adolescence and between adolescence and early adulthood have become very demanding and unpleasant due to the ever-increasing demands of society. Individuals find themselves alone and often stigmatized in this vicious circle of following ideals and expectations. Ideals, expectations, and pressures are the product of the consumer society in which we live. Without investing in systematic prevention, in the framework of which children and youth would be helped to strengthen life-important skills, we are leaving these target groups behind and further exacerbating their problems. In a way, stigma is a tool of society, with which it transfers the responsibility for dealing with a whole range of problems (including those related to mental health) to the affected people, who, due to their helplessness and failure to meet society's high standards, further sink into conditions that further increase their problems.
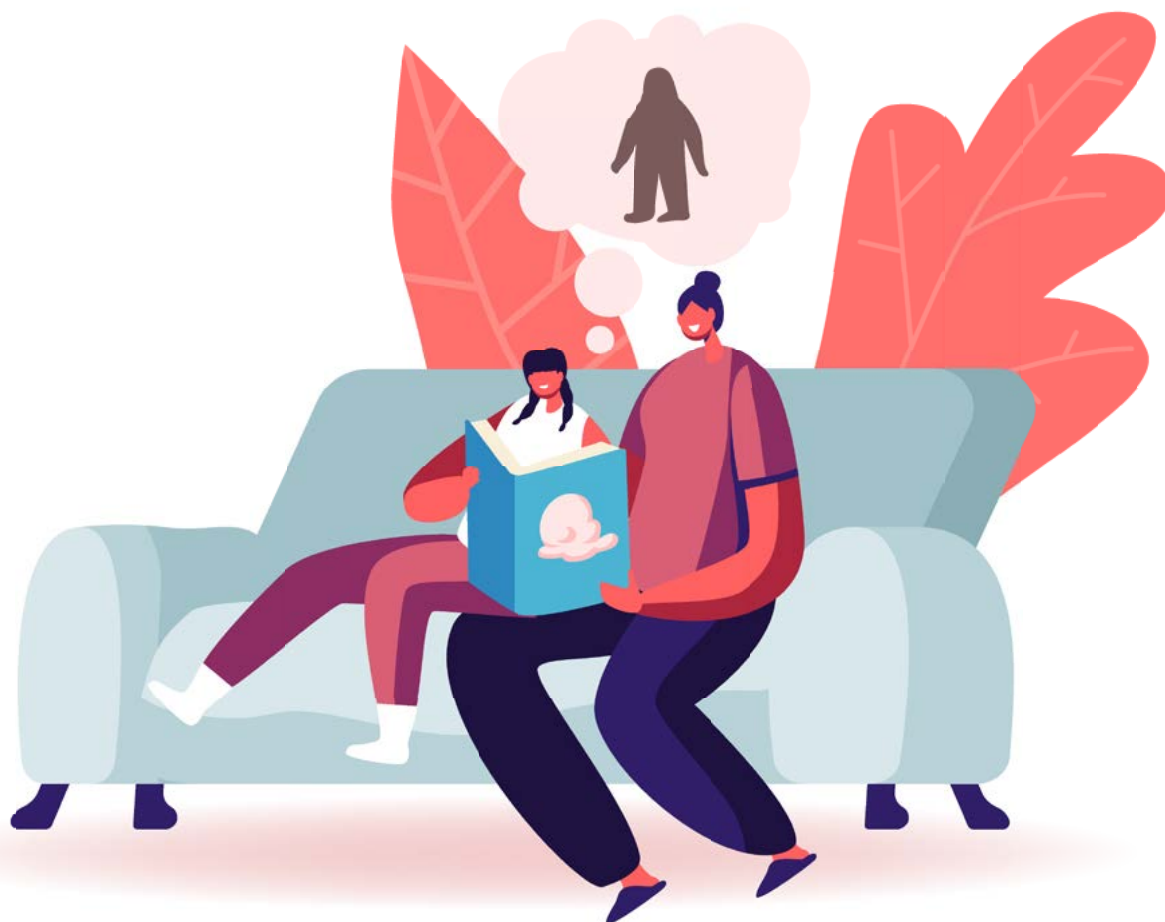
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Mental Health Globally: A Case for Integrating it into Public Health

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Among the myriad obstacles that mental health advocates face in low- and middle-income countries (LMICs), three stand out in an important way. First, mental health disorders (MHDs), including depression, tend not to be prioritized like other more visible conditions and diseases. AIDS, tuberculosis, malaria, and other communicable diseases have received a significant amount of public health attention in LMICs, with noncommunicable diseases receiving their share in the high-income countries. MHDs, however, do not figure prominently in most countries' strategic plans. Neither are they prioritized by international donor organizations, despite estimates of a $6 trillion price tag cost to address global public health problems by 2030.[1]

Second, those suffering from various MHDs are also reluctant (or unable) to speak up or seek care because of stigma and inability to recognize their own condition.[2] Mental health challenges experienced by young people are understudied even though most mental ill health presents itself between the ages of 10-14 years old. [3] Thus, demand for MHD services remain significantly lower than the need for them. Third, even if people who needed services demanded them, most LMICs would not be adequately staffed with services or mental health professionals to address the problem. [4]

In the last few years, the situation has been further exacerbated by the COVID-19 pandemic experience: In many LMICs, resources set aside for most diseases and prevention efforts have been reallocated to combat the COVID-19 threat, leaving behind essential services, including access to family planning methods[5] and routine immunization of infants.[6]

[1] Marquez, P. V., & Saxena, S. (2016). Making mental health a global priority. Cerebrum. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5198754/
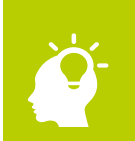
[2] Mak, W. W., Poon, C. Y., Pun, L. Y., & Cheung, S. F. (2007). Meta-analysis of stigma and mental health. Social science & medicine, 65(2), 245-261.

[3] Nature, 7 October 2021., Young people's mental health is finally Young people's mental health is finally getting the attention it needs getting the attention it needs at https://www.nature.com/articles/d41586-021-02690-5

[4] Fricchione, G. L., Borba, C. P., Alem, A., Shibre, T., Carney, J. R., & Henderson, D. C. (2012). Capacity building in global mental health: professional training. Harvard review of psychiatry, 20(1), 47-57.

[5] Stanton, T., & Bateson, D. (2021). Effects of the COVID-19 pandemic on family planning services. Current Opinion in Obstetrics and Gynecology, 33(5), 425-430.

[6] Mansour, Z., Arab, J., Said, R., Rady, A., Hamadeh, R., Gerbaka, B., & Bizri, A. R. (2021). Impact of COVID-19 pandemic on the utilization of routine immunization services in Lebanon. PloS one, 16(2), e0246951.

As a result, it is fair to say that we are not currently seeing a stampede to allocate precious public health resources to addressing depression and other mental health needs in LMICs, especially for young people. Yet, the need is acute.

The WHO[7] indicates that 1 in 7 (14%) of 10–19-year-olds experience mental health conditions, but these are not treated or even picked up. Forms of prevention particularly for youth therefore remain limited.[8] Schools have therefore become spaces where young people, as a captive audience for at least five hours a day, can be the target for intervention.

So, what can the mental health community do in the meantime, knowing that most countries' public health efforts are not, suddenly, going to remobilize their resources to address MHDs, especially for youth? We offer a few initial recommendations.

Perhaps the most important strategy is that we need to think of the issue through an "and" and not an "or" lens: It is not that we must address MHDs by displacing efforts to combat other pressing needs. Rather, we need to think about how the same services we provide to people for their physical health and in schools that can also double up to address their mental health.

Take anemia as an example.

Globally, approximately 30% of women are anemic, and it is higher, at close to 37%, among pregnant women. Preliminary analyses of data from the Reduction in

Anemia through Normative Innovations (RANI) Project,[9] run in rural India, has found that reducing anemia in women has an unanticipated effect: their depression also diminishes. There are likely two explanations for this, one biomedical and the other psychosocial, that have a bearing for approaches to address mental health needs.

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Rather, we need to think about how the same services we provide to people for their physical health and in schools that can also double up to address their mental health.

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Biomedically, when anemia is addressed, women feel more energetic and are then likely to engage in higher levels of physical activity. A preponderance of evidence indicates that depression and physical activity are negatively correlated.[10] Thus, by improving anemia, women likely became more physically active, which in turn reduced their depression and can improve maternal health which positively affects the unborn child

[7]World Health Organisation, 2021., Adolescent mental health at https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

[8]Chadda RK. Youth & mental health: Challenges ahead. Indian J Med Res. 2018 Oct;148(4):359-361. doi: 10.4103/ijmr.IJMR_1585_18. PMID: 30665996; PMCID: PMC6362731.

[9] Yilma, H., Sedlander, E., Rimal, R. N., Pant, I., Munjral, A., & Mohanty, S. (2020). The reduction in anemia through normative innovations (RANI) project: study protocol for a cluster randomized controlled trial in Odisha, India. BMC Public Health, 20(1), 1-13.

[10]Rebar, A. L., Stanton, R., Geard, D., Short, C., Duncan, M. J., & Vandelanotte, C. (2015). A meta-meta-analysis of the effect of physical activity on depression and anxiety in non-clinical adult populations. Health psychology review, 9(3), 366-378.

Psychosocially, it must be comforting for women to know that the lethargy they consistently feel (a hallmark of anemia) has a biomedical (and, more importantly, a known) basis, that they are not just making it up. Further, knowing that there is medication to restore the balance (by taking iron folic acid tablets) must also add to feeling more upbeat about one's condition.

At the school level, by focusing on mental health services as a preventative health measure rather than only on pure clinical support, which is especially lacking in LMICs, one could reach more adolescents where the need is the highest. These interventions should aim to build resilience in youth to avoid risk taking behaviours, which add to their perseverance in dealing with challenging situations faced at school.[11]

Apart from the inclusion of MHD considerations in routine public health screening and interventions, another recommendation is that mental health efforts need to be tailored according to the specific needs of the target audience for women and youth. Globally, women bear the burden of MHDs at significantly higher rates than men, and researchers recommend that public health professionals pay greater attention to the particular needs of women. In addition, the needs of younger people are different from those of other population groups, and hence one-size-fits-all campaigns are likely to be less effective.

In Nepal, for example, many adolescent girls drop out of school when they reach puberty because their schools do not have adequate bathroom facilities that protect their privacy or accord them basic menstrual services. One study[12] found that dropping out of school for these (and other) reasons was associated significantly with emotional stress, which can be reduced by providing hygiene infrastructure in schools and creating a more welcoming environment for girls

This finding is yet another demonstration of the underlying idea that the drivers of overall health and well-being – in this case, the provision of adequate facilities for promoting hygiene – are often also the drivers of mental health. And, of course, mental and physical health are themselves intricately related so that addressing one will inevitably also affect the other. Mental health services whether at clinics, schools or in the community require a multisectoral approach with a range of delivery platforms and require bespoke solutions to reach young people in these communities.

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[11]World Health Organisation, 2021., Adolescent mental health at https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

[12]Yilmaz, S. K., Bohara, A. K., & Thapa, S. (2021). The Stressor in Adolescence of Menstruation: Coping Strategies, Emotional Stress & Impacts on School Absences among Young Women in Nepal. International journal of environmental research and public health, 18(17), 8894. https://doi.org/10.3390/ijerph18178894

Art with **a Message**

Bonjour
Je m'appelle Sami, j'ai bientôt 13 ans et j'habite à Paris.
Je dessine depuis l'âge de 4 ans et je suis passionné de dessins et de manga, d'ailleurs je veux perfectionner, c'est pourquoi je suis des cours aux ateliers des arts du Carrousel du Louvre depuis 1 an.
Je vous présente aujourd'hui, mon premier dessin réalisé avec le fruit de mon imagination.
À très bientôt

- SAMI BENABDELOUAHED

Hello
My name is Sami, I'm almost 13 years old and I live in Paris.
I have been drawing since the age of 4 and I am passionate about drawings and manga, moreover I want to improve, which is why I have been taking classes at the Carrousel du Louvre art workshops for 1 year.

I present to you today, my first drawing made with the fruit of my imagination.
See you soon

- SAMI BENABDELOUAHED

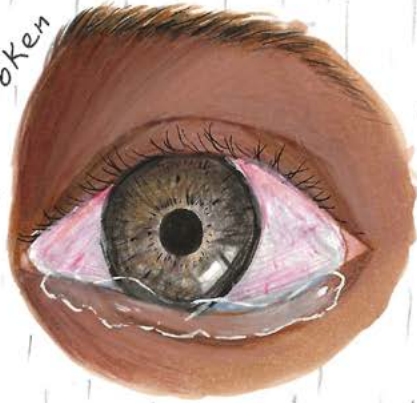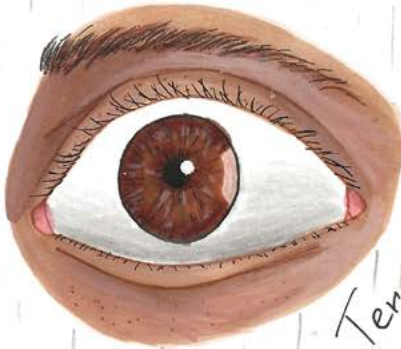Since wars begin in the minds of men, it is the minds of men that the defenses of peace must be constructed

Interviewee: Ms. Karen Pittman, Partner,
Knowledge to Power Catalysts

Interviewer: Ms Akriti Mehra, Communications Specialist, UNESCO MGIEP

1. *Please tell us a little bit about yourself and your work.*

I went off to college 50 plus years ago with the intent of being a middle school math teacher, because I had such rich experiences in the Washington D.C. public schools. I spent my college summers teaching at an educational camp for teenagers. The experience of helping 80 teens from diverse backgrounds and countries build a vibrant learning community each summer changed my trajectory. I have spent my career joining and starting organizations focused on moving asset-based youth development approaches into policy and practice. I recently stepped down as CEO of the Forum for Youth Investment, which I co-founded 20 years ago with colleague Merita Irby, to have more freedom for moving these ideas because of the opportunities COVID-related disruptions have created.

2. *What according to you and in your experience are the drivers for mental health issues amongst young people (18+)?*

The primary driver of mental health issues amongst youth and young adults is our systematic inattention to their mental health. Thriving is more than well-being which is often defined as discrete outcomes (physical health, absence of risky behaviors, educational attainment, employment, lack of involvement in illegal activities, etc.). Thriving is the experience of moving forward with purpose. Well-being combined with groundedness (identity, connections with others, civic engagement) and agency (competencies, confidence and convictions). Ensuring that young people have the supports they need to make connections, make progress, and make-meaning in their lives – even when these tasks are difficult and constrained by forces and injustices beyond their control – helps young people build resilience that can stave

off serious mental health issues. Once present, however, these issues (e.g., depression, isolation, suicidal tendencies, anxiety) need to be addressed.

3. *Who are the "at risk" youth who are most prone to mental health issues?*

The young people who are most prone to mental health issues are those whose identities are being challenged, whose basic well-being is unstable, and who feel a lack of agency (whether from lack of capacity or perceived inopportunity). Youth who are most at risk for individual mental health issues, in other words, are those whose collective identity and agency have been marginalized. In the U.S., this is Black and Hispanic youth, LGBQT youth, youth experiencing homelessness, and youth currently or previously involved with the justice and welfare systems. Interestingly, in the past decade, researchers have seen an increase in individual behavior problems among white youth from working class families in rural and heartland (MId-America) communities and increased morality rates for non-college educated adults. These are young people and adults whose identities are being threatened by the erosion of manufacturing and mining jobs and the increased hegemony of people of color.

4. *What in your experience are some of the preventive measures that can be introduced in early childhood to help build resilience amongst young people?*

The most important thing we can do is to develop a much deeper appreciation for the power of the science of learning and development and the science of adolescence. All young people have the potential to be successful given sufficient and cumulative exposure to people with whom they can build strong relationships and experiences that help them grow and make-meaning of their situations and surroundings. In the U.S., schools talk a lot about supporting "the whole child." But doing this requires an acknowledgement of two things: a) the diversity of developmental places and b) the imperatives associated with developmental stages (from early childhood to young adulthood). Researchers at the UChicago Consortium for School Research have explained the importance (and intersection) of these two fundamentals well in two-page infographic that accompanies their 2015 report, Foundations of Young Adult Success. It's worth downloading.

5.

What sort of competencies are essential to be built in our education systems to help young people deal with some of the setbacks they may face in life?

I like the wording of this question. Certainly, when I look at the public education systems in the U.S., the primary competencies they need to build is to see themselves as a part of a larger learning and development ecosystem that literally surrounds them (early childhood and post-secondary education and training systems bookend the age groups, family and community organizations bookend the time spaces). These are competencies, much like the social and emotional competencies schools expect students to learn through SEL instruction – (e.g., personal awareness, social awareness, self-management, relationship skills, responsible decision-making). It is important for school leaders and school systems to build these competencies at the system level because, while they are not the only systems and settings where learning and development happen or where supports are provided to deal with setbacks, they are the only system that all young people are required to attend throughout the bulk of their developmental years. When they operate like

a closed system (suggesting that what happens within their walls is what is most important), they ignore the fact that young people have fuller lives that create both setbacks and opportunities that inform their capacity and motivation to learn and thrive and, equally important, that there are other organizations and systems providing supports.

6.

Could you please cite an example or two of a programme or project which may have helped young people deal with some of the setbacks they may face in life?

Several come to mind, but I'll share one program, YouthBuild, that has been designed specifically for the youth populations you are focused on and has been adapted internationally. I served on the YouthBuild Board for 10 years and can't sing their praises enough. But for purposes of brevity, I have edited a few paragraphs from their 2016 independent evaluation study, which is available on their website:

"The original YouthBuild program (the East Harlem Youth Action Program) was founded in the late 1970s in New York City. That original program was designed to address

the complex needs of participants and their community with a culture of respect for young people that is still emphasized today. The YouthBuild model continues to include a mix of education, vocational training (usually training in construction), counseling, leadership development, and community service "plus love" (a non-negotiable component that is formally a part of their model).

Eligibility is typically limited to out-of-school young people ages 16 to 24 who have dropped out before completing high school and who meet one of the following criteria: They are from low-income or migrant families, are in foster care or are aging out of it, are ex-offenders, have disabilities, or are children of incarcerated parents."

Programs recruit or rely on word of mouth to identify interested applicants, who then go through assessments before enrolling such as tests of basic skills and one-on-one interviews. Most frequently, programs then implement a rigorous Mental Toughness Orientation, which can last from a single day to several weeks. Mental Toughness Orientation is designed to facilitate group bonding and ready recruits for the program's activities. It also serves as a period when many young people are screened out because they stop attending or otherwise fail to follow established rules.

Most young people who make it through Mental Toughness Orientation enroll in YouthBuild, are offered the program's services, and take part for 6 to 12 months. New participants typically begin the program in a group with other enrollees, and that group alternates weekly or every few weeks between a focus on education and a focus on vocational training. The components of the model are intended to be integrated and designed to be offered together.

YouthBuild graduates about half of its participants after 12 months (a sign of the many external forces on young people's lives,

even after Mental Toughness assessments). Compared to the control group, YouthBuild's graduates showed increased participation in education and training (even though control group participants sought these services), increased receipt of equivalency educational credentials, college enrollment and vocational training, and increased civic engagement, particularly volunteering from low-income or migrant families, are in foster care or are aging out of it, are ex-offenders, have disabilities, or are children of incarcerated parents."

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Towards integrating preventive strategies to promote mental well-being – the case for social and emotional learning

Ammaarah Martinus leads the Programme Team at UNESCO MGIEP while assisting and advising the Director on content and managerial matters. She has over ten years of experience in the public service in South Africa, where she served as the Director for Policy, Research and Analysis, focusing on policy development, design and implementation of strategic and innovative programmes in the social sector. She has worked extensively in designing, implementing and evaluating behaviourally informed programmes and interventions, with the view to scale educational impact. Ammaarah also sits on various international advisory groups including the WHO's Technical Advisory Group on Behavioural Insights and Sciences for Health.

Baiba Martinsone, Dr.psych., is a professor of Clinical psychology and senior researcher in Educational psychology at the University of Latvia. She is also a certified psychologist and supervisor. Her research interests include social emotional learning, promoting mental health and wellbeing, and development of universal prevention programs. She actively works in national and international research projects, and intensively publishes in the field.

Arnaud Cachia is full Professor of cognitive neuroscience at Université Paris Cité'. He conducts his research in the laboratory of developmental psychology and child education (CNRS, La Sorbonne) in collaboration with the Institute of Psychiatry and Neuroscience of Paris (INSERM, Hôpital Ste-Anne) in Paris, France.

Poonam Borah is an educator and researcher with more than 12 years of experience in the field of educational research, teacher training, and classroom teaching. She has experience in both school and out-of-school settings in India, Bhutan, and the US and has worked closely with education stakeholders and led applied research studies to build continuous quality improvement systems and enhance professional development for teachers and administrators. She has a Masters degree in Educational Leadership and Policy from the University of Michigan, Ann Arbor and currently works as an Associate National Project Officer at UNESCO MGIEP.

Maryam was a healthy baby born to a mother who received prenatal care through a local clinic. Her mother ensured that Maryam grew up in a safe and nurturing family. She would often sing, read and play with Maryam during her childhood years. However, things changed quickly when Maryam moved from her middle school to a nearby high school. Her friends teased her and often bullied her. She felt stressed, lonely, helpless and worthless. This made Maryam unable to share her problems with the adults she was close to. She could not regulate her emotions or focus during lessons. This is when her mother took her to an afterschool programme that had recently opened to promote workforce readiness, and which incorporated aspects of emotional regulation and grounding work as part of the curriculum. Maryam found a circle of friends and adults who helped her to be aware of the many emotions she was feeling and regulate them to focus on things she likes doing. Over time she was able to confide in her mother once again and felt confident about receiving professional help. She started pausing and reflecting before experiencing self-doubt that would previously plunge her into a bottomless pit of negative thoughts. Her afterschool mentors and friends, along with the social and emotional strategies she learned, continued to be a source of support when she transitioned to living alone in the nearby city to go to college. She recognized when to seek professional support and continued to have her close circle of friends and family as she transitioned to the workplace.

This vignette tracks the life course of Maryam and illustrates the many transitions she experienced during infancy, school years and young adulthood, along with the support she had, or did not have, for her mental health and well-being. As illustrated in the vignette, mental health is a fluid rather than static condition, that is, with appropriate interventions, it can move from one end of the spectrum (i.e., incomplete/languishing mental health) to the other (i.e., complete/flourishing mental health) (Keyes, 2022). Defining mental health as a continuum highlights the benefits of preventive and promotive measures in young people, such as equipping them with skills, attitudes and mindsets so they are able to better regulate and manage their emotions. This can be developed by fostering the growth of social and emotional competences and creating safe and supportive environments centred on positive and supportive relationships. These social and emotional competences are important to promote mental health and build resilience. These competences are also important to develop better self-awareness for when to seek professional support when well-being and mental health are challenged.

The following sections take a deeper dive into the various life phases highlighted in Maryam's story. They focus on the importance of evidence-based preventive interventions and the need to integrate different approaches to social and emotional learning SEL), both direct and indirect, in the educational ecosystem to promote mental health and well-being.

INTERVENING IN THE EARLY YEARS (0-4 YEARS)

Appropriate child and caregiver interventions implemented in the first 1,000 days (UNICEF, 2013) of a child's life are important to ensure achievement of developmental milestones later in life. Research has shown that children who have stable, safe and nurturing caregiver relationships are more likely to have healthier families themselves and experience less childhood aggression and youth violence later in life (De Lannoy et al., 2015).

If parents and caregivers are provided with the correct tools even before birth, they are more likely to care for their children in an appropriate way and include things like singing, talking and reading to their children, which assists with cognitive stimulation. SEL is important for brain development in

The World Health Organisation defines mental health as a "state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"

Definition note: Social and Emotional Learning (SEL) involves developing competences and/or attitudes necessary to recognize and control emotions, develop caring for others, form positive relationships, make responsible decisions, and deal with challenging situations (Payton et al., 2000; Greenberg et al., 2003; Weissberg et al., 2015).
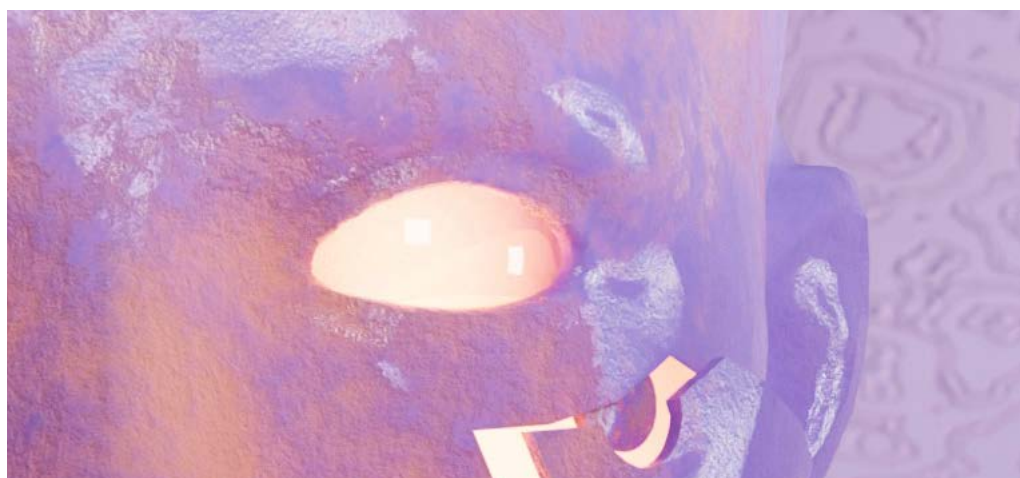
infancy and early childhood (De Lannoy et al., 2015; WHO, 2022). Stimulation earlier in life ensures the greatest impact on brain architecture – which assists with speaking another language, reading, playing music and the ability to have meaningful social interactions later (WHO, 2022). Conversely, caregivers and parents not engaging in these behaviours with their children saw an increase in negative behaviour, such as clinginess, micro-aggression and a sense of neediness (Burkhart and Borelli, 2020).

Evidence shows that life skills received through social development programmes, as well as receiving quality early childhood education (De Lannoy et al., 2015) aimed at building social, emotional and behavioural competences, can build a young person's protective factors, particularly resilience (Singh and Duraiappah, 2021). These programmes help children and youth adequately deal with challenges in their lives, which positively impacts their mental health and well-being.

Poorer communities often bear the brunt of having to deal with multiple deprivations or multidimensional poverty (Alkire et al., 2020). For instance, poorer people are less likely to have access to quality education or to transport and have a lack of social networks. These deprivations can lead to chronic or toxic stress (Franke, 2014), which has a negative impact on the mental health of caregivers, in turn negatively affecting their children. Incorporating time into caregivers' days through focused interventions to help them to spend quality time with their children will greatly assist with positive child and adult outcomes.

INTERVENING AT SCHOOL AGE (5-18 YEARS)

Schools are among the most appropriate sites for interventions. It is possible for schools to reach many children as they spend a considerable amount of time there year by year, and schools are also able to reach parents and caregivers. Addressing social, emotional, and academic skills in education will develop children comprehensively as a whole person. This means going beyond traditional academic emphasis, because self-regulated learning and using meta-cognitive strategies starts with well-managed emotions, thoughts and behaviour. These skills also help students to navigate the multiple transitions from preschool to post-secondary education. Research shows that, even in preschool, better developed social and emotional skills are related to higher academic outcomes (including motivation, engagement and achievements), and lower levels of social, emotional and behavioural problems in children (Martinsone et al., 2021).

SEL programmes not only improve social and emotional skills, but also boost academic performance (Durlak et al., 2011). Evidence suggests that SEL skills may play a key role in remediating/understanding achievement gaps due to racial/ethnic and income differences (Gregory et al., 2016). From the first school years, a positive school climate should be facilitated through building and sustaining positive relationships and establishing physically and emotionally safe learning environments. Doing so fosters a sense of belonging, enhancing
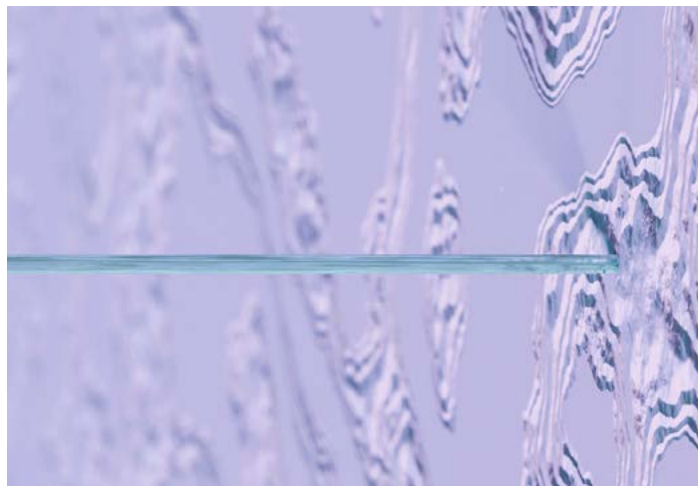
development of social and emotional skills and investing in well-being and quality of life. This also holds true for the early years as previously highlighted. School-based universal interventions (intended for every child in every school) are recognized as having a substantial impact, not only on behavioural and learning adjustment and mental health outcomes for every individual child but also on public health, since improving social and emotional skills reduces the possibility of emotional and behavioural problems developing in the future (Greenberg et al., 2017). Whole-school SEL practices establish inclusive education with less stigmatization of children who are facing social, emotional or behavioural challenges, because, at some point in their life, every child can be at risk, and social and emotional skills are necessary for everyone (Humphrey, 2013).
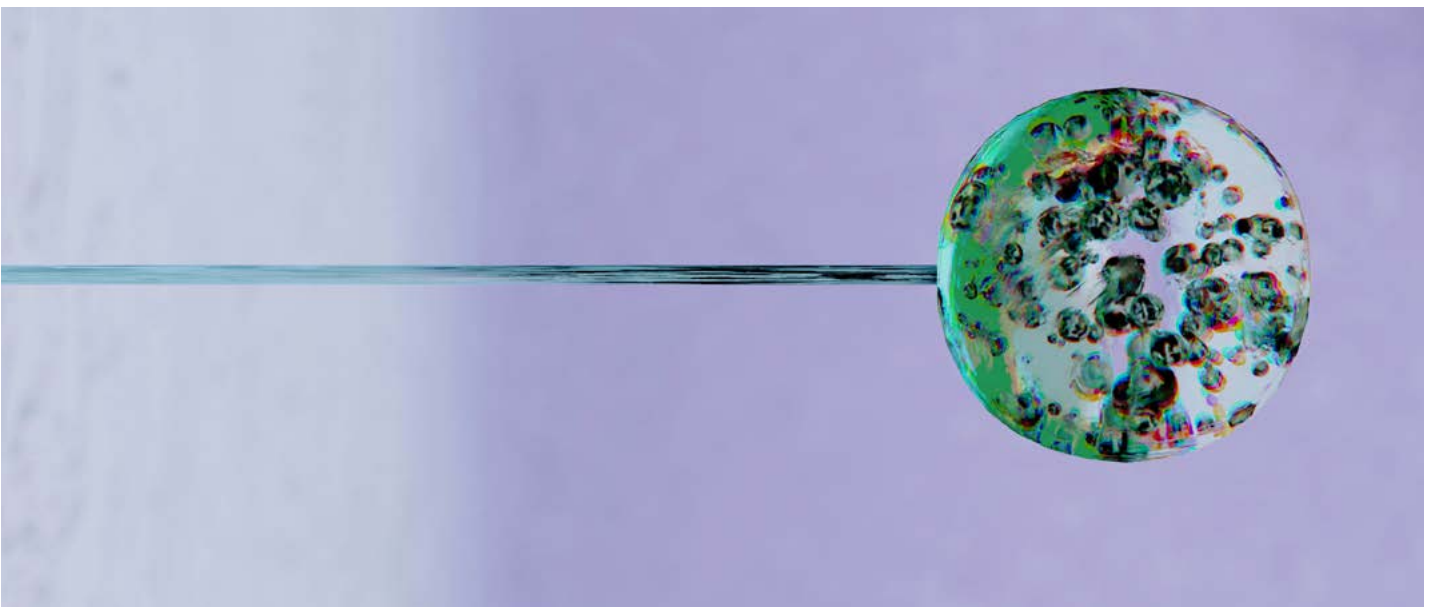
The universal SEL curricula, based on principles such as the whole-school approach, evidence-based content, developmentally appropriate multi-year activities for children, teacher training and ongoing support, and parental involvement, go beyond the classroom. They involve the whole school, building and sustaining the partnership with parents and educational policy makers, thus investing in the promotion of public mental health (Cavioni et al., 2020). These changes in the whole ecosystem increase its resilience and capacity to provide mutual support for all, thus alleviating the demands on public health services.

Intervening during young adulthood: An age of transition (15-34 years)

The age range for youth is not clearly defined, and different countries define it differently, making cumulation or aggregation of available data at the world level difficult. However, for statistical purposes, the United Nations defines youth as those aged between 15-25 years. There is thus an overlap in this paper between older school going youth and school aged children.

Young adulthood is a tumultuous period for many as it marks the beginning of a big transition into adulthood. During this period, young adults tend to move away from a more protected family and/or school system to step into a relatively unknown world of universities, workplaces and financial responsibilities. The WHO World Mental Health Surveys International College Student Project surveyed 13,984 students across eight countries, highlighting that one-third of students had an anxiety, mood or substance use disorder (Auerbach, 2018). This age group also experiences major life events and more mental disorders than any other age groups (Jurewicz, 2015; Kessler et al., 1994). They are often gripped by depression and loneliness (Richard et al., 2022) and the WHO (2022) reports suicide as the fourth major cause of death among young adults (15-29 years).

Research also highlights a strong alignment between the presence of adverse childhood experiences and depressive symptoms, anti-social behaviours and drug use when children transition to adulthood (Breslau et al.,

1991). Early trauma has a moderate association with genetic factors, brain and behaviour (Bogdan et al., 2016). Similarly, being bullied or being a bully in adolescence also leads to reduced mental health in adulthood compared to those who are not bullied or have been a bully (Siagurdson et al., 2015). The need for mental health solutions is of critical importance for young adults, yet this age group is not widely studied. Young adults often do not speak about their mental health and may be less likely to seek help than other age groups (Gonzales et al., 2005).

An analysis of how young adults with mental health problems discuss their health on social media highlights that they usually describe themselves as feeling powerless and lonely and find mental health services alienating and inaccessible (Marcus et al., 2012). There may be stigma attached to a young person going to a local clinic to access mental health services, which may be serviced by people from the community who may not always protect clients' identity (Radez et al., 2021). The inability to connect with others further emphasizes the need for social and emotional skills like empathy, compassion and developing a sense of self. These skills support successful high school and college graduation rates and provide the skills youth need to prepare themselves for the workforce (Yoder et al, 2020).Despite the many challenges for young adults in their approaches to mental health and in gaining access to appropriate mental health services, there is also an opportunity for impactful intervention in this age group given the malleability of young adults' brains (Lee at al., 2014). Indeed,

the hormones associated with adolescence mean that the brain (Laube et al., 2020) is more plastic than it will ever be again (Bethlehem et al., 2022). Adolescence is a developmental period characterized by a high level of anatomical and functional changes, in which cortices support and develop executive, socioemotional and mental functions critical for mental health (Sydnor et al., 2021). Young people also have significant potential to create a 'turning point' in their lives (Gore et al., 2007). While the impacts of adverse childhood experiences on mental health are difficult to reverse, effective preventive strategies and interventions deployed in late adulthood can still help in redirecting young adults' life course. Preventive strategies like creating a supportive learning environment help youth to identify their emotions, connect with others, build compassion, empathy and kindness, and can help youth to feel safe, supported and willing to seek professional help when they face mental health challenges.

A simple one-size-fits-all approach with 'typical patients' requiring standardized intervention cannot be adapted to mental illness, which is not a homogenous disease, but rather depends on the interweaving of individual risk and protective factors acting at different levels. More personalized and integrative approaches are needed for managing individual clinical profiles rather than broad diagnoses.

Education alone cannot assist with providing the necessary support to ensure mental health and well-being for young children. It requires a continuum of care framework that
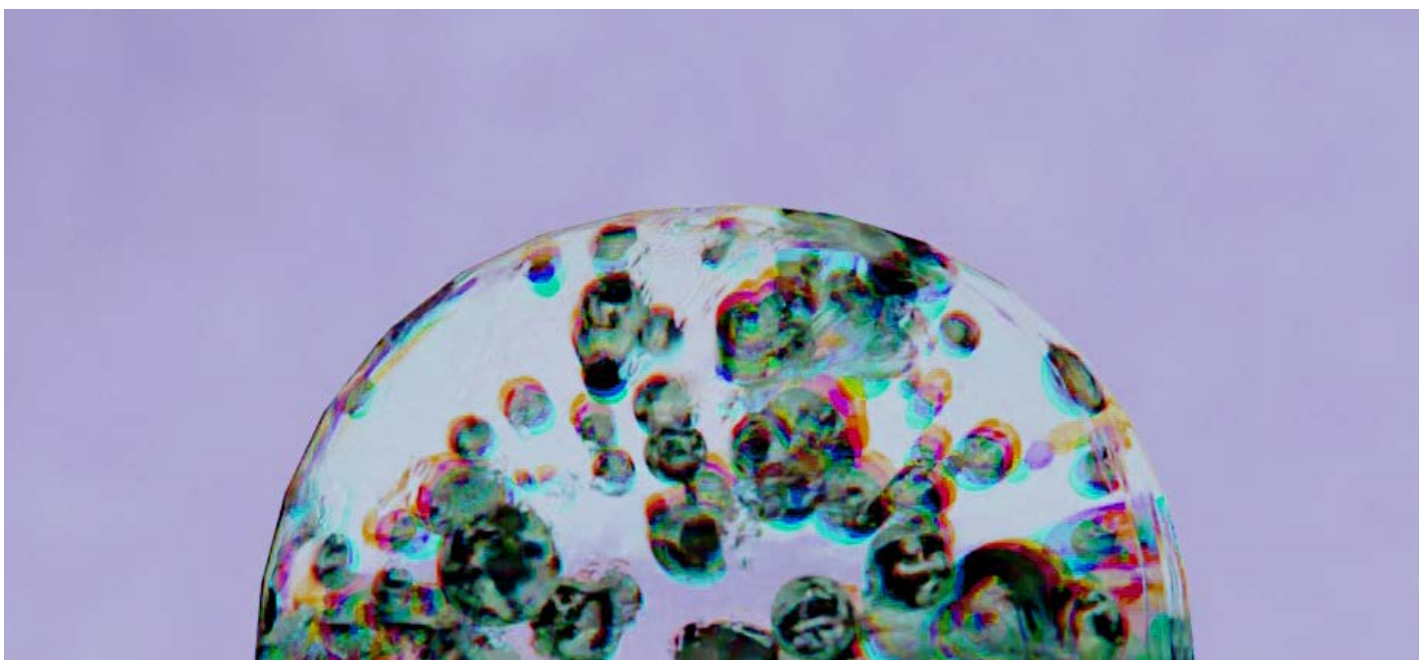
addresses the structural, environmental and behavioural competences that children need to become well-rounded adults. It also requires that adults have good mental health to be able to care for their children. Critical preventive measures include having good health, adequate nutrition, responsive caregiving, security and safety, and

opportunities for early learning that are embedded in policies. These measures are essential to promote child and youth development (WHO, United Nations Children's Fund, World Bank Group, 2018).

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In this issue of the Blue DOT on Social and Emotional Learning and Mental Health, Poonam Borah, Associate National Project Officer at UNESCO MGIEP sat down for a conversation over Zoom with **Dr. Eiko Fried, Associate Professor in Clinical Psychology** at Leiden University. They spoke about the complexity of mental health problems, the challenges of understanding mental health issues as well as the relationship between childhood adversity factors and resilience factors. Read the complete interview below.

Eiko Fried: Associate Professor in Clinical Psychology at Leiden University

Interviewer: Poonam Borah, Associate National Project Officer, UNESCO MGIEP

Poonam Borah: Dr. Fried, you talk a lot about embracing the complexity of mental health problems and learning from other fields, especially systems science. Could you tell us a little bit about systems science and how you think it can help us avoid oversimplification?

Eiko Fried: Over the last few decades there has been what some researchers call the 'systems revolution'. A lot of research has shown that progress in many disciplines comes from embracing the complexity of the systems we want to study. In simple systems, you can understand how a system behaves by understanding its components. A bicycle is a simple system, where a pedal moves a cogwheel that moves a chain, and so on. The system itself stops to work once a component breaks, but you can fully understand the bicycle by understanding its components, and restore the system to functioning by fixing all components. But for systems such as the internet, the stock market, the global climate or mental health, the progress we've made comes from studying these systems as systems. That means we need to study both the components of the system, but also the

relationships between components, due to phenomena such as emergence. Water, for example, is fluid, but you could never find or understand fluidity by studying the component of water, hydrogen and oxygen—fluidity only exists at the system level. The same goes to flocking of birds, which is a behavior of the sytem, not of any individual components. Studying systems as systems gives us the ability to understand and describe these systems better, to predict the future states of these systems better, and also to control these systems, that is, figure out better treatments.

When it comes to mental health problems, we haven't made a lot of progress in developing better treatments over the last 30 years, and the gold-standard treatments are still the same we used at the end of the 90s. Colleagues and I argue that this is in part due to oversimplification in clinical research, where narratives such as that mental disorders are brain disorders have dominated the landscape, and that by finding the particular dysfunction and treating it, the mental disorder will disappear. This is not consistent with what we have learned about mental disorders in the last decades, pointing to the fact that

we're dealing with complex systems in which biological, psychological, and environmental components interact with each other and give rise to mental health problems.

Poonam Borah: **What do you think are the biggest challenges in understanding mental health problems? You have alluded to a few already but especially in terms of measurement, replicability, scalability?**

Eiko Fried: **One concern is that we don't take measurement** as seriously as we should. Currently there are over 280 different scales to measure depression. So when I want to assess if you're depressed, I can perform a clinical interview or I administer a questionnaire, but in both cases, you will answer a number of questions about symptoms, your sleep, your suicidal ideation, your sadness, concentration problems, fatigue, and so forth. If you only look at the most commonly used 7 depression scales, they can differ from each other a lot in terms of what symptoms are measured, or what score you get assigned. That's a really big problem: suppose your doctor had 7 different instruments to measure your fever, and they would commonly give different results—that would reduce your trust in the measurement and diagnosis of fever.

We therefore need to take measurement challenges in mental health research more seriously and provide more funding. The National Institute of Health and

the Welcome Trust recently decided that they're going to mandate that all researchers who want to obtain funding for depression research have to use one of these 280 scales for depression, a short one, called PHQ-9. It has nine questions, and I understand that they want to combat the messy situation in research teams use different instruments. But the PHQ-9 is not a very good instrument, and it was not developed for measuring depression in young people, or to assess efficacy of treatments in clinical trials. So the shortcut of mandating one flawed measure is not the solution. We need to figure out what depression really is and then how to best measure it. But we have skipped the first step, the theoretical basis of the concept we want to measure.

Moving to the second point you asked about, replicability: in psychology we've had what is called 'a replicability crisis'. That means that very important findings that are in our textbooks actually don't hold up to scrutiny if you repeat the studies in bigger samples. The problem is rooted in a number of issues that, in the last decade, we've made a lot of progress in fixing. One crucial element here is increasing transparency. I had to correct one of my papers because I made a mistake in my data analysis. Luckily, I shared the analysis code that I used to conduct my statistical analyses openly with the research community, enabling others to check my analyses. And someone found a mistake in my code, which in turn allowed me to fix the mistake and publish a correction of

my paper. That would not have been possible if I hadn't shared my data or my code. Transparency will help with the replicability crisis, because it will help us find out why certain findings do not replicate.

The last point you mentioned was scalability. One aspect of scalability is carrying out clinical research, which is very expensive, and so it is difficult to collect large datasets. But small datasets just aren't very informative—quite similar to election polls. You would not trust a poll with 20 people trying to forecast who will be the next US president, and you should not trust a study with 20 participants where a new treatment for depression such as Ketamine is heralded as a new miracle cure. The current literature in new treatments such as Ketamine is full of studies with only a few dozen participants, and they have other problems such as financial conflicts of interests. One possible solution here is for funders to put large amounts of money into one or two big research consortia. These should consist of independent experts who do not have financial conflicts of interests, and carry out large-scale research projects on novel treatments.

Another problem regarding scalability is getting treatments to the people who need it. Even in countries such as Germany or the US or the Netherlands, the majority of people with mental health problems cannot access the treatments they need—and it's much worse in other places. One solution for this has been to offer online services, such as smartphone apps. The idea is not to replace clinicians, of course, but that evidence-based smartphone apps can be a lot better than nothing at all. At Leiden University where I work, we have a program where students can access online mental health services. In severe cases, it is of course recommended they seek psychotherapy with a professional psychotherapist, but in case there is a long wait list, or in cases that problems are not severe, online services have shown to be efficacious. In our own research team, we're currently trying to build an early warning system for depression, called WARN-D. We envision this app similar to a weather forecasting app, to try to predict mental health problems before they occur. If we can do this, it may help with the scalability crisis because you can start personalized prevention programs early on before problems grow into full-blown mental disorders. To do so, we're following 2,000 students over two years using smartphones and smart watches. We are then using these data, along with machine learning

and other techniques from systems sciences, to build a forecasting engine. If this works well, the next step then is building the app that will be made available for free.

Poonam Borah: Could you tell me a little bit more about your sample, the challenges you are predicting and the problem you're trying to solve?

Eiko Fried: Our project focuses on a student population for building an early warning system for depression. We do so because focusing on one population makes our job as researchers a little easier. Not every depression in students is the same, and in fact students differ a lot in their risk factors for depression, and problems they experience during depression. But students still have more similarities compared to, say, people in their 60s or 70s, where depression is often accompanied by severe physical health problems such as cancer. Students are also more tech-savvy and for our study, people need to install a few apps on their smartphones to participate. Finally, depression is often chronic, and focusing on preventing the first episode of depression in students might help prevent a lifetime of suffering for many. In our project, students wear a smartwatch for the first three months, and we ask them a couple of questions four times a day about how they're doing on their smartphone. We ask about depression symptoms, but also if they were bullied, how they feel, how well they slept, if they think they can cope with upcoming challenges, what their best and worst experiences have been, and so on—we zoom into people's daily lives. We understand each person as their own ecosystem, embedded in broader systems of family, school, and society, and we try to get an idea of what is going in these systems. Ultimately, we will use this information to forecast upcoming transitions into depression.

Poonam Borah: You write a lot about the need for mental health to be understood as more than neurobiology and the need to understand the relationship between childhood adversity factors and resilience factors. Can you elaborate on the relationship and how that can be helpful?

Eiko Fried: Let me clarify first that when I say 'mental health is more than neurobiology', I don't mean that

researchers should not study the brain, which is crucially involved in the development of mental health problems. But powerful organizations like the National Institute of Mental Health in the US have focused very heavily on the brain, and that came at the cost of better understanding psychological and social risk factors for mental health problems. I've pushed back against this in my work. I would also push back if somebody said mental disorders are environmental disorders; there is a broad host of risk factors, and oversimplification will not help the people that need our help.

Interestingly, many of the risk factors for mental health problems are transdiagnostic—that means that they predict different kinds of problems, such as mood disorders, anxiety disorders, and so on. One important risk factor for developing mental health problems is negative early childhood experiences, but of course also severe stressors later in life. Obviously, a severe stressor might lead to PTSD or major depression or an anxiety disorder depending on the nature of the stressor, and that is why it is so important to study these life stressors.

There are also factors that make you more resilient for a broad scale of mental health problems. Many of the resilience factors are also transdiagnostic. Some of these factors are within the person, such as your personality or outlook on life. Others are external, such as your access to money, health care, and so on. And of course these levels also interact with each other in complex ways: not being able to access health care may impact on the development of your outlook on life as an adolescent, for instance. So from that perspective, it is crucial to try to understand the biological, psychological, and social systems from which mental health problems emerge. Transdiagnostic risk and resilience factors play a crucial role here.

Poonam Borah: **When you say resilience factors, thinking about our audience who primarily come from an education ecosystem, could you talk a little bit more about preventive measures?**

Eiko Fried: **I had the privilege to work with Dr Jessica Fritz and Dr Anne-Laura van Harmelen** on the topic of risk and resilience, who have published work on adolescents and young adults. They identified many important resilience and risk factors, too many to list here.

But important ones included family support and peer support, as well as personality characteristics such as self-esteem, aggressiveness, and the tendency to ruminate.

Poonam Borah: **Finally, you've worked with older youth, 18 plus generally, and their exposure to trauma, stress, depression. How do you think this is more specific to the education ecosystem and how do you think it can better respond when it comes to supporting youth?**

Eiko Fried: **I've learned an important lesson working on a paper led by Dr Astrid Chevance.** We conducted a world-wide survey of over 3,000 people with depression, as well as their caregivers and doctors. We asked them what they think is important to measure in depression studies to assess if people get better during treatment, and found that many people mentioned that depression is characterized by mental pain. We found that none of the most commonly used depression scales actually assess mental pain. The lesson is that we really need to ask people with lived experienced about these experiences. Schools and universities don't need to speculate what should be done, but talk to affected students and staff. We need to get better starting these dialogues to find out what resources are required. We need more work groups and roundtables, and involve people with lived experiences of mental health problems in these discussions. That's the first thing I would do, and together with many fantastic students and colleagues, I'm trying to push these issues at my own University.

We also need to normalize conversations about mental health, which can help reduce stigma. The worst mental health problems are those that fester in darkness. If you have depression or an alcohol use disorder, you are as responsible for that as you are if you have asthma or leukemia: it is not your fault. Most scientists and clinicians know that, but I don't always get the feeling society has fully embraced this idea. And that means we need to have a lot more open conversations about mental health at schools. Not the kind of conversations that are re-traumatizing, but there are ways to talk about these issues in a way that people with problems may be empowered to seek help, and students generally can learn to be more mindful of mental health problems—for themselves and others.

The third thing we need to do is to be more inclusive. People who face mental health problems are, on average, more likely to be from parts of society that are disadvantaged or discriminated against—we have not done enough to make everybody feel welcome at schools and universities. For example, suicide rates are very high for transgender youth, because society puts immense pressure on those folks not be who they are. We need to be more inclusive, and schools and universities need to carry their weight here.

And then, lastly, we need programs that people can access so they can get the care they need. Mental health problems are not always easy to treat, but there are evidence-based treatments that can help a lot of people. So I really encourage folks to seek help if they think they need help. If you think you need help, you deserve help—it's as easy as that. Schools and universities need to do a much better job in informing students about resources, and encourage students to make use of these resources.

Poonam Borah: Is there anything else you would like to share?

Eiko Fried: Making a dent into the global burden of mental disorders requires teamwork. This team must be a team including not only clinicians and researchers: to be successful, it must include, among others, teachers, nurses, social workers, and people with lived experiences of mental health problems.

Poonam Borah: Thank you very much for your time Prof. It has been a pleasure speaking with you.

Eiko Fried: Thank you, Poonam.

"The Universe is revolving around me in a bad way."

GOLIATH: PLAYING WITH REALITY explores the limits of reality in this true story of so-called 'schizophrenia' and the power of gaming communities.

Echo (narrated by Tilda Swinton) guides you through the many realities of Goliath, a man who spent years isolated in psychiatric institutions but finds connection in multiplayer games. Combining heart-felt dialogue, mesmerising visuals and symbolic interactions, weave through multiple worlds to uncover Goliath's poignant story.

GOLIATH

Created by Anagram – Award Winning Creative Studio:
https://weareanagram.co.uk/
Barry Gene Murphy, May Abdalla
United Kingdom, France
2021 | Nominated for the Emmy Award
Winner of the Grand Jury Prize for Best VR Immersive Work at the 78th Venice International Film Festival (2021)

Akriti Mehra spoke to **May Abdalla,** co-founder of Anagram recently about the VR experience, why and how it was created and some of the challenges faced by the creators as well as how VR can help build empathy and compassion in the minds of the users. Read below to know more.

Interviewee: May Abdalla, co-founder of Anagram.

Interviewer: Ms Akriti Mehra, Communications Specialist, UNESCO MGIEP

1. *Tell us about Goliath and what inspired you to create Goliath?*

Goliath is a 25-minute virtual reality, immersive story. It is a true story about a man called Jon whose online name is Goliath. Jon was diagnosed with paranoid schizophrenia and spent many years in a psychiatric hospital. When he left the psychiatric hospital, he faced the stigma and isolation of being somebody with a diagnosis of schizophrenia until he found online gaming. Under the pseudo name of Goliath, he found connection in multiplayer games and became part of this vibrant and fantastical community.

I run Anagram, an immersive studio and we tell stories that are interactive and use technology. We had already made a couple of projects in virtual reality, and it felt like a really perfect medium to tell a story of what it feels like a virtual reality – to be convinced emotionally of something that is widely considered not to be real.

We made Goliath because we really wanted to try and find a way to give a perspective that is hard to show – of what is like to be inside of a mind of somebody who has been diagnosed with schizophrenia.

2. *How easy or difficult was the experience of creating Goliath?*

When you are trying to tell a story using VR, it is still quite a nascent medium in comparison to film making, which has been around for a 100 years and there's lots of perfectly suited tools and everybody knows what to do and the perfect processes. With VR, you are still really experimenting with the basics. For example, how do you come together as a multi-skilled team of designers, coders, and musicians to be able to even draw a storyboard that is clear enough for people to get?

We did everything we could in all different ways we could. We built prototypes. We chatted to lots of different people about their experiences of psychosis. We did workshops using Tilt Brush to allow people to draw sketches.

There are lots of challenges that you face when doing something that is a bit innovative. Especially with VR, which is about experience and how something feels, and you cannot assume if something looks a certain way, it will feel a certain way and so you have to build it really.

We started out three years ago. We had a residency for two weeks at the Venice Biennale. Every day we workshopped the ideas. We wrote. We re-wrote and had long calls with psychologists / psychiatrists, and other people who had experienced similar things. We spoke to Jon and then eventually got a little bit of a grant to make a prototype.

==We tried lots of different things out, however, there were just a lot of ideas that never saw the light of day. Scenes where things had moved behind you but always out of peripheral vision – what does it feel like when that happens in VR - does that give you the impression of paranoia – is interesting.==

And then we just kept going back to Jon doing interviews gradually. We were always quite cautious of him and his needs as we did not want to take him back into some of the really difficult experiences that he had encountered. Every time we did an interview with him there would be something in it that might spark an idea or chapter or scene.

3. *What are you hoping the player / user will do after experiencing the Goliath?*

I think the more that we spoke to people about what their experience of isolation, stigma was,

the more we wanted this experience to carefully help people reconsider their own relationship with reality. We also wanted to give people an essence of what it is like to be associated with this stigma, because more often than not, those associated with a mental health issue such as schizophrenia are represented on an extreme end of the spectrum. For example, people with schizophrenia are often portrayed in horror movies and made to be monsters and our worst nightmares.

The reality is that there is something extremely human and relatable in that inside experience many people know. For lots of people it helps them link to their own difficult experiences that they haven't shared or thought about with a family member or friend who they have become distanced from.

Many societies make it difficult for people to feel like they can reach out and connect and so it was very important that the story was about the importance of connection and how this might be a mysterious condition, but connection, friendship and compassion really still matter, and everybody has the capacity to offer that.

4. *How has the response been to Goliath so far?*

The reception has been pretty incredible, and I think we had a lot of hopes as we were trying to do something that would be useful but we were also aware that VR is quite an experimental medium. This wasn't just a game and the fact that it launched on a platform where many people played games – this is really an abstract and conceptual world.

Initially, we were worried that the audience wouldn't connect with the VR experience, but the opposite happened. It was very well received. It was nominated for an Emmy and won the Grand Jury prize in its category at Venice. However, what was even more touching for us was the comments that people shared across different platforms and

social media – from Reddit to Discord to Twitter to reviews of just how much they connect to the story and why playing games for them is really about protecting their mental health.

It's a community that has been really important and it really does challenge the perception of gaming as something that isn't good for people's mental health – but its also an important way that many people access community – many people who are isolated due to prejudice and stigma can find normalcy in these digital and virtual worlds.

5. *How can games or technology be used as a means to raise awareness about critical issues such as mental health?*

The really important thing is just to acknowledge how important a cultural medium games is right now and how much of the world's population, teenagers, for example are using this medium as a means to process what it means to be alive. The stories there matter to them and to their friends and finding ways to talk about things beyond Hollywood on these platforms is really important. Technology is also something that people are interacting with all the time. Figuring out ways in which those experiences can be nurturing and valuable and can bring learning without necessarily feeling like schooling is something I'm really excited about. There is a really big opportunity for creative storytelling in these mediums that break a lot of conventions that we are used to. It is not linear; it is not passive – it could be worlds that you explore – the way that the new generation is making sense of the world by using these tools is really exciting and offers explosive opportunities for imagination to take hold.
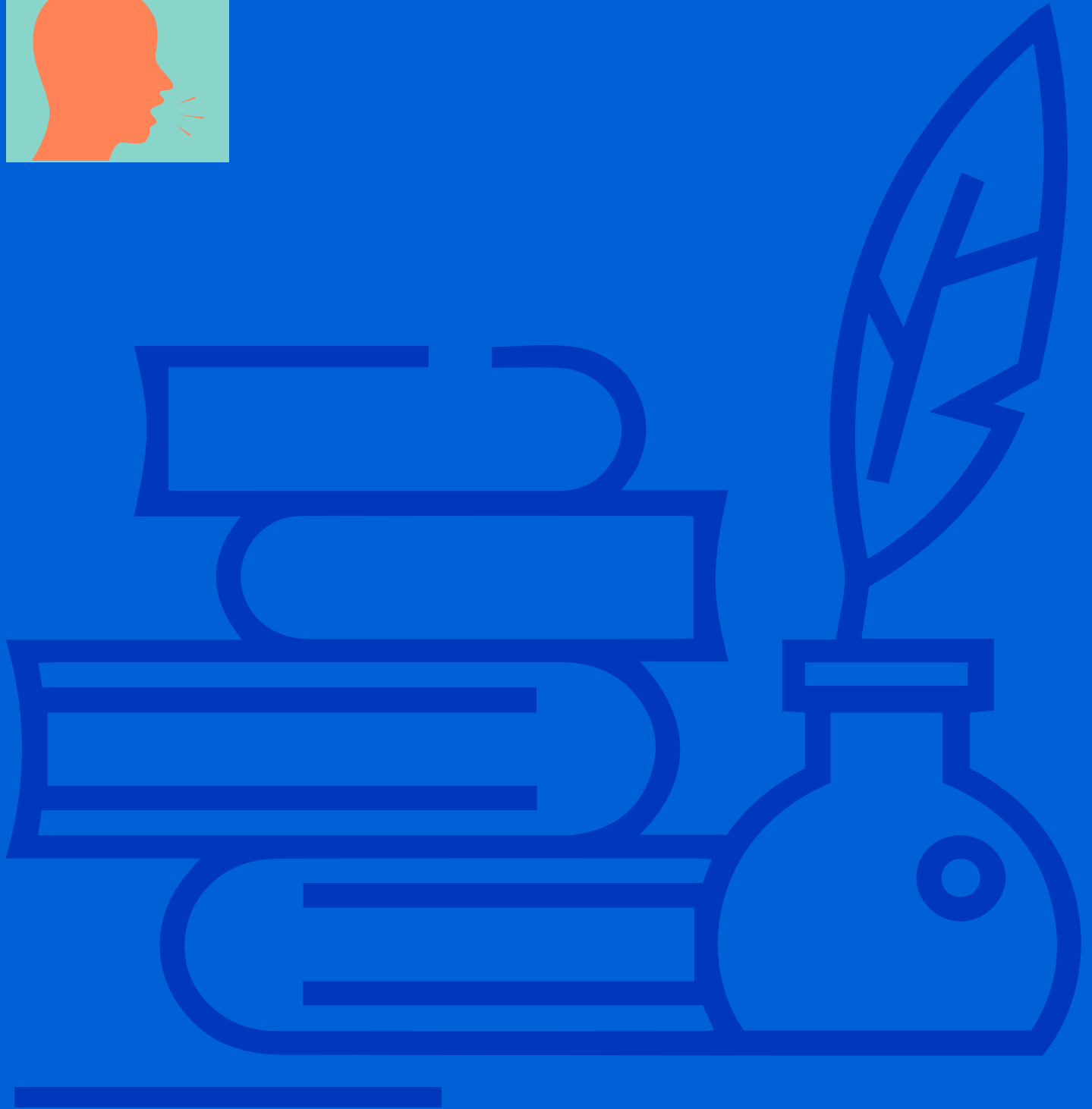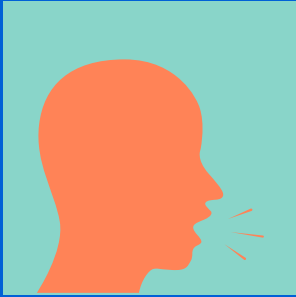
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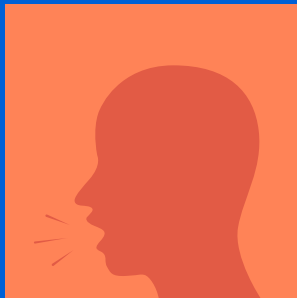
- GAURAVI BHARUKA
- DISHA MUKHERJEE
- CIERRA GARROW
- MONTANA PAYPOMPEE
- DEVON WALPOLE
- HARMONY ESHKAW KOGAN
- MELODY RECOLLET
- PUNYA RAJPUT
- VINEET KAUR

Child mental health *and* *inclusion of* *SEL in schools*

BY **GAURAVI BHARUKA,** STUDENT, LSR, NEW DELHI, INDIA

Mental health of children is a highly neglected topic of research and application in almost all countries. The psychology of children has been studied, children have been studied as subjects of psychology, but what does that give us? We derive parenting styles and education techniques out of it, and study their impact on the child again. But that's what we do with experimental animals, don't we? We study their genetics and behavior, experiment on them, and see how it impacts them. It must be understood that despite having studied so much about children and having formed theories and practices based on those, children will still go through some situations that affect them in several ways. Along with talking and writing about parenting and education, which is outside a child's control, we also need to look at what children should be doing when they go through certain situations, cognitions and emotions. The child needs to talk about it! We never studied what children think about the world, what they feel about parents, teachers, and their school.

As a generalization, we, as a community, look at children from our perspective and treat them as subjects of our judgment and study. It is not surprising that very little work has been done in this area of mental health of children in the world, more so in India. Varied expressions of the same may be "Child is the discovery of the century," "Biggest discovery of the century is our knowledge of extent of our ignorance," and "I knew various theories of child mental development, now I know many children with the distinct problem of their own. (Indian Journal of Psychiatry, 2008)"

I believe it is more important to talk about the mental health of children than to merely understand their behavior patterns. It often happens in common households that when a child expresses what they feel, it is taken as a tantrum or something that would pass away.

Often these complaints are also considered to be signs of hunger and sleepiness. But have we taught our kids how to honestly answer the question 'how are you'? Or have we just taught them that the reply to how you are is 'I am doing well, what about you?'? Have we, as the "intelligentsia" of academia, tried to understand how children feel while playing with their friends? Do we have at least half of the institutional set up for child therapy that we have for adults? For children, you find speech therapy, occupational therapy, etc. Note that these therapies are not 'mental health' therapies. These are "corrective" therapies for children with certain disorders. This does not mean children without a disability do not have mental health issues! The therapists that adults without mental disorders consult, to resolve their mental health problems, should also be available for children, as they have an equal right to health, both physical and mental.

An article based on a survey published by the Cambridge University Press titled "Priorities and preferences for school-based mental health services in India: a multi-

stakeholder study with adolescents, parents, school staff, and mental health providers" suggests that adolescents prioritized resolution of life problems and exhibited a preference for practical guidance. Parents and teachers emphasized functional outcomes and preferred to be involved in interventions.

A good start for bringing child mental health into light would be to first educate the child about mental health itself. It is important for a child to first acknowledge and know her emotions, cognitions and behavior, to recognize any existing or developing mental health concerns. They also need to know how to deal with certain situations of life, as well as their own emotions, in a healthy manner. This is possible through the incorporation of Social and Emotional Learning (SEL) in schools. Some schools around the world have implemented this technique and found positive results. Building Academic Success on Social and Emotional Learning edited by Zins et al. (2004) presents considerable evidence that SEL can not only improve students' social development and mental health, but could strengthen their academic achievement. Schools in Portugal have also received great outcomes from the implementation of SEL in the educational curriculum.

P.C. Shastri (President, Indian Psychiatric Society and SAARC Psychiatric Federation and an Honorable Psychiatrist in Mumbai) writes, "a school mental health programs should get maximum attention and help, as the large majority of children can be reached this way. Thirty percent of the school-going population is in need of mental health care. It is vital that the service model and mental health service delivery system should get top priority to school mental health."

Emotions can facilitate or impede children's academic engagement, commitment, and ultimate school success since relationships and emotional processes affect how and what we learn. Thus, schools and families must effectively address these aspects of the educational process for the benefit of all students (Elias et al., 1997). I hope we start talking about it. Once we start talking about it, a community would be formed. Once a community is formed, scholars would research it. Once we have a library of resources, policies and institutions would come up, children would start claiming their right to mental health, and the perspective of children would come into light.

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SEL-THE NEED OF THE HOUR
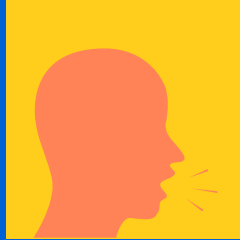
BY **DISHA MUKHERJEE,** STUDENT, NEW DELHI, INDIA

With the growing stresses of the modern world and the brand-new challenges it brings with it, the need to become emotionally capable to handle them becomes all the more important day by day. Especially with the importance of mental health, emotional resilience and psychological well-being coming into the forefront due to the Covid-19 pandemic. The negative impact on childhood development due to social isolation and various other circumstances brought about by the pandemic like parental distress, marital discord, online education, lack of interaction with peers etc. can be seen today in the form of social, emotional and cognitive deficiencies. This leaves all children vulnerable to mental distress and ill-health especially those from disadvantaged and underprivileged backgrounds.

However, most educational curriculums fail to equip children with the essential emotional resilience and management skills needed by them to deal with these issues. Thus, the scope of traditional education must be expanded beyond purely academic to include the development of social-emotional capacities. Such an approach supports the holistic development of children, helping them become well-rounded and adjusted adults who are not only able to successfully deal with the stresses of life but also foster personal growth and supportive relationships.

Social-emotional learning curriculums or programs are the solution to this problem. SEL has been found to be positively associated with improved well-being, academic performance, cognitive development, empathy, prosocial behaviour and attitudes etc. Research also supports that students who underwent SEL training show marked decreases in negative outcomes like emotional distress, conduct issues, substance abuse and emotional dysregulation. While SEL can benefit all age groups, the development of social-emotional skills has been found to be much faster in children as compared to any other age group. Therefore, the most effective way to ensure that the future of the human race is emotionally and socially robust is to introduce it within the education system. We must foster and inculcate it from childhood itself.

My primary introduction to SEL was through a college society in the middle of the Covid-19 pandemic as a part of an
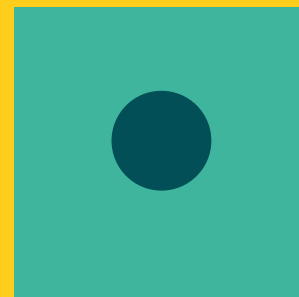
orientation programme in a college society I was working in. I had joined it to participate in a mental health-oriented project but the very word "social emotional learning" was a foreign concept that I had maybe heard being thrown about in the fringes of some conversations about mental health. The more I found out about it, the need and urgency of its requirement became more evident to me.

We developed SEL curriculums for children and early adolescents which we implemented in the form of programmes and workshops. My experience was eye-opening and extremely rewarding, to say the least. In the beginning of the programme, the students who had enrolled in the programme shared stresses, anxieties and pressures faced by them due to the pandemic, their academics and interpersonal relationships. The need for the skills to cope with these situations was highlighted, especially in their absence. As the programme went on, its effects were overtly visible and I could actually see the impact materialise in front of my eyes. The children reported being happier, with improved general emotional awareness and expression, better relationships

with their families and peers, enhanced ability to empathise with others and felt more equipped to make decisions for themselves. They often could not wait for their weekly SEL classes! This helped me open my eyes to the dire need that exists for SEL.

One of the biggest challenges we faced during our campaign was the lack of awareness about SEL. Since it is such a novel concept that is not yet mainstreamed, parents were often unaware of it and were therefore reluctant to get their students admitted to the programme. But those who were willing to give it a chance, did in fact witness the positive impact it had on their children. Thus, SEL needs to be publicised and conversations around it must be made mainstream to generate awareness. The potential of everyone benefitting from SEL is enormous and therefore it is the need of the hour.
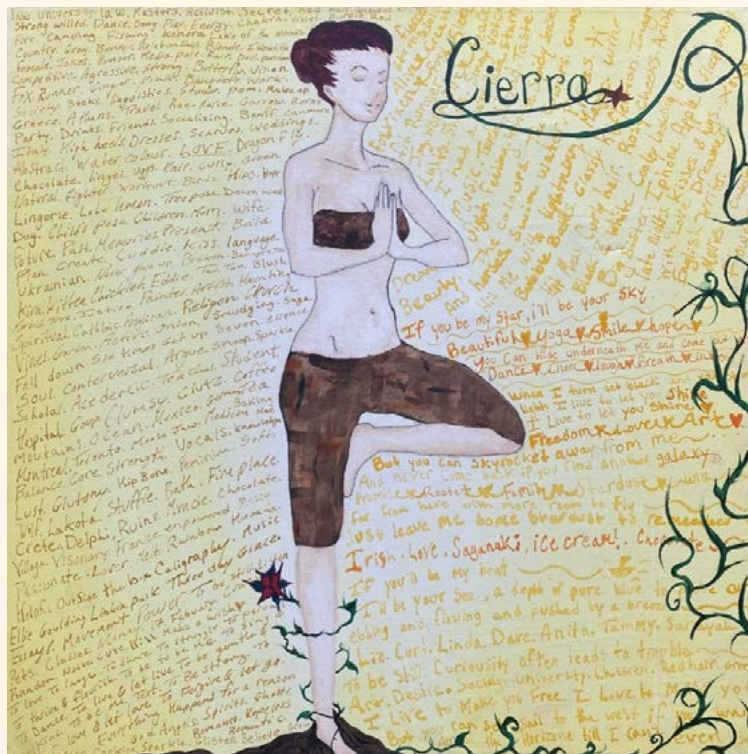
Do you know *who you are?*
Do you know *why you're here?*
Do you know *how you got here?*
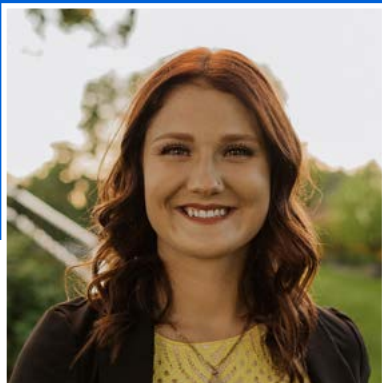
BY **CIERRA GARROW,** ONTARIO, CANADA

Cierra Garrow (She/Her) is a Registered Psychotherapist with lived experience of mental illness previously practised, playing, and living in Northwestern Ontario. She has recently moved to Grey County, where she supports people of all identities and backgrounds through Grey Bruce Health Services as part of their Crisis Intervention Team. Cierra brings many lenses and perspectives to her work through experiencing the mental health system as a youth firsthand, being a direct service provider to youth, families, and couples, and teaching social service work/mental health and addictions to post-secondary students. She has been a part of many different youth mental health advocacy groups and advisories, such as the Youth Wellness Hubs Ontario (YWHO) as a part of their Provincial Youth Advisory Committee (PYAC) and Local Youth Advisory Committee (YAC) for the Kenora Youth Wellness Hub. Cierra now co-facilitates the PYAC and continues to support youth through mentorship.

There are few things worse than being unable to feel... Feeling like you're completely and utterly alone is one of them. Isolated in your crumbling pain, a chaos of fuzzy emotions and unfathomable hurt.

A fist clenched around your gut, twisting and turning. A paralyzing fear that cripples you into a heaping mess of too lates and overambitious dreams. I was supposed to be successful.

Watching the lives of others flash by on a screen as the encoded messages tell me what I'm missing. The pictures of smiles and laughter, friends and drinks, husbands and children fill my newsfeed.

But where am I? I sit here looking at an empty reflection. Trapped behinds a flood of tears and hopeless attempts to be more than nothing. A desperate plea to amount to some worth that exceeds the dirt on the floor.

How did I get here? The worlds spinning a screaming mess of anxiety and pressure. The lids about to explode. And yet, there is stillness. A frozen impairment of functionality and loss of grip with reality. A dissociation of identity that splits me apart from the shreds of humanity I desperately attempt to hold.

Why am I here? What purpose does my existence have on the people around me. My fading in and out of lives while I dance around the relationships I could have had. Did I put myself here? How did I get here

A broken repercussion of high expectations and too many sleepless nights of unachievable perfection. The body I have been given feels sick and weak, everything radiates pain. The muscles feel as if they are untethering from the bone, yet they cling to the fabrics of my being.

It hurts. It hurts to be alive. It hurts to be alone. It hurts to be with people. It hurts to feel. This invisible barrier that separates me from connectedness. Like an animal in a zoo, staring at the happy families, giggling children and infatuated lovers. Segregated away from society... Perhaps it is better this way.

A blessing in disguise meant to save me from myself. At least here maybe I serve a purpose. An example of what sickness looks like. A girl whose dreams amounted to no more than the empty hands she owns. What purpose is there to exist? What use is there to feel this much pain. To barely feel as if I'm living. A zombie who catatonically goes through the motions of existence. Wake up, eat, sleep, repeat. Repeat. Repeat. Repeat.

How many times does the broken record play, always skipping between a D flat and a C sharp. I feel too much, but I feel nothing at all.

So I sit here, alone. I have people around me, people who care but their worry and concerns flutter off my skin. The pit of my stomach churn and tears swell in my eyes. Why does it hurt. My acne laden face filled with poison, a pity to look at really. Disgusting, a revolting circus act that is gawked at for the entertainment of the wicked. It hurts.

It hurts to be mentally ill. It hurts to be alive.

CIERRA GARROW

RESISTANCE

BY **MONTANA PAYPOMPEE,** ONTARIO, CANADA

Anishinaabe writer from Shoal Lake #40 FN, located on Treaty 3 territory

In this poem, I try to capture the growth in my perspective. For many years, I internalized negative stereotypes, which impacted how I saw myself and made goals feel unattainable. Through my healing journey, I have learned to remind myself that stereotypes do not define me, and they cannot tell a story I am still writing. As I decolonize my mind, I use poetry to process and reflect on what I learn, and it has become a positive outlet for which I am very grateful.

I will always be "Just a drunken Indian."

Do not try to tell me that,

I will be successful in life.

There is no doubt

My future is already written, because

I have internalized the oppression. I will never think

I am more than just my trauma. And even though

My race defines my future; I know

It is not reasonable to believe

It is possible to reclaim what was taken. I acknowledge

that,

I deserve the depths of oppression.

The stereotypes overpower my strength and

It is a waste of time to think

Things will change.

NOW, READ BOTTOM TO TOP, LINE BY LINE

MONTANA PAYPOMPEE

Personal Account - Then and Now

BY **DEVON WALPOLE,** ONTARIO, CANADA

Devon Walpole (she/they) is of settler and Mohawk descent from Fort Erie, Ontario. Devon is a long-time advisor with the Provincial Indigenous Youth and Family Advisory Circle (PIYFAC) at the Centre for Addictions and Mental Health.

I grew up in a household where my emotions were always invalidated. I was always getting into something and making a mess to occupy my boredom, which led to me getting in trouble often.

Growing up, everyone knew I had ADHD, but no one ever formally addressed it. Everyone just labeled me as an overactive and emotional child. I fell through the cracks, and I fell through the cracks hard. I wasn't supposed to graduate grade 8 with my classmates whom I grew up with all through elementary school. My grade 8 teacher, who was reluctant to let me move onto high school because I wasn't prepared, let me continue on because she knew that holding me back would be more detrimental to me than letting me move forward, as I was a social butterfly and had made deep connections with all my classmates. In high school, I struggled severely and barely graduated. My one teacher and principal teamed up and agreed that doing booklets of work would be the way I would graduate high school. I did booklets that piqued my interest. I graduated and moved onto college, and when I say I moved onto college, although enrolled in school, I rarely, if ever, attended my classes. I was too busy partying. With the partying came drugs, alcohol and sex. After my year away at college partying, I ended up back at my parent's house where I would smoke relentless amounts of marijuana daily. I ended up in a drug-induced psychosis, and I spent two weeks confined to the walls of a psychiatric unit. I had a couple more stays in the psychiatric unit in the following years. I was diagnosed with Borderline Personality Disorder, ADHD, anxiety, and depression. One day, I somehow ended up at my local Friendship Centre, where I was greeted with a warm and welcoming energy. I had never been connected to my Mohawk ancestry before, so walking in those front doors and being warmly greeted started filling in the missing pieces of my identity. I joined various groups within my Friendship Center, including the women's group, anger management, and a "wellbriety" group. Joining these groups helped me get a better understanding of myself from an Indigenous

lens, which was what I needed. I was able to see into myself on a deeper level than I knew possible. I got a better grasp of how to manage myself, my emotions and feelings. I've been very lucky and grateful as I've been able to take part in various healing ceremonies and activities, such as the sweatlodge, drumming with the women's hand drum group, beading, moccasin making, and other cultural activities. Looking back, my local Friendship Centre gave me the guidance I needed for my healing journey and to get a better understanding of myself and my traditional ways.

The System Needs to Change
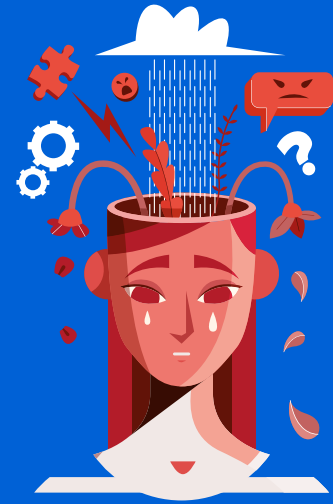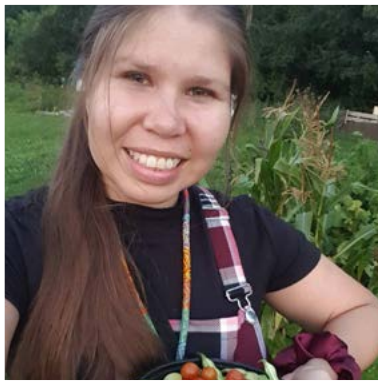
BY **HARMONY ESHKAW KOGAN,** ONTARIO, CANADA

Harmony Eshkaw kogan ndishnikaaz, Wiikwemikong ndoonjiba, Ottawa ndonji. Ginoozhe ndoodem, Niishdana ashi nishaaswi ndisbiboonwe, Anishinaabe Midewiwin-kwe ndaww.

Hello, My name is Harmony Eshkawkogan, I am from Wiikwemikong, an unceded reserve, and live in Ottawa. My clan is Pike and I am 28 winters old. I am a part of the Three Fires Tribe (Ojibwe, Odawa, and Potowatomi) and use she/her pronouns.

I am fortunate to have this connection to my community because I grew up on the reserve with my family. I was always around a lot of language keepers that remind me how our culture is embedded in the language. **There needs to be more opportunities for Indigenous youth to feel comfortable taking up space to speak their language and share their culture because we already lost so much from colonization.**

There is intergenerational trauma in my family, but there is also intergenerational resilience. My grandparents survived the Spanish residential school, which led to a cycle of violence and addictions. My family suffers from addictions, imprisonment, suicides, and homelessness.

I moved to the city for high school with my mother and brothers, and experienced culture shock because I struggled to adapt to this land. I had to move out at 17, and struggled with being homeless because my family drank and fought often. There needs to be more support in navigating the mental health services for youth transitioning into adulthood because I lost track of how many times I had to restart the process to get my intake assessment. I learned to be patient with myself while being on the waiting list, but I would use alcohol and self-harm to cope with stress. I learned that it is alright if you only show up as far as the front door of a group meeting as long as you keep showing up. It is important to practice asking for help because building community support takes time.

Today, I am sober and have lived in my apartment for almost five years with my partner and four cats. I still struggle with culture shock, but I became more familiar with the land by taking walks along the river. It reminded me of my home community on Manitoulin Island. I found spending time with the land and listening to the teachings of the trees, rivers, and animals can be healing.

I prefer asking for help in a more non-formal approach, like reaching out to cousins, aunties or uncles. Other times, we need to reach out for support from someone with specific training, but sometimes, just talking about it can take some of the weight off. I need a more wholistic approach, like ceremony and smudging, for my well-being too. I know that our traditional medicine is important and we need to stand up for our own ways of healing.

Creating a Beautiful Life

BY **MELODY RECOLLET,** ONTARIO, CANADA

I am a member of the Provincial Indigenous Youth Advisory Council. I am from Wiikwemkoong First Nation located on Manitoulin Island.

From my own life experiences of overcoming many obstacles and challenges, I became resilient by staying focused on creating a beautiful life for myself, and knowing that it is never too late to carve out space in my life for what feels right. Knowing yourself is a journey in itself, and it is important to work on a relationship with myself built on honesty and love.

Since becoming a mother, my strength and motivation comes from my son. I strive to always exemplify our Seven Grandfather Teachings to him - Humility, Respect, Truth, Wisdom, Love, Bravery, and Honesty. My late grandmother, Angeline Fox, was a residential school survivor, and in honour of her and as part of healing is to keep my Ojibwe language alive. To speak my language is something I cherish and embrace. I hope one day in full circle that my son and his generation will always speak our Ojibwe language also.

The Journey Within

"For once, on the face of the Earth, let's not speak in any one language, let's stop for one second, and not move our arms so much."
— Pablo Neruda

BY **PUNYA RAJPUT,** VOLUNTEER, UNESCO MGIEP

No matter who I talk to, they say that the older times were better. However, looking back at my mental health situation a few years ago, I feel immense comfort in the present. Flashes of the board examination corridors, the fear that gripped me when I was alone, the palpitations, the uncertainty, I feel grateful to have come a long way. The anxiety seemed to have come out of nowhere but that was untrue. The bottling up of unsaid fears, academic pressure, unnecessary self-criticism and comparison, all culminated into panic attacks, sleepless nights, palpitations and self-doubt. The pursuit of perfection- whether academic or individual- is dangerous. It makes you chase that idealistic image of what "should be," while ignoring "what is." This stemmed from the competitive nature in every sphere of life-starting from the classroom. I always found a lack of space for mental health related discussions and teaching in my curriculum. Back then I gave into the specificities of the academic system however I now realise the necessity of Social and Emotional Learning for any individual to flourish.

This particular episode in life made me reflect upon my schedule which had no "me time." I did not acknowledge the signs of my degrading mental health and kept hustling. It was high time to create space for a life beyond marks and job placements. I realised that I must take time off without pushing myself into a state where I am unable to function. I also noticed how I took a lot of people in my life for granted, the ones whose presence and support made all the difference. It was not that I did not love them, I just did not do enough to acknowledge that "mental health," was not just about my experience. They too might have needed such support that I was unable to provide. It is disheartening to see how many people do not reach out for help because they are afraid of the stigma or even the fact that their problems aren't big enough. I am glad that I am part of a generation that is making efforts to talk about mental health, empathy and kindness.

The coronavirus crisis further strengthened my conviction- to change for the better. I had to heal myself and be compassionate towards anyone else who was struggling. Being trapped in my home was the pause I needed; it was also an unwanted door into the past. My anxiety resurfaced when my parents and I contracted the virus during the second wave. I realised the strength of compassion when I saw how people helped each other during the crisis. It also allowed me to cut some slack to people when they did not behave in expected ways. I was able to look beyond staunch ideas of right and wrong and recognised the need for kindness. I overcame a large part of my anxiety through a combination of counselling, meditation (and a lot of practice.) I was also fortunate to have come across a course in self-directed empathy and kindness, which further widened my perspective. Steady steps have to be taken for creating safer spaces for mental health discussions. It is not enough to talk about mental health, we must stop comparing or trivialising people's trauma, compassion and kindness are key to help not just others but oneself, we must take breaks and reach out when we need help. We must also remember to listen and be there whenever someone reaches out to us. Collaborative and compassionate efforts are the need of the hour. A mental health issue may be the most individual experience but it is not singular.

Self Reflection - Mental Health

BY **VINEET KAUR,** STUDENTS, LSR, NEW DELHI, INDIA

I am submitting a self reflective piece on the theme of mental health.

"I left my home and I grieved for it, lying down on a staircase, just as far from home as I could get before breaking down. I heard them there and wished they could hear me. Hear the child inside a red haired woman, silently yet so loudly, screaming.

(A very beautiful red haired woman descended from above and disturbed me in the middle of this, and verbally hoped it'll get better before I sent her away.)

You assume people will hurt you, leave you, choose someone else over you, because you know deep down, of your unworthiness, despite what they all say. It takes one person(it's been the same person thrice now), one sentence said in the wrong way to undo all the work you've done on your self-confidence and fall down and be all messy and teary again, reaching out for whatever little kindness anyone can offer.

There's so many men here, what's with men occupying every public space so blatantly and shamelessly? Looking at a mad woman breaking down, as if it's a spectacle they're entitled to enjoy while simultaneously being scared to get too close of, deriving a twisted thrill out of the hysteria they've created for her??

I feel like my words have lost meaning, there's so much I want to say, but everything seems like an imposition, as if I am disturbing someone's peace, by merely saying what I feel.

//The desperation to be seen, to be heard//

Someone asked me out for a very wholesome event, and i couldn't go because I didn't want to experience abundance just yet. There's so much comfort in accepting you are alone, (and revelling in that painful loneliness) even when you're not. *Also, because my legs(heart) hurts.

A cat looks at me now, as I miss my friend, sitting alone on this bench."