Mental health promotion in Schools

State of the art

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Schools for Health in Europe

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Background and Context

Positive mental health is vital for an overall sense of wellbeing and enjoyment of everyday life. Whilst most children are faring well, globally 10–20% of children and young people meet the criteria for a mental health condition, and this is increasing (Belfer, 2008; Deighten, Lereya, Casey, et al. 2019; Kessler, Berglund, Demler, et al., 2005; Kieling, Baker-Henningham, Belfer, et al, 2011). Many more children and young people experience varying levels of psychological distress and only a minority report contact with mental health professionals. For instance, in the UK, just one in four children with a diagnosable mental health problem gets access to the treatment and care that they need (National Children's Bureau; 2017). Around 50% of all mental health difficulties have their first onset by age 15 (Kessler et al, 2005; Kim-Cohen, Caspi, Moffitt et al, 2003). Mental health difficulties are associated with negative outcomes across the life span, including lower educational attainment and physical health problems.

Childhood adversity is a key determinant of mental health difficulties. Amongst the most prevalent and damaging of these adversities are childhood abuse, sexual and domestic violence, neglect, war and other life-threatening events, bullying, harassment and discrimination, poverty, and living in a country with high income inequalities (Boyle, 2020; Felitti & Anda, 1998; Rogers & Pilgrim, 2010; Wilkinson & Pickett, 2018; World Health Organization, 2013).

Covid-19 presents another challenge for children and young people. The pandemic has dramatically altered the everyday lives of children, with many experiencing isolation, worry, loneliness, and uncertainty about the future (O'Toole & Simovska, in press, a). Covid-19 mitigation efforts have not been felt equally across the population but have interacted with existing patterns of inequality across dimensions of income, age, gender and ethnicity (Bambra, Riordan, Ford et al, 2020; Lee, 2020; Marmot, Allen, Goldblatt, et al. 2020). EU member states have reported a 60% escalation in reports of domestic violence (Mahuse, 2020), along with rises in alcohol consumption within family homes, all of which has placed children and young people at a higher risk of exposure to violence and abuse (Save the Children, 2020). School closures, during periods of lockdown, not only denied children of their right to education, but also their access to a place of safety, security, and connection (United Nations, 2020).

Schools are an ideal setting for promoting children's emotional and social competencies and fostering an overall sense of psychological wellbeing (Barry, Clarke, Jenkins et al., 2013). Children and young people spend almost half their waking lives at school and the experiences and relationships they have at school can have a substantial impact on their wellbeing, influencing both behaviour and academic performance (Langford et al., 2014). School staff are also well placed to notice changes in young people and to intervene early in relation to mental health or behavioural concerns (Barry et al., 2013; Fazel et al., 2014). Whole school mental health promotion provides real opportunities to enhance a range of outcomes for all children and young people, as well as prevent or reduce emotional and behavioural difficulties in children and young people who are placed at high risk by virtue of their life circumstances (Barry, Clarke & Dowling, 2017; Weare & Nind, 2011).

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Approach to developing the Factsheet

The development of this Factsheet was informed by a *Rapid Realist Review* (Saul, Willis, Bitz et al., 2013) process, which is a collaborative approach to synthesising evidence in a time-sensitive manner, allowing an inclusive integration of quantitative and qualitative research, theory, practice and expertise. The Factsheet is also guided by the values and pillars of SHE, as presented in Figure 1. These values and pillars are reflective of the World Health Organisation Health Promoting Schools (HPS) framework (WHO, 1986), which advocates a holistic and contextual approach; one that moves beyond individual behaviour change, by also aiming at salutogenetic, organisational change through the strengthening of physical and social environment, including interpersonal relationships, school culture, leadership, policy structures, teaching and learning conditions, and school practices (Dadaczynski, Jensen, Viig et al., 2020; Simovska & McNamara, 2016).

In line with the HPS approach, the focus of this review is on whole school approaches to mental health promotion, since it is now well established that complex multilevel and integrated whole school approaches are more effective than curriculum based and uni-dimensional approaches (Lewallen, Hunt, Potts-Datema, Zaza, & Giles, 2015). Whilst focused mainly on mental health promotion in schools, this factsheet also references overlapping literature in relation to mental health prevention, which is about tackling the mental health problems of students who experience more serious difficulties.

The work was guided by the following research questions:

- What types of whole-school interventions, programmes, frameworks, models, and tools are currently being used and implemented in schools and how do these align with the HPS Framework?
- What are the benefits of school mental health promotion activities?
- What are the characteristics of successful school mental health promotion initiatives?
- What are the barriers and facilitators to the implementation of school mental health promotion initiatives?
- What are the gaps and future directions for the field?

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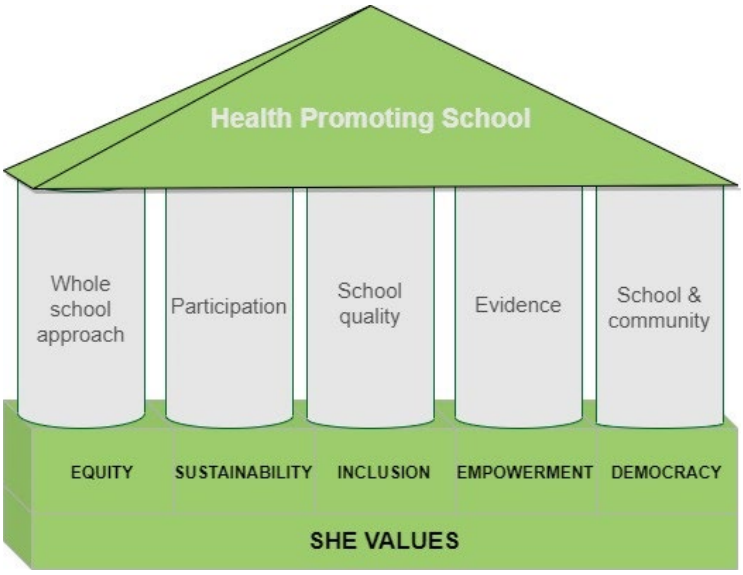

Figure 1. The pillars and values of Schools for Health in Europe (SHE) Network Foundation

Mental health and mental health promotion

The depth and scope of school-based mental health promotion activities are influenced by the prevailing definitions; it is therefore important to consider what is meant by 'mental health'. Whilst there is no overwhelming consensus, the World Health Organisation's definition of mental health is widely used and reflects a salutogenic view of mental health as positive emotional, social, spiritual, and physical wellbeing.

> *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' (WHO, 2013; p. 6).*

Nevertheless, there is concern that current definitions are overly individualistic and fail to take account of social and other contextual determinants of mental distress. There are also calls for more holistic conceptualisations that recognise the relationship between mind and body. These aspects are highlighted in the following definitions by the Canadian Mental Health Promotion Unit and Galderisi and colleagues, respectively.

> *Mental health is the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional, psychological, social and spiritual wellbeing* ***that respects the importance of culture, equity, social justice, interconnections and personal dignity*** (MHPU, 1997).

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> *Mental health is a dynamic state of internal equilibrium*....[It includes] *basic cognitive skills; ability to recognise, express and modulate one's own emotions, as well as empathise with others; flexibility and ability to cope with adverse life events and function in social roles;* ***and harmonious relationship between body and mind*** *represent important components of mental health*... (Galderisi, et al. 2015).

These definitions are highlighted here because as noted above, a holistic and contextual understanding of health (including mental health) is important in the context of the HPS framework. Whilst they are certainly not definitive, they allow for adopting a broader social and cultural lens, which helps to avoid individualistic approaches (that can be stigmatising) and offers greater possibilities for addressing health inequalities and making real improvements to children's and young people's lives (Dadaczynski, Jensen, Viig et al., 2020).

Mental health *promotion* is defined by the World Health Organisation (2018) as actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles. Therefore, fundamental to mental health promotion are empowering actions that facilitate an environment that respects and protects basic civil, political, socio-economic and cultural rights. Without the security and freedom provided by these rights, it is difficult to maintain high levels of mental health.

In the context of school-based initiatives, mental health promotion entails actions that are integrated within all aspects of the school ethos, organisation, and physical and social environment. It requires an understanding that the holistic development of pupils - including their mental health and wellbeing - is central to the goals and purposes of education. This means that mental health promotion is not just about mental health (narrowly defined), it also aims to have a positive impact on students' learning and school experiences in general. Thus, the HPS approach places mental health promotion within the context of a general education mandate (Paulus, 2009).

The benefits of school mental health promotion

A number of well documented high-quality reviews of school-based mental health promotion initiatives have been conducted. Taken together, the evidence demonstrates that well designed and carefully implemented whole school programmes have strong positive impacts on a range of outcomes, at least in the short term; these include:

- Enhanced student wellbeing, sense of purpose, connectedness and meaning (Adi, Schrader McMillan, Killoran, et al., 2007).
- Improved academic learning, engagement, and sense of connectedness with learning and with school (Durlak, Weissberg, Dymnicki et al., 2011)
- Improved staff well-being, reduced stress, sickness and absenteeism, improved teacher efficacy and performance (Jennings & Greenberg, 2009).
- Reduced mental health issues such as depression, anxiety and stress (Clarke Sorgenfrei, Mulcahyet al., 2021; Durlack, et al., 2011; Shucksmith, Summerbell, Jones, et al., 2007).

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- Enhanced social and emotional skills and attitudes that promote learning, success, wellbeing and mental health, in school and throughout life (Durlak et al., 2011)
- Improved school behaviour, including reductions in low-level disruption, incidents, fights, bullying, exclusions and absence (Adi et al., 2007)
- Reduced risky behaviours such as impulsiveness, uncontrolled anger, violence, bullying and crime, alcohol and drug use (Catalano, Berglund, Ryan et al., 2002; Zins, Weissberg, Wang et al., 2004).
- Reduced sexual violence and harassment (Clarke et al., 2021).

Examples of whole school approaches to Mental Health Promotion

In Denmark, *Up* is a whole school approach explicitly aligned with the HPS framework and aimed at promoting mental health by strengthening social and emotional competence among schoolchildren. *Up* consists of four components: education and activities for school children; development of staff skills; involvement of parents; and initiatives in everyday life at school. Social and emotional competence is seen as an aspect of action competence (Nielsen, Meilstrup, Nelausen et al., 2014).

MindMatters was developed by a consortium of Australian health and education experts, working with staff, other stakeholders and government officials. It involves adaptations to the curriculum; school organization, ethos and environment; and partnerships and services (Hazell, Vincent, Waring et al., 2002; Mullett, Evans & Weist, 2004; Wyn, Cahill, Holdsworth, et al., 2000). *MindMatters* has also been adapted and successfully implemented in primary and secondary schools across Germany since 2003 (Franze & Paulus, 2009). More than 1000 schools take part in this whole school mental health promotion program each year.

Gatehouse originated in Melbourne Australia and includes both school-wide and individual focused components to promote the emotional and behavioural wellbeing of young people in secondary schools. It involves provision of whole school support, teaching resources and a school liaison team. (Bond, Patton, Glover, et al., 2004; Patton, Bond, Carlin, et al., 2006). The *Gatehouse* project has also been adapted for Alberta, Canada (Omstead, Canales, Perry, et al., 2009)

Characteristics of Successful Whole School Mental Health Promotion Initiatives

A synthesis of evidence from across systematic reviews and primary studies reveals that successful approaches to school-based mental health promotion involve complex multilevel and integrated adaptations to four intertwined areas of school practice: 1) curriculum and pedagogy, 2) policies and procedures, 3) relationships, and 4) school climate (see Figure 2). These are expanded upon hereunder.

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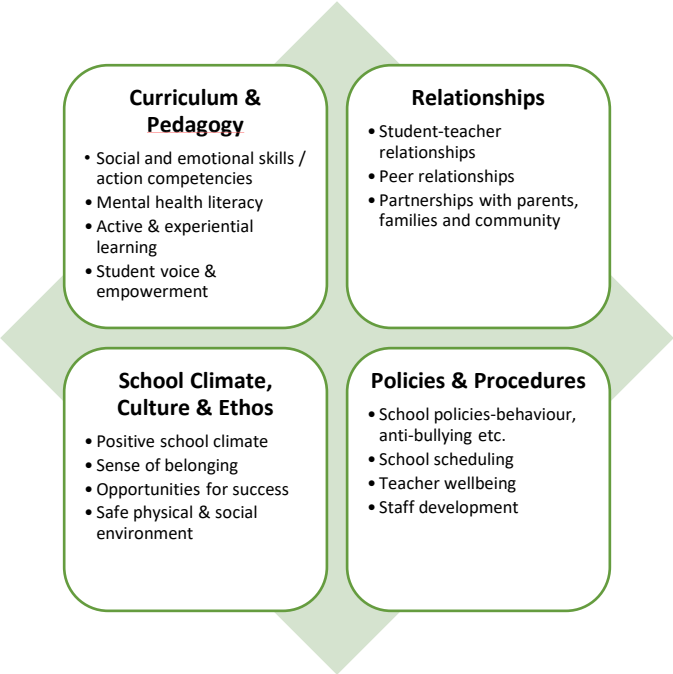

Figure 2. Characteristics of successful whole-school mental health promotion initiatives

Curriculum and Pedagogy

Successful school-based initiatives make considered adjustments to curriculum and pedagogy. Most approaches emphasise explicit teaching of social and emotional competencies such as emotional regulation, empathy, perspective taking skills, and mindfulness. These skills help children and young people navigate the challenges of growing up and confer a range of social, emotional and academic benefits (Durlak et al., 2011; Zins, et al., 2004). Furthermore, teachers' social and emotional competence is linked to reductions in stress and burnout, enhanced teacher effectiveness, and more prosocial classroom environments (Jennings & Greenberg, 2009).

These skills and competencies are often framed under the umbrella of Social and Emotional Learning (SEL; see www.casel.org) or Social and Emotional Aspects of Learning (SEAL especially in the United Kingdom). Nielsen and colleagues (2014) point out these skills can also be considered as action competencies, thus aligning them with the HPS framework. SHE defines an action competence as the ability to plan, initiate, deliver and evaluate actions aimed at improving health and wellbeing in "real life" (www.schoolsforhealth.org/resources/glossary/action-competencies-and-individual-health-skills). For children in school this could involve any action at classroom or community level aimed at improving collective or personal health and wellbeing. The emergence of transformative social and emotional learning (Jagers, Rivas-Drake & Williams, 2019) in the United States, which is anchored in social justice and citizenship, may offer further coherence with the notion of action competence given the commitment to student empowerment, collective action and appreciation of underlying social determinants.

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In relation to student voice and empowerment, evidence suggests that students need to feel they have influence in everyday school and classroom decision making, including teaching and learning approaches. Student voice is about genuine consultation and the authentic involvement of all students, with particular attention to ensuring that marginalised students have their voices heard (Weare, 2015). Evidence also points to the importance of interactive and experiential learning approaches and of integrating learning into the mainstream processes of school life (Weare, 2015). Furthermore, social and emotional competencies must be sequenced in the sense that the activities need to be coordinated and developmentally appropriate (Durlak et al., 2011; O'Reilly, Svirydzenka, Adams et al., 2018).

Mental health literacy (MHL), which refers to knowledge and beliefs about mental disorders, reducing stigma and encouraging help-seeking behaviour, has also been targeted in some literature (Campos, Dias, Duarte, et al., 2018). However, there is concern that MHL can reinforce deficit-based notions of 'mental disorder' and 'maladaption'. Mansfield, Patalay & Humphrey (2020) recommend a shift to 'critical MHL' which involves the integration of culturally sensitive models and acknowledgment of the interaction between individuals and their social and contextual circumstances. The concept of critical MHL would seem to echo a similar shift in toward *critical health literacy* espoused by Chinn (2011) and others, which centres on information appraisal, understanding social determinants, and empowerment for collective action.

School climate, culture and ethos

School climate and ethos refer to the core values, attitudes, beliefs and culture of the school and classroom. It is a tone which permeates every aspect of school and classroom life (Weare, 2015). A climate and ethos which supports a feeling of being accepted, respected, and bonded to the school environment has been shown to be one of the key determinants of wellbeing and mental health in schools (Greenberg, Domitrovich & Bambarger, 2001; Millings, Buck, Montgomery et al, 2012).

At a concrete level, efforts to foster a supportive culture and ethos includes many everyday adjustments to school life, including ensuring a safe and welcoming physical environment, ensuring smooth transitions from one type of activity to another, fostering a sense of warmth and responsiveness, offering multiple opportunities for success and recognition through core curriculum and extra-curricular activities, and modelling appropriate expressions of emotion, respectful communication and problem solving (Jennings & Greenberg, 2009; O'Reilly, et al., 2018; Roeser & Eccles, 2014). Familiar and predictable school and class routines help build a sense of security and environments where everyone feels listened to, understood and empowered (Weare, 2015).

Relationships

The quality of interpersonal relationships formed in schools is fundamental to mental health promotion. Successful schools foster positive relationships at multiple levels including, attuned and supportive student-teacher relationships, positive peer relationships, and collaborative partnerships with parents, families and communities, including local referral services and supports.

A robust body of literature highlights that teacher–student relationships influence socio-emotional and cognitive development as early as preschool and continue to influence students' social and intellectual

capacities throughout childhood and adolescence. Students who reported better quality teacher-student relationships, characterised by mutual respect, active listening, warmth and attunement, are more likely to have higher levels of psychological engagement, academic achievement and school attendance and reduced levels of disruptive behaviors, suspension, and dropout (Barile, Donohue, Anthony, et al., 2012; Fredriksen & Rhodes, 2004; Lan & Lanthier, 2003)

Children who enjoy positive relationships with peers tend to experience higher levels of emotional wellbeing, more positive beliefs about the self, and engage in prosocial forms of behaviour and social interaction, than do children without such friendships. It is important that school staff have an understanding of the peer ecology (i.e., the social dynamics and ways children interact with, influence, and socialise with one another) and model respectful and compassionate relationships (Farmer, McAuliffe Lines & Hamm, 2011). Furthermore, with appropriate training and support, children and young people can become active players in mental health promotion rather than passive recipients. Students can be effective peer educators in teaching social and emotional skills, participating in buddying initiatives and conflict resolution (Rones & Hoagwood, 2000; Weare, 2015). The involvement and participation of students supports sustainability of initiatives by developing a real sense of ownership and engagement (Adi et al., 2007).

Relationships with parents' families and community are a vital part of school-based mental health promotion. The school has an important role in encouraging family participation in ways that boost mental health and wellbeing. Partnering with families is a sensitive area, however, particularly where students are in difficulty. It is important that schools adopt a strengths-based approach, acknowledging the diverse experiences, resourcefulness and aspirations of families, and that parents and carers do not feel patronised, stigmatised and blamed for their children's difficulties (Weare, 2015). Parents should feel that their views, wishes and feelings are taken into account; they should be kept fully informed of decisions affecting their child and feel supported in their role (Weare, 2015).

Mental health promotion in schools is best achieved through the provision of a continuum of support in recognition that individual children and young people can have different needs at different times. Those at greater risk and with greater needs may require more specific and targeted support, in addition to the universal support provided to all children and young people in their age-related class-based groups (Weare & Nind, 2011; Werner-Seidler, Perry, Calear, Newby & Christensen, 2017). It is also important for schools to have clear referral pathways for children and young people who have a higher level of mental health needs. Developing partnerships between health and educational sectors could support a co-ordinated and wrap-around response to children in the most difficult circumstances (O'Reilly et al., 2018; Weist & Murray, 2007). This is especially important in working towards inclusive educational systems.

Policies and Procedures

Successful mental health promotion in school requires systemic and organisational support in terms of school policies, procedures, including the prioritisation of support for teacher wellbeing and staff professional development. Particularly key to mental health and wellbeing are the school's policies and practice around behaviour, diversity, and the challenging of prejudice around ability, disability,

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gender, race, sexual orientation and perceived social status. Anti-bullying and homophobia policies and practice generally need to be strengthened and linked with cyber safety policies (Weare, 2015).

Schools also need to make provision for high quality continuing professional development (CPD) for teachers. This is central to successfully develop teachers' understanding, competence and confidence in delivering and sustaining mental health promotion with their pupils (O'Reilly, et al., 2018).

Barriers and Facilitators

The extant literature highlights many barriers and facilitators for positive change; these are discussed next and summarised in Figure 3.

Evidently, when it comes to mental health promotion in schools, teachers are our greatest asset. They are the main drivers for change in their schools and it is important that they are included in decision making relating to school change (Rowling, 2009). High levels of teacher stress and burnout, poor relationships with colleagues, students and families, and work intensification are significant barriers to mental health promotion (Jennings & Greenberg, 2009). Better teacher wellbeing is associated with better student wellbeing and with lower student psychological difficulties (Harding, Morris Gunnell, et al., 2019). Thus, prioritising teacher wellbeing is just as important as a focus on mental health for students (Rowling, 2009). There is concern that teachers feel they are working outside their area of competence, and they will need to be comfortable and confident in promoting and teaching for mental health. Gaps in teacher training and continuing professional development in this respect are a noted challenge in the literature (Bond et al, 2004; O'Reilly, et al., 2018).

There is also a need for time to be devoted for sharing ideas and brainstorming (O'Reilly et al, 2018). In addition, some authors have recommended professional, reflective supervision be made available to teachers (similar to that offered to other frontline professionals (Lawrence, 2020). This would allow teachers to share some of the distressing encounters their job entails with a trusted colleague so they can be emotionally and practically supported as they engage in increasingly complex and demanding roles (O'Toole & Simovska, in press, a)

Strong, proactive leadership is essential to the success of mental health promotion initiatives. The school principal is often critical in leading and supporting change, but distributed leadership is also essential for large scale educational reform. Characteristics of effective leadership in school health promotion include sound decision making; effective human resource management; a moral purpose; understanding change processes; relationship and capacity building; teamwork and multi-professional work; promoting coherence and "joined up thinking" (Fullan, 2005; Reynolds & Teddlie, 2001; Rowling, 2009; Weare & Markham, 2005; Paulus & Hundeloh, 2020). The nominating of a proactive and enthusiastic 'mental health champion' is also considered essential. This is someone who - as a trained teacher in school health promotion - can act as a strategic lead in implementing interventions, influence other staff, and not have too many competing priorities (Dix, Slee & Lawson, 2012; O'Reilly, et al., 2018).

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The adoption of a complex multilevel, whole school approach to mental health promotion in schools requires allocation of substantial resources including, investing in high quality professional development, paying for teacher release time, and developing curriculum resources. It is important that governments adequately resource school-based mental health promotion initiatives, otherwise the demonstrated value of these initiatives will not be realised, and emerging knowledge, capabilities and practices will be lost (Slee, Dix & Askell-Williams, 2011; Shediac-Rizkallah & Bone, 1998; Patalay, Giese, Stankovic et al, 2016; Pluye et al, 2004). Building partnerships between health and education sectors requires appropriate multi-sectoral support and funding (Bond et al., 2004).

In terms of implementation and sustainability, existing literature emphasises that achieving positive change is a long-term commitment. Multilevel school-based health promotion is fundamentally complex, and success requires commitment by funders, government departments, communities, and an understanding that such interventions are not short term, quick fix solutions (Bond et al., 2004; Dowling & Barry, 2020). Access to appropriate information or local data and the capacity to use these data to guide priorities and strategies is an important component of this work. Schools require continued training and support in accessing and using data to inform their decision making (Bond et al, 2004) Attention also needs to be paid to the school culture and context, to ensure that any the programme or intervention components are fitted to the actual needs of the community, and that the specificities of the school context are taken into account and used as levers.

Mental health promotion competes with other demands on schools, particularly the pressures for academic outcomes. Currently, education systems are typically unbalanced with over-emphasis on exams, qualifications and academic attainment, and not enough focus on the wellbeing of students (National Children's Bureau; 2017; O'Toole & Simovska in press, b). A legislative commitment by governments is needed to support schools in prioritising and resourcing high quality mental health promotion.

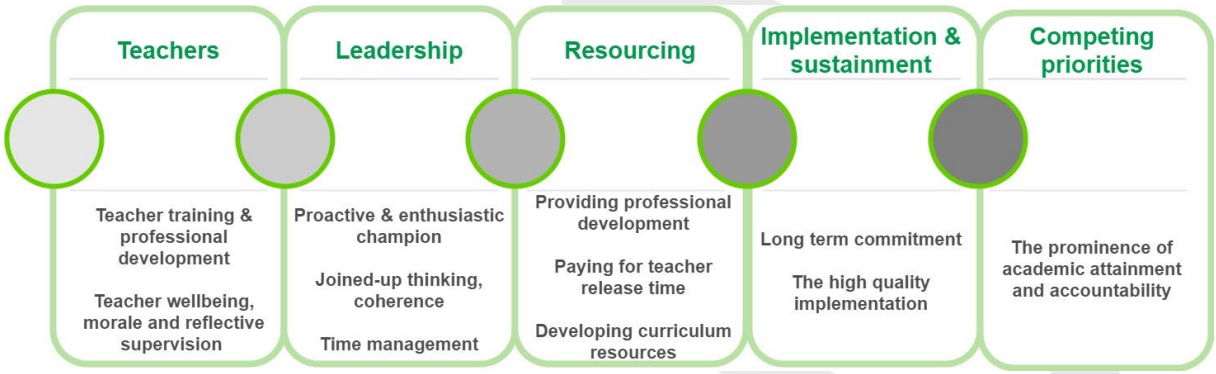

Figure 3. Barriers and facilitators of whole school mental health promotion

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Future directions

Taking account of current research and practice, along with the values and pillars of SHE, the following section outlines some future directions for school-based mental health promotion.

Moving beyond the dominant biomedical model of mental health

The prevailing understanding of mental health is based on a traditional biomedical model that assumes people's distress, difficult or troubling behaviour are the result of a medical disorder or chemical imbalances in the brain. However, there is now abundant evidence demonstrating that the circumstances of people's lives contribute to and maintain psychological distress; amongst the most important of which are childhood adversity and trauma, poverty, discrimination, war and other life-threatening events, bullying and living in a country with high income inequalities (Boyle, 2020; Johnstone & Boyle, 2018; Rogers & Pilgrim, 2010; Wilkinson & Pickett, 2010; World Health Organization, 2013)

The robustness and consistency of these findings has prompted the United Nations Human Rights Commission to assert that psychological distress needs to be understood in terms of the power imbalances in peoples' lives, rather than supposed chemical imbalances in their brains (UNHRC, 2017). Similarly, the Lancet Commission for global mental health acknowledged that the traditional biomedical model of mental health "*can at times lead to unhelpful labelling, diminishing the agency of the affected individual, promoting a reductionist perspective, and over-simplifying and under-valuing complexities of personal circumstances*" (Patel, et al., 2018, p 15).

Thus, traditional approaches have served to obscure people's life circumstances and there is now growing recognition of the need to acknowledge the determinants of mental health and to address the power imbalances and social injustices that contribute to emotional and psychological distress. This focus on social and other contextual determinants coheres with SHE values and principles. Nevertheless, much of the existing work on school-based mental health promotion is located within the traditional mental health paradigm. Further work is needed to explore ways that school-based mental health promotion can move beyond potentially delimiting notions of 'mental disorders' and support actions to address the social and other contextual factors that undermine children and young people's wellbeing and mental health. Childhood adversity and trauma is a key contextual factor.

Childhood adversity and trauma

Apropos of the above, recent years have seen greater awareness of the high prevalence and wide-ranging impact of childhood trauma and adversity. For instance, the landmark Adverse Childhood Experiences (ACE) Study, conducted in the United States, categorised ten types of adversity including abuse, neglect, violence, and parental addiction (Felitti Anda, Nordenberg, et al., 1998). The study found that about two thirds of participants experienced at least one adversity in childhood and similar high prevalence rates have been found in other high, low, and middle-income countries (e.g., Bellis, Hughes, Leckenby et al., 2015; Kessler, McLaughlin & Green, et al., 2010; Manyema, & Richter, 2019; Soares, Howe, Matijasevich, et al., 2016).

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Children from marginalised and underserved communities are at higher risk of experiencing adversities like abuse and violence; but it has also been acknowledged that growing up in communities where there is ongoing oppression, poverty or discrimination, constitutes an adversity in its own right, and therefore the conventional ACE categories need to be expanded to incorporate community level adversities and underlying structural inequalities (Cronholm, Forke, Wade, et al., 2015; O'Toole, in press). The term *trauma* typically refers to a child's response to adverse experiences. Trauma occurs when an adverse event overwhelms the child's capacity to cope and leads to a sense of disconnection and powerlessness (SAMHSA, 2014). It is now well recognised that childhood trauma is major determinant of mental health problems including anxiety, depression, drug and alcohol problems, self-harm and suicide, difficulties with cognitive functioning, lower academic attainment and school dropout (Bebbington, Bhugra, Brugha, et al., 2004; Bebbington, Cooper, Minot, et al., 2009; Felitti, et al., 1998; Dube, Anda, Felitti, et al., 2001). It also correlates with a range of physical health conditions (non-communicable diseases) such as diabetes, heart disease and chronic respiratory diseases (Felitti, et al, 1998; Gilbert, Breiding, Merrick, et al., 2015; Scott, Von Korff, Angermeyer, 2011).

In response, there have been calls for trauma–informed approaches to be integrated into public health and educational policies (Overstreet & Chafouleas, 2016; SAMHSA, 2014) and indeed, into the HPS frameworks (O'Toole, in press). Trauma-informed practice is an approach to building knowledge of trauma and its impact on mind, body and behaviour; responding by integrating knowledge of trauma into school policies, practices and procedures; whilst also emphasising self-care for educators and protection against secondary traumatic stress and burnout (Dorado, Martinez McArthur et al, 2016; Thomas, Crosby & Vanderhaar, 2019). There are a variety of trauma-informed approaches, strategies and frameworks, but underpinning these are core principles of safety, trustworthiness, collaboration, peer support, voice, choice and empowerment, cultural humility and sensitivity to diversity (Harris & Fallot, 2001; SAMHSA, 2014). These principles cohere with the values of SHE and with the concept of co-creation, to which we now turn.

Co-creation

Whilst there is increased discourse around the importance of student voice and participation as part of democratic school health promotion (Simovska, 2007), a commitment to co-creation is not yet fully embraced in the field. Many authors emphasise the merits of programme fidelity, rigorous and accurate implementation, whereby staff might teach pre-determined skills in a step-by-step sequence, usually adhering to generic, manualised guidelines. These 'top-down' approaches are more common in the United States. However, school contexts cannot be considered homogenous and require to shift from programme-fit to programme-tailoring (Darlington, Mannix Mc Namara, & Jourdan, 2020). Such 'bottom-up' approaches that are participatory, designed and initiated by those intended to benefit, are more typical in Europe and Australia (Weare & Nind, 2011; O'Toole, 2017).

The active participation of pupils in the design, planning and implementation of programmes and interventions which concern them improves the outcomes and the sustainability of such programmes (Labonte, Woodard, Chad, & Laverack, 2002; Jourdan et al., 2016). In the Health Promoting Schools framework (Langford et al., 2015), the participation of all stakeholders (pupils, staff, parents) is also both an aim and an enabling process for health-promoting school strategies (Barnekow et al., 2006).

A recent study by Darlington & Masson (2021) proposed a definition of co-creation in the field of health promotion as being a collaborative, 'bottom-up' process that results in a joint creation, a new project or action, based on shared expertise, shared responsibility and joint decision, and which increases the power of participants. It could improve existing projects and practices, all of which are tailored to co-defined needs and will contribute to promoting the health and well-being of each member of the group (Darlington & Masson, 2021). This type of approach aligns with the expressed values and principles of SHE, however there are few examples of school-based mental health initiatives that involve co-creation. Overall, there is a need for greater participation of children and young people in peer-led programmes and respect for children's rights. Additionally, more research is needed on co-creation in mental health promotion, including evaluations that are child-centred and incorporate both quantitative and qualitative elements.

Conclusion

Guided by the pillars underpinning the Health Promoting Schools (HPS) approach, this Factsheet provides a narrative synthesis of the state of the art in school-based mental health promotion, highlighting the types of initiatives currently offered, and the characteristics of successful initiatives based on a whole-school approach. Whilst mental health promotion may compete with other demands on schools, it has become crucial to invest further in research which can support holistic, inclusive and participatory practices in the field of school mental health promotion. The focus on the contextual determinants of children's mental health and wellbeing, the shift to trauma-informed practices in education, as well as the co-creation of mental health promotion projects are among the future directions, which are hoped to improve children's' mental health and wellbeing as well as their academic outcomes.

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