A systemic, whole-school approach to mental health and well-being in schools in the EU

Analytical report

NESET

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Carmel Cefai, Celeste Simões and Simona C.S. Caravita

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List of abbreviations

CBT	cognitive behavioural therapy
HPS	Health Promoting Schools
HBSC	Health Behaviour School Checklist
MHL	mental health literacy
RCT	randomised controlled trial
SEE	social and emotional education
SEL	social and emotional learning
SES	socio-economic status

Executive summary

Aims

A general consensus exists among Member States that gaining academic knowledge on its own is not enough for young people to play a role as active citizens and face the socio-economic realities in their lives, in order to avoid inequity, poverty, discrimination, marginalisation and exclusion. In the 21st century, education needs to go beyond narrow sectoral goals such as academic achievement. In addition, it should contribute actively to the health and well-being of children and young people, whose mental health needs are becoming more evident and demanding. The recent European Commission communication on the achievement of the European Education Area by 2025 (European Commission, 2020) has set in motion a collaborative process to determine how schools can address the learning and socio-emotional needs of their students – in particular, those children who encounter difficulties – and how they can provide students with a balanced, high-quality, education that sets them on a trajectory towards an active, productive and healthy life. This report is in response to such initiatives and to the recognised need for schools across Europe to prioritise and actively promote the mental health and well-being of school children within safe and inclusive contexts. More specifically, it seeks to review the international literature on the promotion of mental health and well-being and the prevention of bullying in schools. In addition, it seeks to develop a theoretical framework to guide the way in which the whole-school system, in collaboration with the community, can be mobilised at various levels to promote mental health and well-being. The report makes recommendations for the effective implementation of a systemic, whole-school approach to the promotion of mental health and well-being and the prevention of bullying in schools across the EU. This report adopts a systemic, whole-school perspective that emphasises the importance of interacting subsystems within and beyond particular individuals and settings.

Methodology

The methodology used in this report is focuses primarily on the use of secondary data regarding the promotion of mental health and well-being in schools. A review of the international literature, particularly more recent systematic reviews and meta-analyses and other key studies in the area, was carried out to determine the impacts of interventions on student outcomes, as well as identifying effective processes. The review focused on a number of specific areas such as literature on Health Promoting Schools, as well as social and emotional education, the prevention of mental health issues, school climate and bullying. We also carried out an in-depth analysis of specific aspects of the whole-school approach such as universal interventions, classroom climate, whole-school ecology, resilience and targeted interventions. Our findings with regard to each of these aspects are presented in separate chapters. Furthermore, we undertook a search for initiatives and examples of good practice, as well as projects in Member States aimed at promoting mental health and well-being and the prevention of bullying in schools. Reference has also been made to EU policy documents, previous NESET reports in the area, such as 'Strengthening social and emotional education as a core curricular area across the EU' (Cefai et al., 2018) and 'How to tackle bullying and prevent school violence in Europe' (Downes and Cefai, 2016), as well as the School Educational Gateway platform and relevant EU-funded projects. This review served to build a theoretical framework to guide how schools can adopt a whole-school approach to promote the mental health and well-being of their members in an effective and sustainable way.

Evidence for a whole-school approach to mental health and well-being

Despite current research having certain limitations of, evidence from the various reviews and meta-analyses of studies nevertheless indicates that school-based interventions to promote students' mental health and well-being are more likely to be effective if they are

organised as part of a systemic, whole-school approach. Provided they are implemented well, are integrated into the fabric of the school context, and are sustained over time, whole-school interventions have a more positive impact on student outcomes than individual components such as standalone programmes. A whole-school approach mobilises the various resources of the entire school community – including the voices and active engagement of students, staff, parents and professionals – in a collaborative effort to promote the mental health and well-being of everyone in the school community. When implemented well, whole-school interventions have a positive impact on a range of mental health, social, emotional and educational outcomes. These include an increase in mental health literacy, social and emotional competences, positive mental health and well-being, and prosocial behaviour, as well as a decrease in mental health symptoms and problems such as depression, anxiety and substance use, anti-social behaviour, violence and bullying. The promotion of mental health also helps to challenge negative views of mental health issues, leading to a reduction in stigmatising behaviour. Various reviews have also reported an impact on members' commitment to the school and a greater sense of belonging, as well as enhanced learning motivation and academic achievement. Such impacts are a key factor in preventing early school leaving, and increase the likelihood of successful post-secondary education and enhanced career prospects. Lastly, whole-school interventions in relation to mental health and well-being have a strong positive impact on children who are at risk or have mental health needs, thus serving to promote resilience and reduce socio-economic inequality.

An integrated framework for a whole-school approach to mental health and well-being in the EU

Based on our analysis of the current literature, and in view of recent EU policies, communications and reports, this report presents an integrated framework for a whole school approach to mental health and well-being, with interventions at curricular and contextual levels, integrated universal and targeted interventions, and the involvement of the entire school community. The framework consists of three components: a set of principles informing the framework; key elements at classroom, school and intersectoral layers; and sustainability processes that support the whole-school approach. The concentric elements of the framework revolve around students, facilitated by interventions at the classroom and whole school layers, supported by the whole school staff, peers, parents. In addition, there is an intersectoral layer that focuses on collaborative, targeted interventions supported by the local community and external professionals and agencies. Each of the layers is circular and influences and contributes to the other layers. Overall, the framework focuses on universal mental health and well-being for all school children as a major goal of the school, complemented by additional targeted interventions for students at risk, as well as those with mental health needs. In addition, the framework also focuses on the education and mental health and well-being of the adults who work with school children, namely the teachers and parents. The three main components of the framework include the following constituent elements

- Key principles: a whole-school approach to mental health and well-being is informed by the following principles: the rights of children and young people to physical and mental health, quality education, protection and participation; holistic education and development; a systemic, whole-school perspective; inclusive and equity-driven; culturally appropriate interventions; a bottom-up, participative approach; health- and strengths-based; relational; multi- and trans-disciplinary; addressing adults' mental health and well-being, including teachers.
- Key elements:
  - o Classroom layer – universal mental health curriculum, classroom climate; teacher education and mentoring;
  - o School layer – school climate, safe spaces, student engagement; active parental engagement; staff well-being and mental health;

- o Intersectoral layer – targeted interventions; partnership with professionals and agencies; partnership with the local community.
- Key sustainability processes – quality implementation; participatory and flexible approach; support from local, regional and national authorities.

Recommendations

In view of the evidence supporting the social, emotional and academic benefits for children and young people of mental health promotion in schools, and considering the increasing mental health needs of children and young people across Europe, we make the following recommendations for the effective promotion of mental health and well-being and the prevention of mental health difficulties in European educational systems.

1. **Mental health promotion as a mandatory key learning goal in 21st-century education**

   In line with the policies currently being developed by the European Commission for on the achievement of the European Education Area by 2025, a supporting Communication should secure mental health and well-being as a major educational objective across the Members States, integrated into the curriculum and supported by a whole-school approach. Such an initiative is supported by the emergence of consistent evidence that schools can effectively promote the mental health and well-being of children and adolescents and prevent the emergence of mental health issues, at critical periods during their development. It also resonates with the rights of children and young people to physical and mental health, quality education, protection and participation, and would help in the realisation of the corresponding Sustainable Development Goals. Lastly, evidence is also emerging which shows that efforts to promote mental health and well-being in school produce substantial economic returns.

2. **Mainstreaming mental health and well-being into the formal curriculum and pedagogy**

   A strategic approach aimed at encouraging schools to broaden their agenda to include mental health and well-being as a key learning objective, is to emphasise its inextricable links between academic learning, curriculum design and pedagogy. Teaching practices that foster connectedness and a sense of belonging, a constructivist collaborative pedagogy involving active student engagement and culturally responsive and inclusive practices, and role-modelling of social and emotional competences, are building blocks for both academic learning and social and emotional competences and well-being. These practices fall within the remit of all school teachers, and placing an emphasis on such 'mainstream' practices may help to reduce resistance to mental health promotion on the part of teachers, providing a 'royal road' to the prioritisation of mental health promotion and well-being in schools.

3. **Adapting the metrics of school success to prioritise mental health and well-being**

   Another important way to encourage schools to prioritise mental health and well-being and provide a more balanced and meaningful education is to increase the currency of mental health and well-being in education. Education systems need to support the change towards 21st-century schools and the positive development and well-being movement by expanding the metrics they use to evaluate school performance. Including students' mental health and well-being as a common indicator of a school's effectiveness and success will ensure these aspects will feature prominently in the school's agenda. Evaluation, however, needs to be formative, inclusive and systemic, and must avoid labelling, ranking and comparisons. This shift in educational priorities also requires the development of educational evaluation systems that are endorsed by the governments of Member States.

4. **Adopting a systemic, whole-school approach**
   School-based interventions aimed at promoting students' mental health and well-being are more likely to be effective if they are organised within a systemic, whole-school approach. They also need to be implemented well, integrated into the fabric of the school context, and sustained over time. A whole-school approach mobilises the various resources of the whole school community, including the active engagement and voices of students, staff, parents, professionals and local community, in a collaborative effort to promote the mental health and well-being of the entire community. Universal interventions are complemented by a whole-school ecology framework that is embedded in the culture and ethos of the school and supported by targeted interventions for students at risk of, or experiencing, mental health issues.

5. **Relatedness and connectedness at the heart of mental health promotion**
   While structures and policies are essential tools to facilitate the implementation of a whole-school approach to mental health and well-being, they need to be framed within an ethic of relatedness and care. A sense of belonging and connectedness, fostered by respectful, caring and supportive relationships among and between the various school members, creates healthy spaces in which individuals can growth and thrive. Such an environment will also help to prevent unhealthy practices at the school that might compromise the mental health and well-being of school members, such as peer bullying, coercive classroom management based on fear and punishment, unequal or unfair treatment, as well as undue pressures on students to achieve, leading to stress and anxiety. Similarly, such an environment works as an antidote against stress and burnout among school staff.

6. **A bottom-up, participatory, approach, including a representative student voice**
   In line with European schools' culture of autonomy, empowerment democracy and ownership, a whole-school approach to mental health and well-being needs to adopt a bottom-up, participatory and flexible approach that fits the ecology of the school and local community. A bottom-up approach also helps to ensure that any initiative is culturally appropriate and addresses the diverse needs of the school population. It will also be an investment in developing interventions that are feasible and relevant to the local context. Teachers, students, parents and the local community must be actively involved in the planning and implementation of programmes and initiatives. The active involvement of parents and the local community will ensure that interventions are relevant, appropriate and adapted to the local context, and thus, parents and the community will be more likely to adopt them. A strong and meaningful student voice is also vital, in order for students to identify with and 'own' the interventions. This includes co-designing of materials, participation in the delivery and implementation of interventions, participation in decision making, and contributing to peer interventions. It is important that the student voice is representative, and incorporates the voices of marginalised and vulnerable children.

7. **Developing a mental health and well-being curriculum for school children across Europe**
   All school children, from the early years to high school, need to be exposed to a curriculum that equips them with the resources and competences they need to take active steps to maintain their mental health and well-being, as well as those of others. Such a curriculum should include social and emotional education, resilience building, and mental health literacy (including addressing stigma and prejudice), and should be adapted to the context and needs of the school. It may be integrated into other existing, related curricular areas, and make use of existing practices, expertise and resources. Such adaptations may make it easier for the mental health to find its way into the curriculum, but care must be taken to retain a focus on the promotion of

mental health and well-being. Further practice-based research should be undertaken with European schools as key partners, to develop a mental health and well-being curriculum that has a European identity. The funding of such collaborative projects by the European Commission has been instrumental in encouraging school staff and researchers to work together towards this goal, and should be further strengthened.

8. **School-based intersectoral support for students with mental health needs**

Mental health is a multifaceted phenomenon, and schools need to work with other sectors and agencies to provide targeted interventions for students who are at risk or experiencing difficulties, starting as early as possible. Close intersectoral collaboration with health services, mental health agencies, social services and other related services and agencies, will ensure schools can address the mental health needs of students using a transdisciplinary, cross sectoral approach that includes parents and students themselves in the decision-making process. It is essential that these intersectoral interventions are as accessible, responsive, appropriate and equitable as possible. The key role of schools in mobilising and coordinating support for students and families also ensures that services are more accessible and destigmatised, and can be linked with other types of support available at the school.

9. **A strategic focus on the mental health needs of vulnerable and marginalised students**

Students exposed to risk, disadvantage and marginalisation are at greater risk of developing mental health problems. These include children coming from low socio-economic status (SES) or migrant backgrounds, as well as children exposed to abuse, violence and bullying, and those who have experienced other forms of trauma. Students who attend high-achieving, competitive schools may also be at risk of mental health difficulties due to academic pressure, high expectations and fear of failure. Schools are in a unique position to prevent the onset of mental health issues and to address the mental health needs of vulnerable students through preventive and resilience-building interventions at a critical time, before these problems become more complex and chronic. Such interventions need to be implemented within an inclusive setting, to avoid labelling and stigmatisation. This strategic focus will be instrumental in strengthening the role of schools in promoting equity and equality.

10. **Involving the whole school community in tailoring interventions to prevent bullying**

Involvement in bullying increases the risk of mental health problems among victims, perpetrators and bystanders. Interventions to prevent bullying should thus be implemented in all schools, within a whole-school approach, by means of priority actions at the level of universal prevention. Joined-up actions aimed at selective and indicated prevention also need to be implemented, targeting at-risk groups and individuals, to increase the effectiveness of interventions. The selection and implementation of interventions and their components need to be tailored to the specific needs of individuals (e.g. adolescents, minority groups), schools, and the community and geographical area. This process requires an assessment of the bullying phenomenon in the school/area in which it occurs, combined with constant monitoring of both the programme implementation and the work of the large network that connects the school with experts, political leaders and other members of the community. School staff and parents should be also targeted by interventions, and their roles in programmes should be strengthened. Students' voices needs to be actively listened to, and their active involvement in a developmentally appropriate manner.

11. Prioritising the education of teachers in mental health and well-being

Teachers are the primary delivery agents of mental health interventions – not only of universal interventions and, in many instances, selective interventions – but also by providing support to students with mental health needs as part of an intersectoral, transdisciplinary team. Adequate teacher education in mental health promotion, at both initial and continuing professional development levels, is crucial to the success of mental health promotion in schools. National frameworks for both teacher education institutions and educational authorities need to outline the key educator competences necessary for the effective delivery of mental health and well-being in schools. Teachers require education not only in delivering mental health interventions at classroom and whole-school levels, but also in engaging in relational, child-centred, collaborative and constructivist pedagogy, as well as in their own social and emotional competence and resilience. Mentoring programmes, professional networks, learning communities and collaboration platforms provide collaborative learning environments in which teachers can share and improve their practice in mental health promotion. Professional development needs to be organised with the teachers themselves, according to their needs.

12. Addressing the mental health and well-being of adults working with children

The mental health and well-being of adults such as school staff, parents and carers has a direct impact on the mental health and well-being of students, and should therefore be targeted for intervention. Teachers need active support from local authorities, the school administration and their colleagues to deal effectively with the challenges and stresses of their profession, and to take care of their health and well-being. Similarly, schools not only need to encourage parents to share responsibility and collaborate actively with them in mental health promotion, but should also empower them in parental education and support them in taking care of their own health and well-being.

13. Strengthening evidence and evidence-based practice

Most of the reviews examined for this study underline the various methodological limitations of the studies, and emphasise the need for more rigorous research to provide stronger evidence on the effective promotion of mental health and well-being in schools. The need for more evidence is particularly evident in relation to multi-layered and complex whole-school approaches, which pose particular challenges in terms of implementation and sustainability. Further research is also recommended on the ways in which the formal curriculum and pedagogy can facilitate and optimise both mental health and academic outcomes. Evidence is also lacking, particularly in the European context (in contrast to North American and Australian contexts), with regard to which universal, selective and indicated interventions work, and for whom. Rigorous evaluation of existing and developing interventions in European schools would strengthen the evidence base and provide schools across Europe with a repertoire of evidence-based interventions from which to choose and adapt according to their needs. Such evaluations must, however, include local interventions that have been developed and implemented in European schools. Providing a stronger evidence base for school-based mental health promotion would also make it easier for the promotion of mental health and well-being to make deeper in-roads into educational systems across Europe.

The recommendations above entail widespread and significant changes in the way education systems are conceived, designed and operationalised. As such, they may encounter resistance from educational authorities, school staff and parents, who may find their understandings, expectations and sense of identity being challenged. A combination of legislation, advocacy, policy development, education and training, and the provision of multi-level support and intersectoral collaboration, would thus be required to empower schools to engage in this transformational process through a bottom-up, participatory approach.

1. Introduction

An increasing movement is taking place for schools to broaden their agenda to include well-being and mental health as one of their key learning objectives for the twenty-first century. Children and adolescents need a balanced set of cognitive, social and emotional competences in order to achieve positive outcomes at school, at work, and in life more generally (OECD, 2015; European Commission, 2020). As young children grow up, they need to develop the requisite social and emotional competences to help them navigate successfully through the developmental tasks, situational challenges and transitions they are set to face in their pathway to adulthood. They need to be able to know themselves and their strengths, to regulate their emotions, to deal with loss, change and adversity, to solve problems effectively and to make responsible decisions. They need to believe they can bring about change in their own lives, and remain determined and focused in the face of challenges, as well as being able to build and maintain healthy relationships, be understanding and empathic, and work collaboratively with others. They need to solve conflicts constructively, appreciate and respect difference and diversity, and take care of themselves, others and their environment (Cefai et al., 2018). These competences are necessary for children to lead healthy, happy and successful lives, and to steer away from mental health problems, particularly in view of the rapid global, social, economic and technological changes taking place in the adult world.

Children and young people in Europe are faced with various challenges, including increasing levels of unemployment; poverty and social inequality; media manipulation, and online safety, cyberbullying and technological addiction (e.g. EU, 2015; Inchley et al., 2020; UNICEF Innocenti, 2020). Bullying is a major risk factor within the school environment that threatens children's and young people's mental health. It is associated with poor health symptoms, negative emotionality, internalising problems, and suicidality (Downes and Cefai, 2016; Giménez Gualdo et al., 2015; Reijntjes et al., 2010). The mental health of children and young people has become a major issue across Europe, with around 20 per cent of school children experiencing mental health problems during their school years, with half of these problems developing before the age of 14 (EU, 2015; WHO Regional Office for Europe, 2018). Among European children, 35 per cent of 13-year-olds and 40% of 15-year-olds reported feeling low, nervous and experienced psychosomatic symptoms more than once a week (WHO Regional Office for Europe, 2020). In a study of 28,160 adolescents, Deighton et al. (2019) report that the scale of mental health problems is higher than previously estimated, with two in five young people scoring above thresholds for emotional or conduct-related problems. Particular risk factors include gender, deprivation and poverty, and ethnicity. Depression and anxiety disorders are among the top five causes of the overall disease burden, while suicide is the leading cause of death among adolescents (10–19 years old) in low- and middle-income countries, and the second leading cause of death in high-income countries (WHO Regional Office for Europe, 2018; Thomson et al., 2014). Marginalised young people are particularly affected. The COVID-19 pandemic has exacerbated these difficulties, with an increase in mental health difficulties (Cowie and Myers, 2020; UNESCO, 2020), particularly among those already at risk of mental health issues (OECD, 2020b).

Some of the findings of the latest study into students' learning and well-being by the OECD (2020a) on the PISA 2018 results, as well as the WHO Health Behaviour School Checklist (HBSC) study (Inchley et al., 2020) also provide cause for concern. Although the majority of students across the OECD countries reported feeling socially connected at school, around one in four disagreed that they made friends easily at school, and around one in five reported feeling like an outsider at school (OECD, 2020a). On average, children also reported a general decrease in sense of belonging compared with 2015, in line with a

gradual decline over the last 15 years[1]. Similarly, the HBSC study (Inchley et al., 2020) shows that positive gains in relation to various aspects of adolescent health and well-being over the last five years have been overshadowed by overall declines in mental and social well-being. The study reported that since the previous HBSC survey in 2013/2014, fewer adolescents say they like school, and more of them experience intense pressure to do well academically[2]. Many school-aged children reported that they lacked supportive environments, especially as they get older. Such students are missing the academic, social and emotional benefits that attachment to school can bring, with schools called to foster a more positive learning environment, as well as trusting and caring relationships for young adolescents (Inchley et al., 2020). A report just published by UNICEF and the European Union (2021) involving more than 10,000 children aged 11-17 years, found that one in five reported growing up unhappy and anxious about the future as a result of bullying, challenges in coping with schoolwork, and loneliness.

Furthermore, in the PISA results (OECD, 2020a) students attending low-SES schools reported a weaker sense of belonging than their more affluent peers. This difference was found in the majority of European countries (27), including 21 Member States, with the largest differences (aside from Argentina) being recorded in Bulgaria, Hungary and Luxembourg[3]. This is a particularly interesting finding, as a sense of belonging moderates the negative impact of low SES on academic achievement and well-being. Similarly, the WHO HBSC study (Inchley et al., 2020) reported adolescents with low SES received lower levels of support from school peers and friends. The report recommended the need to increase opportunities for social interactions at school, in order to reduce social inequalities in the education and promote the mental health of young people.

1.1 Schools as contexts for mental health and well-being

This social and emotional landscape underlines the need for a relevant and balanced approach to education – one that addresses the social, emotional and mental health needs of children and young people (European Commission, 2020). Schools are key contexts for the promotion of mental health and well-being, having access to all or most children and young people for a considerable time during the day, throughout a critical period during which their personalities and social emotional competences are still developing[4]. The conceptualisation of mental health and well-being has moved away from the traditional model of mental ill health to a broader approach that focuses on positive mental health and well-being, with the school system itself operating as a health-promoting context (WHO, 2020a). It is increasingly recognised that education and schools need to go beyond narrow sectoral goals such as academic achievement, and should contribute more actively to the health and well-being of children and young people. Social and emotional education

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[1] In almost all countries, students were more likely to report positive feelings when they had a stronger sense of belonging at school and greater student cooperation; conversely, those students who were bullied more frequently were more likely to express sadness (OECD, 2020a).

[2] In a study involving 12-year-old students in Estonia, Kutsar et al. (2019) identified peer bullying and teachers' behaviour such as problems in coping with personal distress, as the key factors decreasing the well-being of many students, and causing a dislike for school.

[3] The study found a similar relationship between life satisfaction and socio-economic status, with students from low socio-economic backgrounds being less satisfied than their more advantaged peers. On average, across OECD countries, 67% of students reported being satisfied with their lives, with higher values being observed among many Eastern European countries, whilst Northern and Western European countries were close to the OECD average.

[4] The mental health and well-being of children and young people is a multifaceted phenomenon, and this report's focus on the school context should not be interpreted as indicating that this is an exclusively education-related issue, thus absolving other sectors of responsibility for mental health promotion. Indeed, this report adopts a systemic approach to mental health and well-being, advocating close collaboration between education, health, social services and other agencies.

and initiatives such as the WHO's Health Promoting Schools are two key drivers in this broad and holistic approach to education.

Incorporating programmes aimed at the promotion of mental health and well-being and bullying prevention into schools has been found to be one of the most effective strategies to support the mental health and psychological well-being of children and young people, including vulnerable and marginalised children (Durlak et al., 2011; Goldberg et al., 2019; Tfofi and Farrington, 2011; Weare and Nind, 2011). Mental health and well-being interventions in schools are more likely to have an impact when they adopt a systemic, whole-school approach towards building individual competences, developing school policies, and improving social relationships (Cefai et al., 2018; Goldberg et al., 2019; Weare and Nind, 2011)[5]. The WHO framework for health promotion in schools (WHO, 2020a) stresses the importance of supporting teaching and learning through a school's ethos and environment, as well as family and community partnerships. Within a whole-school approach, mental health and well-being interventions are integrated into daily classroom practice at both curricular and classroom-climate levels, as well as in out of class activities and the whole-school ecology. Such an approach engages all staff at the school, supports parental engagement and collaboration, and coordinates work with services and agencies outside school.

1.2   Objectives

A general consensus exists among EU Member States that academic knowledge on its own is not enough for young people to engage in active citizenship and face the socio-economic realities in their lives, in order to avoid inequality, poverty, discrimination, marginalisation and exclusion (European Commission, 2017). The European Commission's recent review of the Recommendation on Key Competences for Lifelong Learning led to the inclusion of 'Personal, Social and Learning to Learn' (PSLL) as one of the key competences for lifelong learning (EU Council, 2018). The recent European Commission communication on the achievement of the European Education Area by 2025 (EC, 2020) has launched the Pathways to School Success initiative to help all students reach a baseline level of proficiency in basic skills, with a special focus on groups that are more at risk of underachievement and early school leaving. The Communication also provides for the setting-up of an expert group to develop proposals on strategies to create supportive learning environments for groups at risk of underachievement and to support well-being at school (European Commission, 2020). These and other related initiatives at European level, such as policy actions on early school leaving, children's rights and social inclusion, have sent a clear message to Member States regarding the importance of recognising and adequately addressing the social and emotional aspects of education and providing students with a quality education as a trajectory for an active, productive and healthy life[6]. This resonates with the rights of children and young people to physical and mental health, quality education, protection and participation, in line with the UN Sustainable Development Goals (UN, 2021)[7].

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[5] Investing in the mental health and well-being of children and young people produces social and economic returns. Cost-benefit ratios range from 1:11 in the case of social and emotional education (Belfield et al., 2015) to 1:5 in the prevention of depression and anxiety among school children (Chisholm et al., 2016).
[6] In a study involving 1,346 schools in 10 European countries, Patalay et al. (2016) found that many of the schools surveyed reported not doing enough to support their students' mental health, with less than half indicating that mental health was a high priority, and more than half not implementing a mental health policy.
[7] Another recent initiative is the EU Council (2019) Recommendation on a comprehensive approach to the teaching and learning of languages, recommending the adoption of comprehensive language education policies and innovative and inclusive language teaching methods.

This report is in response to these initiatives, particularly the 2020 Communication (EC, 2020) and the recognised need for schools across Europe to actively promote the mental health and well-being of school children within safe and inclusive contexts. More specifically, it seeks to:

- Review the international literature on the promotion of mental health and well-being and the prevention of bullying in schools
- On the basis of the literature review, and in accordance with EU polices, communications and actions, to develop a theoretical framework to guide the way in which the whole-school system, in collaboration with the community, can be mobilised at various levels to promote mental health and well-being
- Identify examples of good practice and projects from various Member States in relation to the promotion of mental health and well-being and the prevention of bullying in schools.
- Make recommendations for the effective implementation of a systemic, whole-school approach to the promotion of mental health and well-being and the prevention of bullying in schools across the EU.

1.3   Methodology

The methodology of this report focuses primarily on the use of secondary data regarding the promotion of mental health and well-being in schools. A review of the international literature – in particular, more recent systematic reviews and meta-analyses and other key studies in the area – was carried out to determine the impacts of interventions on student outcomes, as well as identifying effectiveness processes. The literature review made use of three key academic databases –SCOPUS, ERIC and PSYCHINFO – and focused primarily on review of studies or meta-analyses carried out in approximately the last 10 years. The primary criteria for inclusion were that the reviews had been carried out systematically, paying particular attention (though not exclusively) to reviews based on randomised controlled trials, and which evaluated the quality of the trials and included European-based studies. To merit selection, reviews had to focus on a number of specific areas relating to the objectives of this study, namely: evaluations of whole-school approaches to mental health; social and emotional education; the prevention of mental health issues; school climate, and school bullying. In our discussion of the findings, we pay particular attention to findings that come from large-scale, rigorous reviews or meta-analyses rather than to small reviews that include studies of lower quality. We also undertook an in-depth literature analysis of specific aspects of the whole-school approach such as universal interventions, classroom climate, whole-school ecology, resilience and targeted interventions. Findings in relation to these aspects are presented in separate chapters. We also looked for initiatives and examples of good practice and projects from the Member States with regard to the promotion of mental health and well-being and the prevention of bullying in schools. Reference was also made to EU policy documents, previous NESET reports in the area, such as 'Strengthening social and emotional education as a core curricular area across the EU' (Cefai et al., 2018), and 'How to tackle bullying and prevent school violence in Europe' (Downes and Cefai, 2016); as well as the School Educational Gateway platform and relevant EU-funded projects. This review served to build a theoretical framework to guide the way in which schools can adopt a whole-school approach to promote the mental health and well-being of their members in an effective and sustainable way.

1.4   Outline of the report

The next chapter of this report reviews recent international literature on the promotion of mental health and well-being and the prevention of mental health difficulties in schools, with particular attention to recent review studies (over the last 10 years) as well as studies

carried out within the EU. On the basis of the literature review and in the light of related EU policies, communications and reports, Chapter 3 presents a theoretical framework for an integrated, whole-school approach to the promotion of mental health and well-being in schools, including interventions at curricular, classroom-climate, whole-school ecology and targeted levels. The elements of this framework are described in further detail in Chapters 4-7, specifically: universal interventions (Chapter 4), classroom climate (Chapter 5), whole-school ecology (Chapter 6) and targeted interventions (Chapter 7). Chapter 8 makes various recommendations regarding the effective promotion of mental health and well-being within a whole-school approach across the EU.

2. Review of the international literature

As mental health and well-being interventions are becoming more integrated into schools across EU Member States, and the COVID-19 pandemic underlining the value and relevance of social and emotional dimensions in education, it is necessary to evaluate the effectiveness of such interventions in bringing about positive change in education. This helps schools in selecting and adopting evidence-informed policy and practice, making it more likely for any initiative to achieve its desired impact. In this chapter, we review the recent literature on the impact of mental health and well-being promotion in schools, including research on core areas such as health-promoting schools, social and emotional education, the prevention of mental health problems, the school climate, and bullying. In particular, we focus on recent reviews and meta-analyses. First, however, we will define what we mean by mental health promotion and well-being in school, according to the scientific literature.

2.1 Defining mental health and well-being in school

Traditional definitions of mental health in children and young people have tended to focus on mental *ill* health, such as anxiety, depression and problems with conduct. More recently, however, a movement driven by the World Health Organization among others has sought to distinguish between 'mental health' and 'mental illness'. One of the most commonly used definitions of mental health is that of the WHO (2018), which defines mental health as a state of well-being in which a person realises his or her own abilities and can cope with the normal stresses of life, including a positive sense of identity, an ability to manage thoughts and emotions, to build social relationships, and to acquire an education that allows active citizenship as an adult. This definition is sometimes referred to also as *positive mental health,* to distinguish it from the traditional concept of mental health difficulties or mental illness. *Mental ill health,* on the other hand, refers to mental health issues such as anxiety, depression, self-harm, substance misuse, conduct disorders and eating disorders, the first two being the two most common mental health difficulties among children and young people. In a recent systematic literature review of international research studies on the conceptualisation and measurement of mental health literacy (MHL), Mansfield et al. (2020) reported that the mental ill health approach has continued to dominate the area, with relatively few articles assessing knowledge of mental health promotion. The authors recommended a need to move away from 'mental disorder literacy' towards 'mental health literacy'.

The definition of mental health provided by WHO (2018) refers to a 'state of well-being'. The term *well-being* is frequently used interchangeably with positive mental health, but while various studies define mental health as a component of overall well-being (e.g. Lehtinen et al., 2005), other studies conceptualise well-being as a component of mental health (e.g. Hanlon and Carlisle, 2013). Well-being may be defined as a dynamic state in which children and young people are able to develop their potential, learn and play creatively and productively, build positive relationships with others, and belong to and contribute to their community (cf. WHO, 2018)[8]. Broader definitions of well-being also include physical as well as mental health, quality of life and subjective well-being. *Subjective well-being* includes three different but interrelated components, namely psychological well-being (positive self-esteem, agency, satisfaction with life, hope for the future); emotional well-being (the presence of positive feelings such as happiness and gratitude and absence of negative feelings such as sadness, anger); and social well-being

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[8] Deighton et al. (2016, p.6) provide a definition of well-being formulated by the children themselves: 'Children and young people feeling good, feeling that their life is going well, and feeling able to get on with their daily lives.'

(developing healthy relationships with others; participating in the community and having a sense of belonging) (see Rees et al., 2020).

Brown and Shay (2021) suggest the use of the term well-being instead of mental health, as it implies a universal approach encompassing all students in school, as an educational rather than a health issue. They also argue that the concept of children's well-being may be more easily accepted and integrated into schools in comparison to the more 'polemic' mental health. However, they argue that children's health, welfare and education need to become more 'squarely integrated', as they cannot be addressed through 'separate policy agendas'. Rosen et al. (2020) argue, in fact, for 'creative new collaborations' between health and education in the promotion of mental health and well-being through social and emotional education. Schools are being challenged to move beyond limited and narrow remits to take greater responsibility for public health (Greenberg et al., 2017).

The dual-factor model of mental health (Huppert and So, 2013) construes well-being (life satisfaction, positive affect) and symptoms of distress (internalised and externalised problems) as forming distinct aspects of mental health, rather than being two ends of a single continuum. Patalay and Fitzsimons (2016) investigated the dual-factor model by looking at 12,347 children aged 11 years old from the UK Millennium Cohort Study. They found that mental ill health and well-being are weakly correlated in children, and that the correlates of children's mental health and well-being are largely distinct, with different causal determinants and mediating factors. The authors stress the importance of considering these concepts separately rather than as two ends of the same spectrum. In a more recent study involving middle-school students, Peterson et al. (2020) found that well-being was a key component of mental health in children, underlining the importance of school interventions that focus both on improving well-being, as well as reducing symptoms (mental health problems).

Social and emotional education is the process by which children and adults acquire and effectively apply the knowledge, attitudes and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, build resilience, and make responsible decisions (CASEL, 2021; Cefai et al., 2018). Other terms used interchangeably include social and emotional learning, life skills, soft skills, and social and emotional skills. The EU Lifelong Learning Competence 'Personal, Social and Learning to Learn' (EU (EU Council, 2018) includes a cognitive dimension (Learning to learn) in addition to the usual *intra* (Personal) and *inter* (Social) domains of social and emotional education. This new key competence is defined as 'the ability to reflect upon oneself, effectively manage time and information, work with others in a constructive way, remain resilient and manage one's own learning and career… (it) includes the ability to cope with uncertainty and complexity, learn to learn, support one's physical and emotional well-being, to maintain physical and mental health, and to be able to lead a health-conscious, future-oriented life, empathise and manage conflict in an inclusive and supportive context' (EU Council, 2018).

Definitions of well-being and mental health frequently also include *resilience* as one of important attributes of children's well-being and mental health (e.g. Lubans et al., 2016). Resilience is sometimes construed as a social and emotional competence – that is, the ability to persist and cope with challenges. However, resilience research usually defines resilience as growth and thriving (including well-being and mental health, as well as academic achievement and learning) in the presence of adversity/disadvantage such as abuse, trauma, poverty, a linguistic/cultural/ethnic minority background, violence or civil strife, migration or forced displacement (Masten, 2011). More recent definitions underline the availability of protective and supportive contexts that provide children and young people with the services, support and resources required for positive development (Ungar, 2012).

Mental health and well-being interventions in schools are commonly grouped into a three-level, multi-tiered framework (Suldo et al., 2010). *Universal interventions* (Tier 1) are school- and class-wide prevention strategies that seek to proactively promote students' mental health and well-being. The target audience is the whole school population, and interventions usually include social and emotional education, life skills, mental health promotion, positive youth development, sexual and substance use education, and bullying prevention, among others. Universal interventions seek to reach all students, including those at risk of or experiencing mental health issues, within an inclusive and non-stigmatising context. *Selective interventions* (Tier 2) are addressed towards students who may be at risk of mental health difficulties, such as those from deprived backgrounds or with low SES, students with a migrant background, students exposed to abuse, violence or bullying, and students with learning difficulties or disabilities. Interventions are more focused, and include cognitive behavioural interventions, mindfulness, coping skills, stress management, resilience education and psychoeducational interventions. These are usually held with the whole class or in small groups. *Indicated interventions* (Tier 3) are targeted towards students who are already manifesting symptoms of mental health issues. These involve intensive and personalised one-to-one or small-group therapeutic interventions, such as cognitive behavioural therapy, and usually involve multidisciplinary teams (see Chapter 7). Selective and indicated interventions are sometimes referred to as *targeted interventions*, in contrast to universal interventions.

2.2 A whole-school approach to mental health and well-being

Bronfenbrenner's (1979) socio-ecological framework for child development situates the child within a series of nested social systems, with each layer interacting with the others, and the changes that occur in one layer having an impact on the other layers. Within this framework, mental health and well-being are dependent on the psychological world of each child at the micro level; close contexts such as the family at the meso level; and broader environments such as the school and community at the macro level (Askell-Williams and Cefai, 2017). Contemporary frameworks for mental health promotion in schools typically take a whole-school approach, focusing on aspects of schools such as policies, social relationships and individual competencies (Adi et al., 2007; Weare and Nind, 2011). One of the most commonly used frameworks is the WHO's whole-school approach to mental health promotion based on three interrelated pillars: curriculum, teaching and learning; the school ethos and environment; and family and community partnerships (WHO, 2020a). Rather than being a reactive approach that focuses on mental health issues, a whole-school approach is thus a proactive, comprehensive and systemic approach that focuses on building individual competences, developing school policies, and improving social relationships. Strategies focus on the creation of a school environment that promotes and sustains positive mental health for all school members, with policies, activities and interventions designed to enhance promotive and protective factors, build resilience against adversity, and reduce symptoms of mental ill health (Macnab et al., 2014; Oberle et al., 2016; Weare and Nind, 2011). Interventions are integrated into daily classroom practice at both curricular and classroom-climate levels, into out-of-class activities and the whole-school climate. They engage all staff at the school, support parental engagement and collaboration, and coordinate work with services and agencies outside the school (Cefai et al., 2018; Goldberg et al., 2019; Williams et al., 2020).

Curricular, cross-curricular and extra-curricular activities help to build individual mental health and well-being competences and social relationships. The curriculum facilitates the development of social and emotional and resilience competences such as emotional regulation, overcoming challenges, empathy, establishing healthy relationships, and constructive conflict management (Durlak et al., 2011; Weare and Nind, 2011). Students are also supported in recognising the signs and symptoms of mental health issues in

themselves and others, and taking active steps to seek help for themselves or others (Kutcher et al., 2016). At classroom level, mental health is also facilitated through a positive classroom climate that fosters intrinsic motivation, collaborative learning, safety, a sense of belonging, supportive relationships, inclusion, active participation, and individualised learning support (Cefai et al., 2021; Wang et al., 2020). Health-promoting extra-curricular activities include physical activity and sports, creativity and arts, and nature-based activities (Brown and Shay, 2021; Oberle et al., 2020).

The broader school climate itself pays particular attention to the interpersonal relationships between school members, underpinned by such values as respect, solidarity, diversity, connectedness and collaboration, both among the various members of the school, as well as with the school, parents and professionals (Allen et al., 2017; Brown and Shay, 2021; Thomas et al., 2016). School members are supported in participating actively in the life of the school, with all members having an active voice in what happens at the school. The school provides safe physical and social spaces, with school policies in place that provide clear expectations regarding academic, social and emotional behaviours. These are reinforced by daily routines and school structures, both inside and outside the classrooms (Jones and Bouffard, 2012; Oberle et al., 2016).

Parents and the community also make an active contribution to the school's efforts to promote mental health and well-being. Engaging families and the community as key partners within a whole-school approach to mental health and well-being reinforces the complementary roles of parents and educators and extends opportunities for learning and development across the primary social systems in children's lives (Goldberg et al., 2019). Furthermore, community partners facilitate access to external support and mental health services within the community, thus ensuring that students with mental health issues are provided with the additional support they require (Goldberg et al., 2019). Targeted interventions for students at risk of or experiencing mental health difficulties, organised by the school in collaboration with professionals and mental health support agencies, are an essential component of a whole-school approach to mental health and well-being (Cefai et al., 2018; Weare and Nind, 2011). Targeted interventions support students in overcoming challenges and adversity and preventing mental health issues such as depression, anxiety, anti-social behaviour and delinquency (Twum-Antwi et al., 2019).

Box 1. Health Promoting Schools (WHO)

The **Health Promoting Schools (HPS)** initiative (WHO, 2020a) seeks to promote classroom and whole-school activities that enhance knowledge about health and facilitate healthy behaviours (physical, mental, social) through a whole-school approach. The initiative employs six strategies to promote health and well-being in school. These are school policies, the physical environment, the social environment, the health curriculum, and links to community and health services (WHO, 2020a). Recently, there has been an effort to encourage schools to adopt the HPS model through the 'Making Every School a Health Promoting School' initiative (WHO, 2020b) and the development of global standards for health-promoting schools, including one standard that focuses on creating a safe social-emotional environment for students (WHO, 2020c). HPS has been adopted in numerous schools across Europe. Inchley et al. (2007) identified four processes that are essential for effective HPS: ownership and empowerment, with school staff empowered through 'shared ownership' of activities and active participation in decision making; effective leadership to drive the change and embed the programme into the structure and life of the school; collaboration leading to a common understanding of the underlying principles of the HPS intervention, and the agreement of common goals and expectations; and integration, with the programme permeating all aspects of school life and linking to the core objectives and ethos of the school.

Developed by the authors

More recent frameworks for a whole-school approach to mental health and well-being have taken a socio-ecological perspective, focusing less on policies and structures and more on

social and relational processes such as interpersonal relationships, connectedness and a sense of belonging (Brown and Shay, 2021; Thomas et al., 2016; Glazzard, 2019; Allen et al., 2017). As Glazzard notes, 'a whole-school approach to mental health offers the potential to reshape the identity of the school through prioritising the values of care, respect and empathy above the need to accelerate academic standards' (Glazzard, 2019, p.7). In a large-scale study in Australian schools on understandings of well-being and the school factors that contribute to them, students and teachers understood well-being primarily in terms of interpersonal relationships, in contrast to policy documents, which mainly focused on mental health issues (Thomas et al., 2016). Similarly, Brown and Shay (2021) propose a relational and social identity approach as a viable alternative to existing mental health promotion frameworks in schools. Basing their approach on students' voices, the authors underline the centrality to the well-being of young people of authenticity, relatedness, and connectedness with nature. Among the key processes that are essential to the effective implementation of mental health within the Health Promoting Schools initiative, Inchley et al. (2007) underline the 'rooting' of the initiative into the school, with 'shared ownership, collaboration and empowerment' of the school community, and the programme permeating all aspects of school life and linking to the core objectives and ethos of the school[9]. These and other studies underline the relational, contextual and participatory processes involved in mental health promotion in schools (Rosen et al., 2020).

'The question about the outcomes of the health promoting schools cannot, and should not be limited to narrowly defined health outcomes achieved through single health promotion interventions… health promotion in schools needs to be closely linked with the core task of the school – education, and to the values inherent in education, such as democracy, inclusion, participation and influence, critical literacy and action competence in relation to health' (Simovksa, 2012, p.86).

2.3 What works in the promotion of mental health and well-being in school?

Over the last two decades, there has been considerable growth in mental health research and interventions. Currently, there are thousands of school-based mental health interventions around the world (Weare and Nind, 2011). In this section, we will review the key studies on the promotion of mental health and well-being in schools, focusing in particular on recent reviews of studies and meta-analyses, to identify their impacts on student outcomes, as well as effectiveness processes. The studies will be categorised according to various themes, namely: reviews of whole-school mental health; social and emotional education; prevention of mental health issues; school climate, and bullying. We mainly focus on the key systematic reviews and meta-analyses in each area – in other words, large-scale studies that make use of rigorous quality assessment of the studies; however, we also refer to small and less rigorous reviews, while underlining their limitations.

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[9] O'Toole (2017) argues for a critical pedagogy approach to mental health and well-being, with students becoming more aware of, and more connected to, their broader social, cultural and historical contexts, as well as being more committed to confronting the social injustices that impact children's lives, and collectively seeking to create positive change for themselves and others.

2.3.1 Promoting mental health and well-being within a whole-school approach

Mental health provision in Europe

Patalay and colleagues (2016, 2017) carried out a survey of school staff in 10 European countries, regarding the approaches and interventions used in mental health provision in schools. Close to 1,500 schools from France, Germany, Ireland, Netherlands, Poland, Serbia, Spain, Sweden, the UK and Ukraine participated in the study, with questionnaires mostly completed by the school administration or by teachers. Less than half of the schools (47%) reported that mental health provision was a high priority, while more than half had not implemented a school mental health policy. Half of all schools reported providing insufficient mental health support, with respondents mentioning limited staff capacity, as well as a lack of funding and access to services and specialists, and national policies. While secondary schools were more likely to have a school policy in place and better links with mental health services, existing provisions offered less support than primary schools. On average, schools focused more on universal and whole-school interventions than on targeted interventions, but the focus of provision was more 'treatment-oriented', with most support going to students with learning disabilities (78%) and students with mental health problems (66%) than on the prevention of problems (55%) or the promotion of student well-being (50%). The most frequently used interventions in schools were traditional curriculum and classroom-based, such as social and emotional skills, and anti-bullying interventions, as well as behaviour support and creative activities. More innovative strategies such as mindfulness and the use of designated spaces for well-being had begun to make some headway in European schools, but their frequency among respondents was quite low. Similarly, only around 17% of schools were actively engaged in mental health education, while 27% did not undertake any mental health education at all (Table 1).

Table 1. Mental health interventions in European schools (adapted from Patalay et al., 2017)

	Not at all/ A little (%)	Quite a lot/ Very Much (%)	Average Score
Developing social skills	11	60.9	3.64
Developing emotional skills	19.1	46.8	3.34
Creative activities	9.3	65.4	3.79
Physical activities	5.2	73.6	3.97
Signposting	24.2	38.3	3.19
Peer support	25.6	39.2	3.17
Behaviour support	9.1	65.5	3.76
Designated space for well-being/ mental health support	63.9	16.2	2.18
Infrastructure for extra-curricular activities	27.6	42.9	3.23
Individual therapy	43.9	31.3	2.74
Group therapy	59.2	16.3	2.25
Mindfulness	71.6	8.5	1.99
Anti-bullying programme	21.4	53.2	3.43
Risky health behaviour programme	20.3	50.8	3,38
Mental health education	54.1	16.8	2.39

Adapted from Patalay et al. (2017)

Across the study, no country offered the whole range of integrated targeted and universal approaches that would provide adequate support for all of their students. Barriers preventing schools from providing such interventions included staff capacity, the availability of professionals, and funding. The provision of support appeared to be led by learning and educational support professionals present in many schools, with fewer reported interventions by non-educational professionals such as psychologists. Wide variations existed between countries with regard to the type of professionals involved in

mental health, depending on the country's traditional approach. The authors recommended increased training and support for both staff and parents in relation to awareness, early identification and intervention.

As part of the Joint Action on Mental Health and Well-being under the EU Second Programme for Community Action for Health 2008-2013, *Rampazzo et al. (2016)* carried out an analysis of the mental health and well-being of children and adolescents in 11 European Countries (Croatia, England, Estonia, Finland, Italy, Iceland, Malta, Norway, Slovakia, Spain (one region), and Sweden (one municipality). The review was based on an evidence review and analysis of the situation in each of the participating countries, consultations with experts, and a review of the international literature. The authors found that the school context was the setting of choice for the promotion of mental health and the prevention of mental health problems, with schools collaborating with students, parents and external professionals and agencies within a whole-school approach (cf. Health Promoting Schools). Although a recognition of the importance of mental health and well-being of children and adolescents was noted in the 11 countries, the authors contended that this needed to be given higher priority at European level, as well as by national and regional governments. Although numerous examples of good practice were identified, these were not part of a formal policy framework[10]. At country level, a mental culture of health promotion had not yet been systematically formalised at institutional level. The majority of good practices included in the dataset follow a universal approach, but few targeted (selective) interventions were addressed towards children at risk such as LGBTQI individuals, victims of bullying or children living in poverty. Moreover, the integration into the curriculum of subjects such as mental health promotion and social and emotional education was still either lacking or at a developing stage. The authors also found that while some European countries had developed multidisciplinary teams in and around schools for those children and young people with the highest needs, intersectoral collaboration was weak. The review recommended the need for a process to facilitate the implementation and evaluation of evidence-based interventions, and adequate training in mental health for all professionals, including school staff.

Box 2. Policy recommendations for schools as contexts for mental health promotion

> To promote schools as a setting in which health promotion and the prevention of mental and behavioural disorders and early identification can reach all children and young people:
>
> 1. Recognise the role of early childhood education, school and peer education as having a core function of creating opportunities for collaboration among children, parents, caregivers, teachers, school staff and staff of school medical services, according to a whole-school approach
> 2. Mandate school administrations to develop and formalise a mental health promoting culture in their statute, so as to systematically address risk factors such as bullying and cyber-bullying.
> 3. Actively consult children and adolescents and their families when developing any programmes to ensure their best interests are taken into account, particularly in the definition of objectives and quality criteria.
> 4. Put in place evidence-based interventions to combat early school leaving, since education is a protective factor for the mental health and well-being of children and adolescents.

Rampazzo et al. (2016)

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[10] The WHO Regional Office for Europe (2018) argues that too many countries report that their national school policy does not include mental health promotion.

Health Promoting Schools (HPS)

One of earliest reviews of HPS was the systematic review of reviews by Steward Baron (2006), which focused on 15 reviews conducted between 1997 and 2004, mostly in the USA. The review took a rigorous approach to selecting existing reviews, and included only robust, systematic reviews of RCT trials. Five of the reviews focused on mental health promotion, and three on substance use prevention. The author concluded that HPS are generally effective, with moderate to large effects, but are not always so. In addition, he found that programmes promoting certain aspects of health, such as mental health, are more effective than programmes promoting other areas such as the prevention of substance use. The major finding from this review was that school-based programmes promoting mental health (including the prevention of violence and aggression) were among the most effective in promoting mental health, particularly if they made use of the whole-school HPS framework (i.e. involving the whole school, focusing on the transformation of the school climate and the development of social and emotional skills, and involving the parents and the wider community). These findings contrast with those of a review of 67 RCT studies by Langford et al. (2014). The authors of this latter review did not find any effect of HPS on mental health, violence and bullying. However, only a very small number of the studies reviewed focused on mental health (2), violence (2), and bullying (7). Furthermore, the experimental schools (which included the three dimensions of HPS) were also compared with control schools that implemented one or two dimensions of HPS.

In a more recent review, *Thomas and Aggleton (2016)* synthesised evaluations of HPS published between 2004 and 2014. On the basis of 42 studies, mostly undertaken globally or in the US or UK, the authors reviewed the evidence across six health-related areas: mental health, school connectedness, bullying, substance use, sexual health and access to services. Different types of evaluations and assessments were included, but in their analysis the authors gave priority to findings from high-quality systematic reviews and studies. The authors found that successful mental health programmes shared a number of common characteristics. These were:

- o promoting mental health rather than preventing mental illness;
- o starting early in primary schools and continuing throughout secondary school;
- o including multi-component interventions, with both universal and targeted activities;
- o providing a range of opportunities to develop and practice social and emotional competences;
- o adopting an experiential rather than didactic mode of delivery;
- o making use of targeted interventions for children at risk of, or in the early stages of mental health problems;
- o including teachers' professional development as well as the engagement of professionals in targeted interventions;
- o being actively supported by the school management; and
- o focusing on the broader context such as the positive school climate; and systemic engagement (school, home, community).

The authors concluded that in order for a whole-school approach to mental health and well-being to be effective, it must be well coordinated, well resourced, and supported by outside agencies. In addition, it must involve adequately trained school staff, give students a meaningful and representative voice both in the classroom and across the whole school, and ensure the engagement and support of the parents and the community.

In a review of peer-reviewed presentations regarding what factors contribute to the effectiveness of HPS, *Macnab et al. (2014)* reported that HPS increased health knowledge and developed positive health behaviours among children, and represented an investment in the well-being of the wider community. HPS were more likely to be effective when

programmes were relevant and meaningful to students; were owned by the whole school community, which actively participated in the initiative; included adequate staff training; were supported by local and national institutions, and adopted a flexible and participatory approach. *Samdal and Rowling (2013)* reviewed the literature on Health Promoting Schools, and reported that effective whole-school practices are supported by broad factors at school level relating to the implementation process, such as the school leadership, the school's readiness for change, and organisational support in the school context.

Whole-school approach to mental health and well-being

One of the most important reviews considered in this chapter is the meta-analysis of reviews on mental health promotion in schools carried out by *Weare and Nind* (2011). This is significant not only because of its focus on mental health and its inclusion of a substantial number of reviews from Europe (20 out of 52 reviews), but also because it adopted a rigorous analysis of the quality of the studies (which included an element of control).The great majority of the reviews were evaluations of universal interventions (46) and featured studies spanning the school years. The authors reported that in general, school-based mental health interventions had small to moderate, short-term positive effects on a range of mental health, social, emotional and educational outcomes. They found strong-to-moderate effects on social and emotional competences, and small-to-moderate impacts on commitment to school and academic achievement. They also found small-to-moderate impacts of universal interventions on positive mental health and prosocial behaviour, and a decrease in mental health problems, violence and bullying. Effects were significantly higher, and quite strong, when targeting higher-risk students. Consensus was found across the reviews that the teaching of social and emotional competencies is a central part of any comprehensive and effective intervention, but that the active involvement of teachers and students in the development and implementation of programmes was crucial to ensuring that interventions were relevant and sustainable. The authors found that many of the reviews supported the use of holistic, participatory and interactive approaches in contrast to less effective behavioural, information-based and didactic approaches: 'European theory tends to be holistic, emphasizing not just behaviour change and knowledge acquisition, but also changes in attitudes, beliefs and values, while European health education has long pioneered active classroom methodologies, involving experiential learning, classroom interaction, games, simulations and group work of various kinds' (p.65).

The reviewers also found that an integrated approach to mental health, combining both universal, curricular approaches with targeted interventions for students with mental health issues, provides a more effective environment for students with mental health issues. One of the major contributions of this review is that a whole-school approach was found to be more effective than interventions that focus only on one aspect of the school – a finding that underlines how important it is for schools to promote core values and attitudes such as respect, inclusion, connectedness, and a sense of belonging. The authors concluded that a whole-school approach making use of bottom-up principles such as empowerment, autonomy, democracy and adaptability (e.g. HPS) is more likely to be effective in European contexts that have a tradition of operating in a 'non-prescriptive, flexible and principle-based' manner.

A more recent systematic review by *Goldberg et al. (2019)* included 45 whole-school interventions in social and emotional education, as well as mental health and well-being (28 US; 8 European; 9 other). Goldberg et al. analysed the quality of the studies and classified them into three groups (high, moderate and weak quality); the great majority of the studies were of strong or moderate quality. All studies used an RCT design. Those interventions which were carried out in primary and secondary schools aimed to enhance social and emotional competences or to reduce bullying through the application of a whole-school approach to social and emotional education. All interventions included a classroom

curriculum, strategies addressing the whole-school ethos and environment, and a parental component. More than half also included a community component, and close to half a targeted component.

The authors reported a small but statistically significant positive impact on social, emotional and behavioural adjustment and internalising difficulties. No effect was found on academic performance, however. Interventions that contained a community component showed significantly higher impact in social and emotional adjustment than interventions without such a component. This finding resonates with similar conclusions from evaluations of HPS, underlining the importance of school links with community agencies (MacNab et al., 2014; Thomas and Aggleton, 2016). Although the effect sizes were lower than those of previous meta-analyses of universal social and emotional interventions (e.g. Durlak et al., 2011), the authors refer to previous research that reported difficulties in implementing school-wide interventions, which require considerable planning, resources and training. They illustrate how the SEAL programme in the UK, one of the programmes included in their study, failed to make an impact due to a lack of teacher training and poor-quality implementation. Samdal and Rowling (2013) reported similarly in their review, that whole-school practices were more effective when supported by school-level implementation processes such as management and organisational support.

Finally, the authors found that whole-school interventions evaluated in the US were found to have achieved a significantly higher impact than those evaluated outside the US, such as in Europe. The authors suggest that this may be related to the way schools in Europe operate. In contrast to the US, where interventions are more prescriptive and manualised, European interventions tend to be more flexible and bottom-up, which may be more difficult to organise and implement effectively (Weare and Nind, 2011). Furthermore, whole-school interventions were more likely to be successful when supported by local and national educational authorities (see Barry et al., 2017). Such support may have been more widely available at district and national level in the US than in other countries. The authors quote Oberle et al. (2016) that 'support from the education system at national level has the power to catalyse systemic change at school level by communicating a culture of 'what matters' in school learning... [this] support helps to create the conditions required for a whole school intervention'.

We will also briefly discuss a number of other, relatively small-scale, reviews that include lower-quality studies. These studies are included primarily because they are fairly recent and include a number of European studies; however, the findings from these reviews need to be treated with caution, and corroborated by larger, more rigorous reviews:

- *O'Reilly et al. (2018)*: review of 10 studies on whole-school/child-centred mental health promotion, seven of which are from five European countries. Seven studies were quantitative (not all used experimental design), and three qualitative. Eight studies reported a positive impact, but the authors concluded that there remains a need for a stronger and broader evidence base that focuses on both universal and targeted approaches, to fully address the mental health of students. They underlined the need for long-term, whole-school interventions. The apparent lack of effectiveness of whole-school approaches may be attributed at least in part to poor implementation and a lack of support for teachers delivering the intervention. The authors recommended that schools might need to adapt the scale of their

implementations according to their resources[11], while ensuring adequate teacher education and the active engagement of students in programme development and delivery.

- *O'Connor et al. (2018)*: review of 29 studies (10 European). This review examined whether universal mental health promotion programmes improved children's mental health and emotional well-being. The inclusion criteria used were fairly broad, resulting in many of the studies having one or more identified shortcomings. The authors found positive effects in coping skills, help-seeking and social skills and emotional regulation, and a reduction in symptoms of depression and anxiety. Three major positive outcomes were identified: help-seeking and coping behaviours, improved social and emotional well-being, and increased knowledge of mental health. The review identified the need for a whole-school approach with adequate training for all school staff, and strong links between education and health sectors.

- *Tomé et al. (2021):* review of 19 studies (10 based in Europe) on interventions promoting mental health and well-being in schools; six used RCT and 11 quasi-experimental designs. Most of the studies indicated a positive outcome (though in the case of mental health promotion initiatives, the effect was small), with the results highlighting the importance of a whole-school approach to improve effectiveness.

- *Casañas et al. (2020)*: review of 13 experimental or quasi-experimental studies (five European) on the evaluation of mental health promotion programmes (mostly in secondary schools). Interventions increased mental health knowledge, improved help-seeking and reduced stigma behaviour. The authors emphasised the need for schools to adopt programmes adapted to their contexts and needs.

- *Garcia-Carrión et al. (2019):* review of seven studies (USA/UK) on universal interventions focusing on supportive interactions between students, teachers, families and mental health professionals. Not all studies were experimental, but studies were evaluated for their quality. The authors reported a decrease in disruptive behaviours and symptoms of depression and anxiety, and an increase in social skills and personal well-being. The authors identified various factors that contributed to effectiveness, such as an emphasis on engaging children and adolescents in supportive interactions with peers and significant adults in their lives, and culturally appropriate interventions, particularly with regard to the involvement of families and communities, with schools playing a key role in facilitating family and community involvement.

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[11] Jones and Bouffard (2012) suggest that one way to address the issue of lack of resources in schools is to adopt a continuum of interventions, ranging from full-scale programmes to less intensive evidence-informed strategies and practices ('kernels') integrated into everyday school practices. The latter approach would help schools to integrate these essential and effective kernels into school practices, and to move away from packaged programmes.

Box 3. Promoting Mental Health in Schools (EU-funded project)

Promoting Mental Health in Schools (PROMEHS)[12] is an Erasmus+ Key Actions 3 project co-funded by the European Commission (2019-2022). PROMEHS is designed to develop, implement and evaluate a mental health promotion curriculum in schools, serving to create a bridge between evidence-based school programmes and educational institutions, thus linking research, practice and policies. The project is coordinated by the University of Milano Bicocca, Italy, and includes eight other European partners. The partners have developed a mental health curriculum spanning from the early years to secondary school, with four manuals comprising activities in social and emotional education, resilience building, and the prevention of risk behaviour and mental health difficulties. The curriculum has been implemented by trained teachers with 6,000 students in schools in Croatia Greece, Italy, Latvia, Portugal and Romania, and evaluated using a randomised controlled trial. The curriculum is being evaluated for its outcomes on the mental health and well-being of both students and classroom teachers (Cavioni et al., 2020).The multi-lingual curriculum will be published in 2022.

Developed by the authors

2.3.2 Social and emotional education

In 2018, the European Commission published a NESET analytical report on strengthening the integration of social and emotional education in schools across the EU *(Cefai et al., 2018)*. The report included a qualitative review of 12 reviews of studies and meta-analyses of universal social and emotional education published between 2009 and 2018. These include the most rigorous and large-scale reviews by Durlak et al. (2011), Sklad et al. (2012), Weare and Nind (2011), Taylor et al. (2017), and Wilson and Lipsey (2007). All reviews included only studies that made use of RCT or semi-RCT studies. The report had two main objectives: to evaluate the social, emotional and academic impact of social and emotional education; and to establish the conditions for effectiveness. The authors reported that universal social and emotional education is associated with increased social and emotional competences, prosocial behaviour, mental health and improved academic engagement and achievement, as well as a reduction in mental health difficulties such as anxiety, depression, substance abuse and antisocial behaviour. These positive impacts were found across the school years, from early years through to high school, and across a range of geographical, cultural and socio-economic contexts. Universal interventions have an aggregate positive impact on children, including children at risk of or experiencing mental health issues, and thus serve to reduce socio-economic inequity. Such children would, however, benefit from additional targeted interventions. Interventions were most effective when they began from early childhood education and facilitated both school education and lifelong learning. On the basis of its reviews and other related literature, the report proposed a whole-school approach to social and emotional education – that is, a curricular approach involving direct instruction and transversal implementation; a focus on the classroom and school climates (including policies and practices for behaviour, bullying and diversity); the inclusion of student voices in planning, implementation and evaluation; the active engagement of parents and the community; attention being given to staff education and well-being; targeted interventions for students at risk or in difficulty; and quality implementation balanced with adaptation to the local culture and needs of the school population.

Wigelsworth et al. (2020) carried out a rigorous review of reviews of social and emotional education, to examine classroom activities and school-level processes and practices. These reviews were published between 2004 and 2018, and were located in numerous countries,

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[12] www.promehs.org

with at least 10 reviews involving initiatives based in Europe. The 34 reviews selected were evaluated for quality, and greater weight was given to the findings of those considered to be of high quality; sources with low scores were used only in instances where higher-quality evidence was unavailable. The authors reported that the effect sizes from the major reviews ranged for average to high, showing that universal SEL programmes are effective in promoting social and emotional competences. They found that SEE programmes typically involve classroom activities with teacher guides, to be implemented as part of the curriculum, making use of role plays, role-modelling, storytelling, practical activities, and multimedia aids. The authors report considerable variation in the way programmes are designed and implemented, such as in their duration, content focus and age range.

The authors found that the evidence for a whole-school approach is mixed, with some reviews finding a stronger impact of whole school interventions compared with single component interventions such as curricular programmes, while others did not find such an advantage, or reported lower effect sizes for whole-school approaches. These variations relate in particular to the complexity of implementing multi-component interventions (Goldberg et al., 2019) and the need for adequate and appropriate teacher education in whole-school implementation. The authors conclude that there is a need for further empirical data to determine how multi component interventions can be effective. Finally, the authors report that the evidence for the impact of interventions on different sub-populations of students is also mixed. Students with low SES obtained similar outcomes to their more privileged peers, suggesting a compensatory process that levels the pre-post test difference and thus operates as a lever for equity. Evidence of impact on racial/ethnic minority students was mixed, with indications of little distinct difference in programme effects. With regard to individual educational needs and disabilities, some evidence suggested that social and emotional education benefits certain special educational needs, such as Attention Deficit Hyperactivity Disorder. Finally, the authors report that those whose mental health is at risk may benefit in particular if interventions take place early before mental health issues become fully developed.

In a review of the evidence of universal social and emotional education interventions, *Domitrovich et al. (2017)* identified three levels of evidence of the positive impacts of socio-emotional education. The first level consists of longitudinal research showing that social and emotional education promotes success in key developmental areas in childhood and adolescence, and also moderates the relationship between risk factors and developmental outcomes, thus serving as a driver of resilience. This indicates that social and emotional education is a key factor in preventing early school leaving by increasing the likelihood of successful post-secondary education and enhancing career prospects, in addition to positive socio-emotional outcomes in adulthood. The second level of evidence comes from interventions aimed at promoting social and emotional competences, with various meta-analyses showing that such programmes enhance social and emotional competences, positive social behaviours and academic achievement, while reducing aggressive behaviour, substance use and emotional distress. These effects apply to all children in the school (and in some instances, have more impact on vulnerable children), and also persist over time. The third level of evidence comes from studies with students at risk. These show that that such interventions promote social and emotional competences that mediate the relationship between risk factors and developmental outcomes. Overall, the authors conclude that in addition to direct instruction regarding social and emotional competences, a parallel focus on the classroom and school climates is equally important, and that interventions led by trained school staff are equally or more effective than those implemented by external professionals.

An interesting conclusion by the authors is that universal interventions for the whole student population have a higher impact on public health than targeted interventions, since epidemiological research indicates that mental health problems will become more prevalent

in the general population than in the sub-population in which mental health issues are present. Greenberg et al. (2017) describe this as the 'prevention paradox', explaining that 'a large number of people exposed to a small risk may generate many more cases [of an undesirable outcome] than a small number exposed to a high risk' (p.13) Universal interventions can thus impact the social and emotional development of students who would otherwise not receive the support they need through targeted interventions, while doing so using an inclusive, non-stigmatising approach (Stallard et al., 2012). Furthermore, universal interventions help to raise the overall positive adjustment of all school children while informing interventions for those who need additional support. Woods and Pooley (2016) similarly argue that universal (and selective) programmes will have the highest payoff in terms of reducing the population-wide incidence of mental health issues; however, these need to be delivered before the emergence of mental health problems at the onset of adolescence.

Other reviews of social and emotional education such as Durlak et al. (2011), Goldberg et al. (2010), Sklad et al. (2012) and Weare and Nind (2011), are included in the previous section and in Chapter 4.

2.3.3   Prevention of mental health problems

In a meta-analysis of the effectiveness of school-based mental health services for primary school children delivered by school staff, *Sanchez et al. (2018)* reviewed 43 controlled trials evaluating a total of around 50,000 school children. These studies were rigorously evaluated for quality. Most of the studies were on universal interventions implemented by teachers, which addressed internalising and externalising behaviours, mental health issues and substance use. The authors found a small-to-medium effect size in decreasing mental health problems, with the largest effect being for indicated interventions, followed by selective interventions. Interventions had a stronger effect when they were integrated into students' academic learning, occurred multiple times during the week, included contingency management techniques, and targeted externalising behaviours. The authors argue, however, that teachers need to be adequately trained and supported in providing such support to their students.

Dray et al. (2017) carried out a systematic review of 49 universal school-based, skills-focused interventions targeting child and adolescent mental health in primary and secondary schools. The RCT/CRCTs, which involved a total of 41,521 participants, were conducted with children (19) and adolescents (38) across 16 countries (13 in Europe). All trials were school-based and included universal components only. The largest number of interventions were based on cognitive behavioural therapy (CBT) techniques, but various other approaches were used including social and emotional competences, coping skills, psychological well-being therapy, mindfulness, and mental health promotion. The authors found that interventions were effective in relation to reducing depressive symptoms, internalising problems, externalising problems, and general psychological distress. A reduction was seen in anxiety symptoms and general psychological distress among children, and in the internalising of problems by adolescents. Effect sizes were small to moderate, with follow-up effects found only in relation to internalising problems. In contrast to other approaches, CBT was found to be more effective at reducing the

symptoms of depression and anxiety, as well as general psychological distress[13].

Werner-Seidler et al. (2017) conducted a comprehensive systematic review and meta-analysis of RCT trials of school-based psychological programmes to prevent depression and/or anxiety. The review consisted of 81 studies (evaluated for quality and risk of bias) involving 31,794 students (aged 5 to 19 years). Most of the studies came from North America, with 16 based in Europe. More than half of the studies (44) were universal interventions, while 32 were targeted interventions. The authors found small effect sizes immediately post-intervention for both depression and anxiety prevention programmes, as well as small effects after 12-month follow-up for both depression and anxiety. They also found that universal depression prevention programmes had smaller effect sizes at post-test when compared with targeted ones, while effect sizes were comparable in the case of anxiety. The authors concluded that targeting both types of interventions in schools may be more effective, and suggest a staged approach, with universal interventions followed by targeted interventions for students at risk or experiencing difficulties[14]. There was some evidence that externally delivered interventions had more impact than those delivered by school staff for depression, but not for anxiety. No difference was found between trials making use of CBT strategies and other forms of intervention (e.g. social and emotional education, mindfulness). The authors conclude that high-quality, school-based prevention interventions have the potential to reduce mental health difficulties and promote mental health.

Stockings et al. (2016) carried out a meta-analysis of 26 review studies reporting on 146 RCTs (involving a total of 46,072 participants). These trials comprised 54 universal, 45 selective and 47 indicated interventions for the prevention of depression and anxiety among children and adolescents. Most of the studies made use of psychological interventions such as CBT and were carried out in schools, mostly by clinicians or trained experts. Studies were evaluated for quality and risk of bias. The authors reported that interventions, whether universal or targeted, were effective in reducing the onset of depression and anxiety in children and adolescence. For universal interventions only, reductions occurred up to 12 months post-intervention, while in the case of selective and indicated interventions, reductions were short-term. This finding indicates the need for universal preventive interventions as an early intervention for children at risk, as well as the need for repeated and continued support for children and young people at risk and those with mental health difficulties throughout their school years. The authors also found that psychological interventions such as CBT, provided together with educational material, were more effective than either educational (provision of information) or physical (physical exercise such as team sports) interventions. Finally, in the case of universal interventions, a positive effect was found with regard to the onset of mental health problems if teachers (or other school staff) delivered the interventions, as opposed to clinicians or clinical researchers. This finding again underlines the role of schools and school staff in preventing mental ill health and promoting positive mental health at a critical time in young people's development.

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[13] *Woods and Pooley (2016)* undertook a review of 12 studies on programmes aimed at preventing depression and anxiety during the transition from primary to secondary school. Most programmes made use of CBT interventions. The authors found that the majority of the programmes had a positive effect when implemented rigorously, and that universal and selective interventions can help to prevent the incidence of depression and anxiety in early adolescence. They concluded that sustained results can be obtained when universal interventions are delivered before adolescent depression and anxiety symptoms begin to emerge.

[14] In their review of 28 RCTs consisting of both universal and targeted interventions to prevent mental health problems in adolescence, *Corrieri et al. (2014)* suggested a mixed approach that makes use of both universal and targeted interventions in schools so as to achieve as broad a reach as possible. The authors found that most interventions were effective, both for depression (65%) and anxiety (73%), but the overall mean effect sizes were small.

Caldwell et al. (2019) carried out a review of 137 experimental studies on school-based interventions to prevent depression and anxiety in primary and secondary schools. The reviewers carried out a rigorous quality assessment of the studies, concluding that 'most studies were at unclear risk of bias for random sequence generation and allocation concealment'. They underline the need for universal as well as targeted interventions, and for a whole-school approach in addition to classroom-based programmes. They report weak evidence to suggest that CBT interventions might reduce anxiety in primary and secondary settings. In universal secondary settings, mindfulness and relaxation-based interventions showed a reduction in anxiety symptoms. There was a lack of evidence to support any one type of intervention being effective in preventing depression in universal or targeted interventions. School-based interventions that focus solely on the prevention of depression or anxiety were found to be ineffective, and need to be part of a multi-level, systems-based approach. This finding also emerged from the review by Williams et al (2020), who concluded that single-faceted school-based anxiety and depression programmes had a limited impact and need to be replaced by the more feasible and promising whole-school approach to mental health.

These and other studies are discussed further in Chapter 7.

Box 4. Promoting resilience to prevent mental health difficulties

Fenwick-Smith et al. (2018) carried out a relatively small-scale systematic review of universal, resilience-enhancing programmes in primary schools. The review consisted of 11 papers (six published in Europe) evaluating seven mental health promotion programmes specifically targeting resilience, such as social and emotional competences, mindfulness, stress management, and emotional well-being programmes. The studies made use of quantitative, qualitative or mixed designs, and were evaluated for the quality of their methods. Ten out of the 11 studies reported positive outcomes, with improvements in resilience and protective factors, including frequent use of coping skills, decrease in internalising behaviours, and the enhancement of self-efficacy. Effectiveness factors included implementation by the teachers themselves (making it easier to adapt the programmes to respective groups, and to implement them in the curriculum if provided with support and training), as well as the adaptation of programmes according to students' learning, literacy and mood. The authors concluded that while children at risk benefitted more from these programmes, the interventions are indicated for all students as a strategy for mental health promotion and the prevention of mental health issues.

Developed by the authors

2.3.4   School climate, connectedness and sense of belonging

'School climate' refers to the 'pattern of students', parents', and school personnel's experience of school life [that] reflects norms, goals, values, interpersonal relationships, teaching and learning practices, and organizational structures' (National School Climate Council, 2007, p. 4). In their integrative review of school climate, *Thapa et al. (2013)* identified five key dimensions of school climate. These are safety (physical and socio-emotional safety, norms and rules including those related to bullying prevention); relationships (connectedness/engagement, respect for diversity, social support, leadership, and students' race/ethnicity and their perceptions of school climate); teaching and learning (social and emotional education, support for academic learning, support for professional relationships, and teachers' and students' perceptions of the classroom climate); institutional environment (physical environment and school connectedness/engagement); and school improvement. On the basis of 206 studies, which included experimental studies (5%), correlational studies (45%), literature reviews (25%), and other descriptive studies (25%), the authors reported that the school climate has a

strong impact on students' mental health and well-being[15], and is critical to effective risk prevention and health promotion interventions. In middle and/or high school, it has been found to promote positive self-concept, self-esteem, and emotional and psychological well-being, and to decrease mental health problems, drug use and absenteeism. School climate was also found to enhance motivation for academic learning and achievement, as well as moderating the negative impact of socio-economic status on academic achievement, preventing early school leaving, and decreasing aggression, bullying and sexual harassment. The authors concluded, however, that there was a need for more rigorous and empirically sound research.

In their systematic review of studies, *Aldridge and McChesney (2018)* analysed 48 studies (2000-2017) conducted in 16 countries. These comprised studies conducted in North America (28), Europe (8), and Australia (7). The review selected peer-reviewed studies that had been published since 2020 and focused on one or more aspects of the school climate and mental health. The authors reported a clear association between the school's psychosocial climate and adolescent mental health. Positive relationships with teachers and peers (respect, connectedness, support, respect for diversity, and lack of bullying), positive perceptions of school safety (such as policies and the clarity of rules and their enforcement) and of school connectedness and belonging, were associated with an increase in psychosocial well-being and prosocial behaviours, and a decrease in mental health problems and risk behaviours. In particular, social connectedness and relationships appeared to be one of the strongest factors related to mental health, well-being and the prevention of risk behaviours. No evidence was found for relationships between the academic environment and psychosocial well-being or prosocial and preventive behaviours. The authors concluded that these findings support the role of schools and school staff in the promotion of mental health and well-being, with a particular focus on improving social connectedness and relationships at school, as well as students' sense of belonging and of safety, and the school-level academic environment. Since most of the studies were non-experimental and cross-sectional, the authors caution that one needs to speak of relationships rather than causality. They emphasise the need for more rigorous research to provide stronger evidence on the complex relationship between school climate and student outcomes.

Various studies have also focused on particular aspects of the school climate such as school connectedness and sense of belonging and community, and found that these are similarly related to students' mental health and well-being (e.g. Carney et al., 2018; Lester et al., 2013; Prati and Cicognani, 2021). *The PISA 2018 (OECD, 2020a)* results in relation to students' sense of belonging found that students who reported a sense of belonging to their school had better literacy scores, reported higher levels of peer co-operation, and were also more likely to expect to complete a university degree. Although the majority of students across the OECD countries reported that they felt socially connected at their school, around one in four reported problems in making friends easily at school; roughly one in five felt like an outsider at school; and around one in six reported feeling lonely at school. On average, there has been a general decline in children's sense of belonging over the last 15 years. Furthermore, students attending low-SES schools reported a weaker sense of belonging than their more affluent peers. Similarly, the latest WHO study on children's health and well-being (Inchley et al., 2020) reported a decrease in students liking for school, and an increase in intense pressure to do well academically since the previous study.

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[15]A recent study involving 23,215 primary school children in the UK, Patalay et al (2020), reported that between 29.5 and 48.8% of the variation in children's mental health outcomes that is attributed to school factors, is explained by school climate. A positive school climate was associated with lower emotional and behavioural symptoms and a lower likelihood of mental health difficulties.

School connectedness also serves as a protective factor against mental health issues during times of stress such as the transition from primary to secondary school. In a longitudinal study involving 3,459 Australian students, *Lester et al. (2013)* investigated students' attitudes and experiences of bullying victimisation and perpetration during the transition from primary school to secondary school. They found that during the first two years of secondary school, an increased sense of connectedness to school was associated with reduced depression and anxiety, while increased depression and anxiety were associated with reduced connectedness to school. They concluded that this association indicates the need to intervene during the transition period to improve students' mental health and well-being (see Box 5)[16].

Box 5. Relationships and school transitions

Kiuru et al. (2020) carried out a longitudinal study in Finland into the impact of interpersonal relationships and sense of well-being on academic achievement during the transition from primary to secondary school. Data from 848 students (average age 12.3 years) showed that high-quality relationships promoted higher academic achievement through increased well-being, while high well-being promoted higher academic achievement through the increased quality of interpersonal relationships. The authors conclude that promoting learning and helping students with challenges during transitional periods supports well-being and the formation of high-quality interpersonal relationships.

Developed by the authors

2.3.5 Bullying

Prevalence

In 2018, 25% of young people in Europe reported having been bullied at school (UNESCO, 2018). In a meta-analysis of 66 systematic reviews and meta-analyses, *Zych et al. (2015)* found that victimisation by bullying is associated with psychosomatic symptoms, sleeping problems, psychotic symptoms both concurrently and later in life, suicidal ideation, depression, internalising and externalising symptoms, carrying weapons, lower academic achievement (all with a high effect size); and loneliness, general and social anxiety, suicidal behaviour, and lower general and social self-esteem (medium effect size). Perpetration of bullying was associated with violence later in life, carrying weapons, drug use, suicidal ideation (all high effect size); and offending later in life, and suicidal behaviour (medium effect size).

Being a passive bystander in bullying situations is also connected with potential negative outcomes for young people's mental health. Witnessing bullying or cyber-bullying increases children's level of stress (Caravita et al., 2016), while passive bystanders also develop more negative attitudes towards the victims, as well as attitudes of self-justification of bullying, which can lead to the active perpetration of bullying (Killer et al., 2019). Hence, in order to moderate the negative impact of bullying on the mental health of all students exposed to bullying, including passive bystanders, whole-school anti-bullying interventions need to be implemented, mitigating the negative outcomes of bullying directly by preventing it, and indirectly by improving students' socio-emotional and coping resources.

In one of the most recent meta-analyses (comprising 100 studies) on school-based anti-bullying interventions, *Gaffney et al. (2019a, 2019b)* identified 65 programmes whose effectiveness was tested via randomised controlled trials, quasi-experimental or age-cohort

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[16] In a review of 12 studies on the prevention of depression and anxiety during the transition from primary to secondary school, Woods and Pooley (2016) found that the majority of the interventions had a positive effect when implemented well, helping to prevent the incidence of early adolescence depression and anxiety.

designs. All 65 interventions were found to be effective in reducing the perpetration of bullying by around 19-20%, and bullying victimisation by 15-16%. Nevertheless, variations existed in the effectiveness of these programmes, indicating that various factors can moderate programmes' effectiveness.

Geographical area

The effectiveness of school-based programmes varies between countries. In Europe, Gaffney et al. (2019a; 2019b) found the greatest reduction in the perpetration of bullying in Greece (40%), followed by Norway and Italy, and the highest reduction in victimisation in Italy (31%), followed by Spain (28%), Norway (23%), Finland, Germany and the UK (approximately 8-12%).
Variations in the effectiveness of school-based anti-bullying interventions across geographical areas have also been reported with reference to the same intervention programme, such as KiVa Koulu (KiVa). Large-scale randomised controlled studies carried out in Finland showed that KiVa is effective in reducing bullying perpetration and victimisation among both 4th to 6th graders (Kärnä et al., 2011), and among 1st to 3rd graders (Kärnä et al., 2013). The programme also achieved a positive effect among 7th to 9th graders, even though these results were weaker and more mixed when compared with those of younger children (Kärnä et al., 2013). In a randomised controlled trial study in the Netherlands involving 4,383 students in the 3rd and 4th grades, a stronger and more significant reduction in self-reported victimisation and bullying was reported in KiVa schools in contrast to the control schools (Huitsing et al., 2020). A study at 41 primary schools (7-11 years old) in Wales reported a significant reduction in victimisation and bullying perpetration after one year of implementation of two KiVa units (Clarkson et al., 2019). However in a randomised controlled trial in 22 primary schools (7–11 years) in Wales, Axford et al. (2020) found no significant decrease in victimisation in 11 KiVa schools compared with 10 control schools. These studies underline the cultural sensitivity even of widely validated interventions when implemented in different contexts. Variations in programme effectiveness across geographical areas might also reflect differences in society, e.g. in the rates of violence prevalent within the community.

Age of students

Recent meta-analyses of school-based bullying prevention studies (Chalamandaris et al., 2017; Yeager et al., 2015) indicate stronger effects among primary school students than among those at secondary school. *Yeager and colleagues (2015)* found that interventions were effective up to grade 7, but not effective in grade 8, and that they may lead to an increase in bullying in grades 9 to 12. This finding is in line with those of Kärnä et al. (2013), suggesting weaker and less consistent effects of KiVa among 7th to -9th-graders compared with younger children. Lower effectiveness of interventions among adolescents may depend on the implementation of the strategies used (e.g. direct instructions or skill repetition, which are more effective with younger children), an emphasis on activities facilitating basic social skills that have already been developed in adolescence, and the focus on direct forms of bullying rather than indirect and relational forms (more common in adolescence) (Yeager et al., 2015). In adolescence, activities based on peer-education and support might be more effective, as at this age peers become a more relevant source of socialisation.

Programme components

Gaffney et al. (2019b) identified four programmes (out of 65) that had been tested more than twice, and therefore produced more reliable data on the effectiveness of single components: KiVa Koulu, NoTrap! (Menesini et al., 2012), Olweus Bullying Prevention Program (OBPP; Olweus, 1993) and the Viennese Social Competence Program (ViSC; Gradinger et al., 2015). These four programmes were developed and tested mainly in

Europe, and share a systemic theoretical model of bullying. KiVa, OBPP and ViSC include interventions that target all the individuals who are involved in students' lives (teachers and school staff, peers, parents and the community), as well as specific training for teachers, curriculum activities, and work on classroom rules. NoTrap! has been developed to be implemented in secondary schools, and is based on a peer-education approach, also implemented through online forums.

Gaffney et al. (2019b) found that OBPP is the most effective programme in reducing the perpetration of bullying: 35% in Europe and 25% in US. KiVa produced a marginally significant reduction (9%) in bullying perpetration. Both OBPP and KiVa include components addressing parents (information on bullying) and teachers/school staff (training in confronting bullies and supervising hotspots). These components, in particular the supervision of hotspots, seem to be particularly effective (Ttofi and Farrington, 2011). Saarento and colleagues (2015) also showed that KiVa reduces the perpetration of bullying through changes in students' perception of their teachers' bullying-related attitudes, highlighting the need to address teachers in interventions. A reduction in bullying victimisation was produced by OBPP (29% in Norway vs. 11% in US) and KiVa (11%), but the highest decrease (37%) was reported for NoTrap!, suggesting that peer involvement is particularly effective in reducing victimisation. This effect may be strengthened through the use of online forums in NoTrap!, as such online settings may promote victims' disclosure (Gaffney et al., 2019b).

When considering all 65 programmes (Gaffney et al., 2021), bullying perpetration was reduced as a result of a whole-school approach to bullying, anti-bullying policy, classroom rules and management, cooperative group work and curriculum material, information for parents, informal peer involvement, working with victims, and mental health intervention. Bullying victimisation was reduced only through information for parents and informal peer involvement. Accordingly, in their meta-analysis of 13 studies, *Lee et al. (2015)* found that programmes that included training in emotional control, peer counselling and school policy, had the greatest impact on victimisation. Lastly, *Ttofi and Farrington (2011)* highlighted that those programmes that achieved the greatest impact in terms of reducing both perpetration and victimisation were the most intensive ones, with the longest duration, and which included parent training, improved playground supervision, and firm disciplinary methods.

Individual susceptibility

Aside from age, the effectiveness of school-based programmes is also moderated by other individual characteristics. Some evidence exists that school-based interventions are more effective in reducing bullying perpetration and victimisation among boys rather than girls (Kennedy, 2020), possibly because boys are involved in more direct forms of bullying. In a study involving 9,122 students between the 2nd to 5th grades (Kaufman et al., 2018), KiVa had less impact in reducing victimisation among victims with a high trajectory of victimisation, who reported high levels of internalising symptoms and peer rejection, and had low-quality relationships with their parents. School-based interventions may also have a negative impact on certain clusters of victims. Huitsing et al. (2020) found that at a one-year follow-up assessment, victims of ongoing or new victimisation reported higher depressive symptoms in KiVa schools than in control schools. One possible explanation is that in the intervention schools, the students who continue to be victimised may blame themselves and evaluate themselves more negatively, thus increasing the risk of depression (Garandeau and Salmivalli, 2019). In similar situations, additional indicated interventions should be considered to support the victims.

Perpetrators are characterised by different levels of peer popularity status, different motivations to bully, and different social competences. Thus, there are popular, socially

competent perpetrators, popular, moderately skilled perpetrators and unpopular, less socially competent perpetrators (Peeters et al., 2010). This latter cluster of perpetrators is likely to overlap with the group of victims of bullying (Menesini and Salmivalli, 2017). Less socially competent perpetrators and victims of bullying are likely to benefit more from school-based programmes that include interventions to develop social and emotional competences. Popular, socially competent perpetrators, who are do not lack socio-cognitive competences but mainly bully to maintain their own status among peers, may be more sensitive to school-based interventions that focus on peer group dynamics to promote anti-bullying and pro-defending attitudes among bystanders (e.g. KiVa).

In a systematic review of 40 studies on empathic competences related to bullying, *Van Noorden et al. (2016)* found that the perpetration of bullying is associated with lower social competences in the affective component of empathy (i.e. the skill of sharing others' emotions), whereas lower competences in the cognitive component of empathy (i.e. the ability to understand others' emotions) are more typical of victims. Defending victims is associated with competence in both affective and cognitive empathy. These results highlight the fact that interventions should include universal interventions such as curriculum activities, targeting both the cognitive and affective components of empathy, with the aim of promoting more positive pro-victim attitudes and the active defending of victims among all students. Indicated interventions that focus on the individual components of affective and cognitive empathy may be added, targeting perpetrators and victims, respectively.

Box 6. Evaluation of interventions to prevent school bullying

Differences in the effectiveness of school-based anti-bullying interventions may also reflect discrepancies in the methods used. There is a need to develop common frameworks and recommendations to standardise the evaluation and implementation of intervention programmes (Chalamandaris et al., 2015). Moreover, there is the possibility of a gap between the intervention research upon which the programmes are developed, and their implementation by practitioners who receive this mandate from local authorities. These two lines of work need to be integrated more systematically, by developing a more active dialogue between researchers, practitioners and policy makers.

Developed by the authors

2.4 Conclusions

Despite a number of limitations to current research, and numerous calls for more rigorous research into whole-school approaches to mental health and well-being, evidence from the various reviews and meta-analyses of studies on mental health promotion, social and emotional education, the prevention of mental health issues, school climate and bullying, indicates that school-based interventions to promote students' mental health and well-being are more likely to be effective if they are organised within a systemic, whole-school approach. Whole-school interventions have a more positive impact on student outcomes than individual components such as standalone programmes, provided they are implemented well, are integrated into the fabric of the school context, and are sustained over time. A whole-school approach mobilises the various resources of the whole school community, including the active engagement and voices of students, staff, parents and professionals, towards a collaborative effort to promote the mental health and well-being of all the community.

Well-implemented whole-school interventions have a positive impact on a range of mental health, social, emotional and educational outcomes. These include an increase in mental health literacy, social and emotional competences, positive mental health and social and emotional well-being and prosocial behaviour, as well as a decrease in mental health

symptoms and problems such as depression, anxiety and substance use, anti-social behaviour, violence and bullying. Mental health promotion also helps to challenge negative views of mental health, leading to a reduction in stigmatising behaviour. Various reviews also report an impact on students' commitment to school and their sense of belonging to the school, as well as enhanced motivation towards learning and higher academic achievement. Whole-school interventions are also a key factor in preventing early school leaving by increasing the likelihood of successful post-secondary education and enhancing career prospects and success. Lastly, in many instances such interventions have a positive impact on children at risk of, or experiencing, mental health difficulties (e.g. by moderating the relationship between risk factors and developmental outcomes), thus serving to promote resilience and reduce socio-economic inequality.

The reviews discussed in this chapter have also identified various processes that have contributed to the success and effectiveness of the interventions studied.

- One of the most consistent and clear findings is that the promotion of mental health and well-being in schools needs to be organised according to a systemic, multi-level approach, at curricular and contextual levels, and involving the whole school community, as well as the local community and support agencies. Standalone, time-limited programmes that focus only on one component are unlikely to achieve a significant lasting impact on student outcomes.
- A whole-school approach to mental health and well-being should include the following key components:
  - o Universal interventions, including social and emotional education, resilience building, and mental health literacy, integrated into the curriculum from the early years to high school.
  - o Positive classroom and school climates, with a focus on caring and supportive relationships, collaboration, diversity and inclusion, and addressing school issues such as bullying and undue academic pressure on students.
  - o School-wide expectations and rules informing the behaviour of the whole school community, guided by such values as connectedness and collaboration.
  - o The active engagement by parents and the local community.
  - o Targeted interventions for students at risk of or experiencing difficulties, starting as early as possible and with the support of professionals and agencies within a transdisciplinary approach. An integrated approach that combines both universal, curricular approaches and targeted interventions for students with mental health issues, provides an effective environment for students with problems, with universal interventions being more effective in promoting health and preventing ill health, and targeted interventions being more effective in reducing mental health issues. Targeted interventions usually involve support staff and professionals from other sectors and services.
- Interventions led by trained school staff, particularly universal interventions, are equally or more effective than those implemented by external professionals. Teachers have more opportunity to encourage students to apply in practice the skills they are learning, and are better able to adapt the interventions according to students' needs and level. However, in order to do this effectively, they need to be adequately trained and supported. In the case of targeted interventions – particularly indicated interventions for students experiencing mental health issues – the role of support staff and professionals becomes more central, though teachers still play an active role in supporting such students in collaboration with professionals and parents.

- Close links are needed between education and health, with schools establishing close collaboration with professionals in support services in their efforts to mobilise the necessary resources to support the mental health and well-being of students as part of an inter-sectoral transdisciplinary approach.
- The education, mental health and well-being of adults such as the school administration, school staff, parents and carers, has a direct impact on the mental health and well-being of students, and should therefore be targeted for intervention within a whole-school approach.
- Teacher education in mental health promotion as well as in relational, child centred and collaborative pedagogy, both at initial level and through continuing professional development, is crucial to the success of mental health promotion in schools. Areas for education include mental health promotion, implementing mental health programmes in the classroom, creating a positive classroom climate, constructivist and collaborative pedagogy, dealing effectively with bullying, working collaboratively with colleagues, parents and professionals, identifying the symptoms of mental health difficulties in students, developing their own social and emotional competences, and taking care of their own health and well-being.
- Culturally appropriate and sensitive interventions at both universal and targeted levels are another effectiveness process. Schools can also play a key role in facilitating family and community involvement and positive interactions among the school's members.
- Attention must be paid to the mental health needs of vulnerable and marginalised students who are more at risk of mental health problems, such as those coming from low-SES or migrant/ethnic backgrounds, children exposed to abuse, violence and bullying, and children who have experienced other forms of trauma. Mental health interventions at school may thus serve as a lever for equity – particularly if they begin early, before mental health issues develop into serious and chronic conditions.
- Quality implementation, monitoring and evaluation are particularly important for the success of school-wide and sometimes complex interventions. A whole-school approach requires considerable planning, resources and training, and the lack of impact reported in some of the studies may be explained in part by the lack of quality implementation. Supportive policies, structures and practices are key to sustaining the quality of implementation and the sustainability of the whole project. This requires effective leadership and organisational support to drive the change and embed the interventions into the structure and life of the school.
- A participatory, flexible, bottom-up approach is required, based on empowerment, autonomy, democracy and adaptability to local context. The sustainability of successful interventions is dependent on their adaptation and fit with the ecology of the school and community. School staff, students and parents need to be actively involved in the planning and implementation of interventions. Behavioural, information-based and didactic approaches appear to be less effective in European contexts.
- A strong and representative student voice, both in the classroom and across the whole school, including in the co-design and implementation of interventions, is necessary for students to 'own' and identify with the interventions and to foster a sense of belonging, which is one of the underlying mechanisms for effectiveness
- The active involvement of the local community and agencies is essential for the success of a whole-school approach, providing much-needed support and resources, while serving to embed its principles and practices into the heart of the local community
- In view of the resources and 'culture change' required, whole-school interventions are more likely to be successful when supported by local, regional and national educational authorities. Such support helps to create the conditions required for

whole-school interventions by advocating policies for a whole-school approach and providing adequate resources for implementation.

The next chapter presents a theoretical framework guiding how schools can promote mental health and well-being within a whole-school approach, informed by a set of principles and the evidence reported in this chapter.

3. An integrated framework for the promotion of mental health and well-being in schools in the EU

On the basis of our analysis of the studies in the previous chapter, and in view of recent EU policies, communications and reports, this chapter presents an integrated framework for a whole-school approach to mental health and well-being, encompassing interventions at curricular and contextual levels, universal and targeted interventions and the involvement of the whole school community. This chapter will first present the key principles underlying the framework, followed by a description of the various components of the framework. The various elements of the framework are then described in more detail in Chapters 4-7. Figure 1 illustrates the three elements of the framework: the set of principles that inform the framework; the key components at classroom, school and intersectoral layers; and the sustainability processes supporting the whole-school approach. The concentric elements revolve around the students, facilitated by interventions in the classroom and whole-school layers, supported by the whole school staff, peers, parents, as well as an intersectoral layer focusing on collaborative, targeted interventions supported by the local community and external professionals and agencies. The layers are circular, and influence and contribute to one another. The framework focuses on universal mental health and well-being for all school children as a major goal of the school, complemented by targeted interventions for students at risk of, or experiencing, mental health difficulties. In addition, the framework also focuses on the education, mental health and well-being of the adults who work with school children, namely teachers and parents.

3.1 Key principles

3.1.1 Based on children's rights

The UN Sustainable Development Goals (UN, 2021) underline the rights of children and young people to health care, quality education, protection and participation, among others. These rights contribute directly to the goals of a whole-school approach to mental health and well-being – to provide a balanced, high-quality education that addresses both academic learning as well as social and emotional well-being, together with the provision of safe spaces and a positive climate, and protection from bullying, violence and exclusion. All children are entitled to the provision of mental health and well-being without discrimination, labelling or stigmatisation. Furthermore, children also have the right to self-expression and participation in their education and health. Article 12 (1) of the UN Convention on the Rights of the Child declares that 'States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child'. As Cefai et al. (2021, p.24) note, 'Freedom of expression is a more holistic notion than either freedom of thought or freedom of speech… it includes emotional-relational aspects, such as freedom of experience'. The evidence also shows that when children and young people are given a meaningful and representative voice in the design and implementation of mental health and well-being interventions, such interventions are more likely to lead to positive outcomes for students (Garcia-Carrión et al., 2020; Thomas and Aggleton, 2016). The voices of marginalised children, who are more vulnerable to mental health difficulties, also need to be actively represented throughout the whole school. Lastly, children and young people have also a right to privacy: 'an agenda to promote emotional well-being could undermine the privacy of the individual by subjecting it to the powerful gaze of the State' (Cefai et al., 2021).

Figure 1. An integrated framework for the promotion of mental health and well-being in school
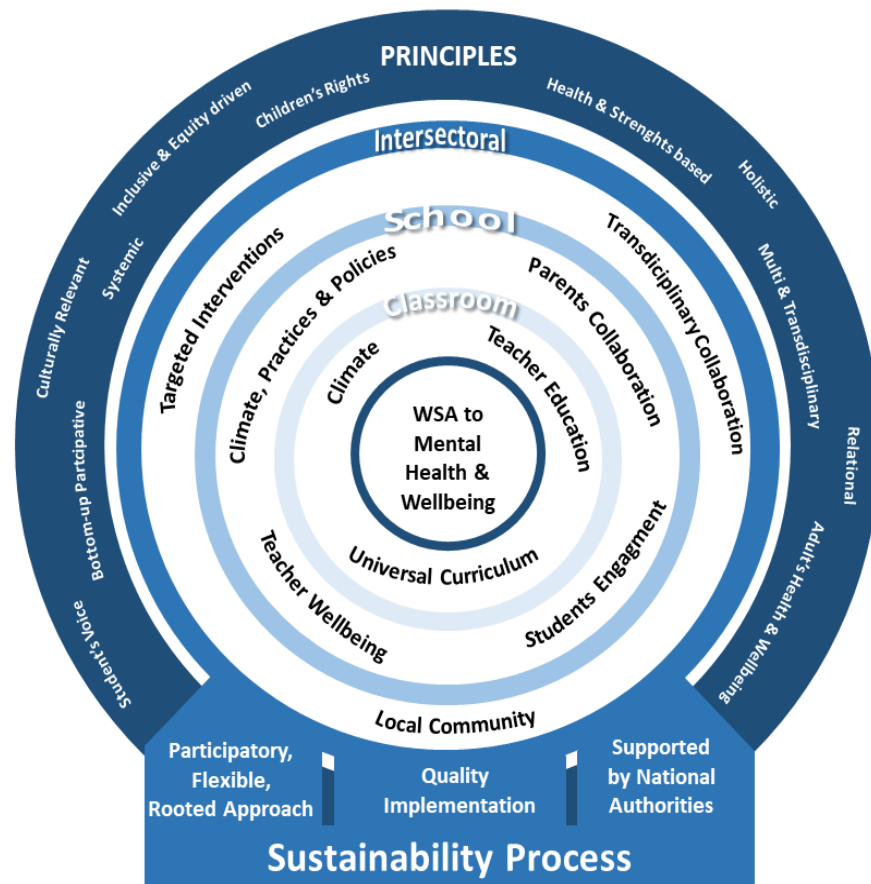
Developed by the authors

3.1.2 Holistic

The goals of education are gradually shifting from their previous, traditional focus on academic performance, towards a more holistic education that addresses the challenges of the 21st century (EC, 2020; OECD, 2020a). Children and adolescents require a balanced set of cognitive, social and emotional competences in order to achieve positive outcomes in school and in life more generally. A holistic approach to education recognises the social, emotional and physical needs of children and young people, and includes well-being and mental health as a key learning goal. At the same time, the inextricable link between academic and social-emotional learning has been clearly underlined by neuroscientific research (e.g. Lieberman, 2013) and empirical evidence (e.g. Durlak et al, 2011), which show that learning is a relational and emotional process that impacts academic achievement. The literature reviewed in the previous chapter underlines the role of relationships, connectedness and a sense of belonging in the promotion of mental health and well-being (e.g. Aldridge and McChesney 2018; Thapa et al., 2013; Wang et al., 2020) fostered by caring teacher-student relationships and 'constructivist' pedagogical strategies that promote student autonomy and active engagement in meaningful activities, student voices in decisions, and collaborative learning (Atkinson et al., 2019; Feis et al., 2019; Weare and Nind, 2011). (See Chapter 5 for further discussion).

3.1.3 Health- and strengths-based

The distinction between positive mental health and mental ill health underlines that the major thrust of mental health and well-being promotion in schools is to support children and young people in remaining healthy and thriving academically, socially and emotionally (EC, 2020; WHO, 2021a). Universal interventions at curricular, classroom and school levels aim to encourage and empower students to take responsibility for their own health and growth, as well as that of others (WHO, 2021a). It does so through a school-based approach, utilising the resources and strengths of the key stakeholders in this process. Children and young people who are at risk of or experiencing mental health issues are exposed to universal interventions together with their peers in an inclusive context, while being supported with additional targeted interventions as required, without labelling and stigmatisation. The focus on mental health and well-being also helps to destigmatise mental health (Kutcher et al., 2016; Stallard et al., 2012). Cefai et al (2021) suggest that 'the adoption of a dynamic conception of growth – acknowledging that children are growing and developing, and that education is part of facilitating this developmental growth… challenges the application of static, essentialising labels to children and young people's personalities, and recognises that life experiences can bring about shifts in personality for growth'.

3.1.4 Systemic

School-based interventions to promote students' mental health and well-being are more likely to be effective if they organised within a systemic, whole-school approach in contrast to single-component or fragmented interventions (Barry et al., 2017; Caldwell et al., 2019; Cefai et al., 2018; Thomas and Aggleton, 2016; Weare and Nind, 2011; Williams et al., 2020). A whole-school approach mobilises the various resources of the whole school community, including the active engagement and voices of students, staff, parents and professionals, towards a collaborative effort to promote the well-being of all the community's members. Universal interventions such as mental health promotion for all students at school at curricular and classroom climate levels, are complemented by a whole-school ecology embedded in the culture and ethos of the school. This framework underlines the social embeddedness of mental health promotion, with the various layers of the school system operating as a health-promoting context (WHO, 2020a). The beliefs and attitudes of, as well as the social interactions and relationships among, the various members of the school, have an influence on the teaching and learning processes that take place within the school (Downes et al., 2017). The physical and social climates of the classroom and the whole school and the sense of connectedness, belonging and community among the school members (Aldridge and McChesney, 2018; Thapa et al., 2013; Wang et al., 2020) are key conditions impacting students' learning, health and well-being. Similarly, family-school-community partnerships are key factors in promoting the sustainability and impact of mental health promotion in schools (Goldberg et al., 2019).

3.1.5 Inclusive and equity-driven

In line with the UN Convention on the Rights of the Child, mental health and well-being in school needs to ensure equality and non-discrimination, so that all school children enjoy an equal opportunity to have their needs addressed. This requires a commitment to culturally appropriate and sensitive interventions at both universal and targeted levels, with schools embracing diversity within the school culture and promoting inclusion in policies and practice (Cefai et al., 2018; Garcia-Carrión et al., 2019). Schools also need to be responsive and empathic to the diverse needs and views of parents, including those from marginalised backgrounds (Cefai et al., 2021). Commitment is also required to the mental health needs of vulnerable and marginalised students who are more at risk of

mental health problems, such as those coming from low-SES or migrant backgrounds, children exposed to abuse, violence and bullying, and children who have experienced other forms of trauma. Mental health interventions at school may serve as a lever for equity in this respect, particularly if they begin early, before the development of mental health conditions (Stockings et al., 2016; Wigelsworth et al., 2020; Woods and Pooley, 2016).

3.1.6   Culturally relevant

The success of mental health promotion depends on its adaptation and fit to the ecology of the school and local community in question (Garcia-Carrión et al., 2019; Weare and Nind, 2011). Culturally relevant interventions adapted to the diverse needs of the school population are becoming more salient as the European Union becomes more socially and culturally diverse. Curriculum content and material need to be culturally relevant and reflect the socio-cultural determinants of behaviour, while interventions need to address the broader social context and avoid recreating the individual deficit approach (Assessment Work Group, 2019). Cefai et al. (2021) also argue that in being culturally sensitive, schools 'need to address cultural biases in the conceptions of self and personality that may underpin aspects of (mental health and well-being), while still holding on to a universalist conception of human rights such as a child's right to a voice, enshrined in the UN Convention on the Rights of the Child' (p.27).

3.1.7   Bottom-up, participatory

A participatory, flexible, bottom-up approach to mental health promotion, based on the principles of empowerment, democracy and ownership, is more likely to be adopted in the European context and thus more likely to be successful (Weare and Nind, 2011): 'European theory tends to be holistic, emphasizing not just behaviour change and knowledge acquisition, but also changes in attitudes, beliefs and values, while European health education has long pioneered active classroom methodologies, involving experiential learning, classroom interaction, games, simulations and group work of various kinds… European contexts have a tradition in operating on a non-prescriptive, flexible and principles basis' (p.65). School staff, students and parents need to be actively involved in the planning and implementation of programmes and initiatives through a bottom-up approach (Rosen et al., 2020; Weare and Nind, 2011). Inchley et al. (2007) emphasise the need to 'root' mental health interventions at school, with 'shared ownership', collaboration and empowerment of the school community, and with the intervention being linked to the core objectives and ethos of the school (see also 3.2.4).

3.1.8   Relational

A socio-ecological perspective on mental health promotion focuses less on policies and structures and more on social and relational processes such as interpersonal relationships, connectedness and a sense of belonging (Allen et al., 2017; Brown and Shay, 2021; Thomas et al., 2016). Thomas et al. (2016) found that students and teachers construed well-being primarily in terms of interpersonal relationships, in contrast to policy documents which focused mainly on mental health issues. School and classroom climate reviews (Aldridge and McChesney 2018; Thapa et al., 2013; Wang et al., 2020) and other studies (e.g. OECD, 2020a) have consistently found that social connectedness and relationships are among the strongest factors relating to mental health and prevention of risk behaviours. Brown and Shay (2021) argue that a 'relational and social identity approach' to mental health promotion underlines the centrality to young people of authenticity, relatedness, and connectedness to nature as being the things that matter to their well-being.

3.1.9 Multi- and trans-disciplinary

As interventions move from universal towards selective and indicated interventions addressing the mental health needs of students at risk of or experiencing mental health difficulties, they become more multi- and trans-disciplinary. Schools will need to] collaborate closely with various professionals and mental health services to address the multifaceted needs of vulnerable and marginalised students (Goldberg et al., 2019; O'Connor et al., 2018; Rampazzo et al., 2016; Thomas and Aggleton, 2016; Weare and Nind, 2011). They will need to have access to a range of professionals to address the more complex needs of children with mental health difficulties (multi-disciplinary) within a school-based team that includes the students, their teachers and their parents (transdisciplinary). The issues of children's voices, children's rights to privacy and confidentiality, as well as equity (their needs being adequately addressed) are also pertinent here.

3.1.10 Addressing the well-being of adults

The adults who are significant in the primary social systems of children and young people, such as school staff and parents, have a significant impact on the mental health of children and young people through their interpersonal relationships, attitudes, behaviours, and role-modelling. It is therefore crucial that a whole-school approach to mental health and well-being should also address the mental health and well-being of school staff, particularly teachers and parents and carers, and should provide opportunities for personal development, professional development and parenting education, among others (Jennings et al., 2017; Weare and Nind, 2011).

3.2 Key elements

3.2.1 Classroom layer

The classroom layer is the most proximal to the students. It includes the following components:

- **Curriculum**
  At the very core of a whole-school approach to mental health and well-being is a curriculum with an explicit focus on educating children to make healthy choices and promote their own health and well-being and that of others (Cefai et al., 2018; Goldberg et al., 2019; Weare and Nind, 2011; Wigelsworth et al., 2020). The curriculum includes social and emotional education (emotional awareness and regulation, setting goals, positive identify, self-esteem and self-efficacy, empathy, relationship building, collaboration, constructive conflict resolution); resilience building; and mental health literacy (awareness of mental health, recognising symptoms, seeking help, removing stigma), from early years to high school (Goldberg et al., 2019; Kutcher et al., 2016; Thomas and Aggleton, 2016; Weare and Nind, 2011). It has a high preventive value and reaches out to all school children. If they are adequately trained and supported, teachers are well placed to deliver the curriculum, as they have more opportunity to encourage students to apply in practice the skills being learnt, and are better able to adapt the interventions according to students' needs and level (Durlak et al., 2011; Stockings et al., 2016).The curriculum should be adapted to the needs of the group while being culturally responsive (Garcia-Carrión et al., 2019; Weare and Nind, 2011). See also Chapter 4.

- **Classroom climate**
  A positive classroom climate that focuses on caring relationships, collaboration, equality and inclusion, is essential for mental health and well-being to thrive. Foundational processes include supportive peer relationships, inclusive practices, caring teacher-student relationships, and 'constructivist' pedagogical strategies that promote student autonomy and active engagement in meaningful activities and collaborative learning (Atkinson et al., 2019; Feis et al., 2019; Weare and Nind, 2011). The classroom climate becomes a laboratory for students to experience care, support, empathy, respect, connectedness, inclusion, and sense of belonging, and to practice their skills in emotional regulation, setting goals, problem solving, overcoming challenges, giving and receiving support, working collaboratively and solving problems collaboratively (Aldridge and McChesney 2018; Cefai et al., 2018; Thapa et al., 2013; Wang et al., 2020). A social-relational approach to mental health and well-being provides the foundational support on which the other components build and develop. Peer bullying, coercive classroom management, unequal treatment, exclusion, and undue academic pressure and stress on students (which are themselves potential causes of mental health issues) have no place in such a climate (Inchley et al., 2020; OECD, 2020a). (See also Chapter 5).

- **Teacher education and mentoring**
  Teachers need to be adequately trained and supported in delivering the curriculum if they are to provide quality implementation that produces positive student outcomes. They need to feel competent in engaging in practice and providing support for mental health and well-being (Goldberg et al., 2019; Rampazzo et al., 2016; Sanchez et al., 2018; Thomas and Aggleton, 2016). Areas for teacher education include understanding children and young people's social and emotional development; promoting mental health and well-being, including the use of interactive and experiential pedagogy and evidence-based practices; implementing mental health programmes in the classroom; addressing bullying; working collaboratively with colleagues, parents and professionals; identifying symptoms of mental health difficulties in students; developing their own social and emotional competences; and taking care of their own health and well-being (Cefai et al., 2018, Goldberg et al., 2019; Rampazzo et al., 2016). They also need to appreciate the importance of and adopt a relational, child-centred, collaborative and constructivist pedagogy, sharing the construction of knowledge with the students themselves (co-designing of material, engagement in participation, collaborative learning and assessment) (Atkinson et al., 2019; Hamre et al., 2013) (see Chapter 5). Professional learning needs to begin in initial teacher education and continue as part of ongoing, school-based professional learning that includes mentoring, professional networks and learning communities (see also Chapter 6).

3.2.2   School layer

- **School climate**
  A positive school climate characterised by connectedness, a sense of belonging, and collaborative relationships between the staff, students, parents and professionals, operates as a health-promoting context in which school members feel respected, recognised, supported, connected, included and safe (Aldridge and McChesney 2018; Thapa et al., 2013; Weare and Nind, 2011). Connectedness and a sense of belonging are particularly impactful with regard to mental health and well-being (Aldridge and McChesney 2018; Thapa et al.,

2013; Wang et al., 2020), acting as protective factors during transitional periods (Kiuru et al., 2020; Lester et al., 2013). Indeed, various authors argue that these are more crucial for mental health promotion than policies and structures (Brown and Shay, 2021; Thomas et al., 2016; Allen et al, 2017). However, school-wide expectations and norms concerning behaviours, informed by policies, structures and rules developed collaboratively by whole school community, are also important in ensuring that all parts of the school community work coherently towards common goals (Aldridge and McChesney, 2018; Barry et al., 2017; Oberle et al., 2016). These include policies and practices in relation to bullying, diversity and inclusion, behaviour, and mental health, among others (See Chapter 6). A key aspect of the school climate is the sense of physical and psychological safety experienced at school. In the school context, the values of mutual respect, respect for diversity, inclusion, equality, kindness and solidarity need to be embedded across the whole school. In addition, policies and structures need to be implemented that address inappropriate behaviour. All members need to feel protected from prejudice, discrimination, violence or harassment, and bullying. The importance of guaranteeing a safe school environment in order to prevent bullying emerged from the meta-analyses underlining school policy on bullying (Lee et al., 2015), improved playground supervision and firm disciplinary methods (Ttofi and Farrington, 2011) (see Chapter 6).

- **Student engagement**
  Students need to be active partners in the mental health and well-being project, not only in the classroom but across the whole school context, including the planning, implementation and evaluation of initiatives such as policies, practices and interventions (Atkinson et al., 2019; Kutsar et al., 2019). Students may also participate in the delivery of the interventions themselves, such as peer-mediated support for mental health (Atkinson et al., 2019; Feis et al., 2019). (See Chapter 6).

- **Close collaboration with, and active engagement by, parents**
  Family and community partnerships are one of the three pillars of the WHO framework of health promotion in schools (WHO, 2020a). The active engagement and collaboration of parents is imperative in realising a school's goals in mental health promotion and well-being (Goldberg et al., 2019; Rampazzo et al., 2016; Weare and Nind, 2011). Engaging families and the community as key partners within a whole-school approach reinforces the complementary roles of parents and educators, and extends opportunities for learning and development across the primary social systems in children's lives (García-Carrión et al., 2019; Goldberg et al., 2019). Parental involvement also helps to reduce prejudice and stigmatisation of mental health issues among parents (and students), and empower parents to take a more active role in supporting the mental health and well-being of their children through parental education, as well as developing their own growth and well-being (Cefai et al., 2018; Weare and Nind, 2011). However, schools need to take a more empowering and culturally responsive approach when collaborating with parents, as well as being more responsive to their diverse needs and views, including those of parents from marginalised background (Paseka and Bryne, 2020). (See Chapter 6).

- **Staff well-being and mental heath**
  There is a symbiotic relationship between the mental health of teachers and that of students. In order to promote the well-being of their students, school staff need to enjoy positive mental health themselves. The classroom and school

climates are strongly mediated by the relationships between staff and students and within the staff and the students themselves. A whole-school approach thus considers the well-being of the staff as paramount to their effectiveness (Cefai et al., 2021, Jennings et al., 2017). (See Chapter 6).

3.2.3   Intersectoral partnerships

- **Targeted interventions**
  An integrated approach to mental health and well-being in school combines universal, curricular approaches for all school children with targeted interventions for students at risk of (selective interventions) or experiencing mental health difficulties (indicated interventions), beginning as early as possible and involving the contributions and support of professionals and agencies (Goldberg et al., 2019; O'Connor et al., 2018; Rampazzo et al., 2016; Sanchez et al., 2018; Thomas and Aggleton, 2016; Weare and Nind, 2011). Targeted interventions do not replace universal interventions, but provide additional support at school, in collaboration with professionals and agencies as required. Such interventions are particularly effective in reducing mental health symptoms. Selective interventions for students at risk of mental health also serve as resilience-building interventions by protecting children from mental health issues, and thus also help to foster equity (Domitrovich et al., 2017**;** Stockings et al., 2016; Werner Seidler et al., 2017). They need to begin early to prevent the development of mental health issues, and are repeated over time during the school years (Stockings et al., 2016; Woods and Pooley, 2016). In the case of targeted interventions, particularly indicated interventions for students experiencing mental health issues, the role of support staff and professionals becomes more central, though teachers still have an active role to play in supporting such students in collaboration with professionals and parents. (See Chapter 7).

- **Partnerships with professionals and agencies**
  As interventions move from universal towards selective and indicated interventions, they become more intersectoral. Schools will need to work in close collaboration with various professionals and mental health services to address the multifaceted needs of vulnerable and marginalised students (Goldberg et al., 2019; O'Connor et al., 2018; Rampazzo et al., 2016; Thomas and Aggleton, 2016). They also need to have access to a range of professionals to address the more complex needs of children with mental health difficulties (multi-disciplinary) within a school-based team, where possible including the students, their teachers and their parents (transdisciplinary). An intersectoral approach in which professionals, school staff and parents work collaboratively as a team and with the active participation of the students themselves, will ensure that interventions are child-centred rather than service- or profession-centred, and that they remain school-based rather clinic-based (see Chapter 7).

- **Partnerships with the local community**
  The local community is a key stakeholder in the life of the school and its efforts to promote mental health and well-being. Support from the community, such as the provision of resources and services, disseminating information and organising/co-organising complementary health promotion activities for families, children and young people, is instrumental in helping schools to realise their mental health and well-being goals (Goldberg et al., 2019; Rampazzo et al., 2016; Weare and Nind, 2011; WHO, 2020a). The involvement of the

community is also crucial in helping to reduce prejudice and stigmatisation towards mental health issues, and contributes towards changing social norms that may put children and families at risk of mental health problems (WHO, 2017). Furthermore, community partners can facilitate access to external support and mental health services in the community, thus ensuring that students with mental health needs are provided with the additional support they require (Goldberg et al., 2019). (See Chapter 6).

3.2.4 Key sustainability processes

- **Quality implementation**
  One of the challenges for the success and sustainability of the whole school approach is quality implementation, which includes planning, implementation, monitoring and support. This is particularly salient in the case of comprehensive, multi-level and sometimes complex whole-school approaches, which require considerable planning, resourcing, monitoring and support over an extended period of time (Goldberg et al., 2019; Weare and Nind, 2011). The low level or lack of impact reported in some of the whole-school studies reviewed could be attributed to a lack of quality implementation such as training, resourcing and monitoring (Goldberg et al., 2019; O'Reilly et al., 2018). Supportive policies, structures and practices are key to sustaining the quality of implementation and the sustainability of a project in the long term (Barry et al., 2017). This requires effective leadership and organisational support to drive the change and embed interventions into the structure and life of the school (O'Reilly et al., 2018; Samdal and Rowling, 2013).

- **A participatory and flexible approach, 'rooted' in the school context**
  In their meta-analysis of reviews of mental health programmes, Weare and Nind (2011) distinguished between what appeared to work in the European context as opposed to the US context. They argued that a whole-school approach in European schools is more likely to be successful and sustainable if it adopts a participatory, flexible, bottom-up approach. School staff, students and parents need to be actively involved in the planning and implementation of programmes and initiatives to ensure that these are relevant and sustainable in the long term. The sustainability of successful interventions depends on their adaptation and fit to the ecology of the school and the community in which they are implemented (Barry et al., 2017). Inchley et al. (2007) emphasise the need for mental health interventions to be 'rooted' in the culture, ethos and core objectives of the school, with 'shared ownership', collaboration and the empowerment of the school community. However, as underlined in the previous point on implementation, 'bottom-up', consultative, relational approaches are often difficult to implement and are often subject to staff resistance due to the wider social-political pressures both on and within schools. Some teachers may find this approach runs counter to their professional craft knowledge, which may often have been developed in top-down, teacher-centred contexts, casting students in passive roles. Adequate teacher education, mentoring and support is thus crucial to the success of a whole-school approach (see Chapter 6).

- **Support from local, regional and national authorities**
  A whole-school approach is resource-intensive, placing high demands on the school over an extended period of time. Schools may also face resistance in bringing about this 'culture change' in education in their community (Barry et al., 2017). Whole-school interventions are thus more likely to be successful when they are supported by local, regional and national educational authorities,

both in terms of advocacy for polices that recommend a whole-school approach to mental health, as well as through resourcing (Oberle et al., 2016).

In the following chapters, we will discuss in greater detail the key elements of this framework, namely: universal curricular interventions (Chapter 4), classroom climate (Chapter 5), whole school ecology (Chapter 6) and targeted interventions (Chapter 7).

4. Promoting mental health and well-being through the curriculum

This chapter and the chapter that follows describe how the curriculum and the classroom climate can serve to promote mental health and well-being at a universal level for all school children. The formal academic curriculum, including pedagogy and assessment, as well as students' learning experiences, are inextricably linked with students' well-being and mental health. All teachers in all subject areas are responsible for ensuring through their attitudes, relationships, and pedagogy, that they engage with their students in ways that are conducive to the children's well-being and mental health. This is discussed in the next chapter on the classroom climate. In this chapter, we focus specifically on how a mental health curriculum based on social and emotional education, resilience building and mental health literacy, can help to develop students' competences in well-being and mental health.

4.1   Social and emotional education

Social and emotional education is the educational process by which an individual develops social and emotional competences for personal, social and academic growth and development through curricular, embedded, relational and contextual approaches (Cefai et al., 2018). The OECD (2017) refers to these competences as 'social and emotional skills', while the Collaborative for Academic, Social, and Emotional Learning (CASEL, 2021) refers to 'social and emotional learning'. CASEL presents five domains of social and emotional competences. These are self-awareness, social awareness, self-management, responsible decision making, and interpersonal relationships. Self-awareness is the ability to identify and understand one's personal emotions, thoughts and values and their impact on behaviour. It includes the ability to recognise one's own strengths and weaknesses, self-confidence and self-efficacy. Self-management encompasses the group of abilities relating to emotions, thoughts and behaviour management in different situations and contexts, to achieve the established objectives successfully. Social awareness refers to the ability to acknowledge others' emotions and strengths, and to show empathy and compassion. Relationship skills comprise the ability to form and maintain positive, supportive relationships with various people and groups. These involve communicating clearly, actively listening, collaborating, working in teams to solve problems, negotiating conflicts, seeking and offering help, and standing up for others' rights. Responsible decision-making refers to making ethical, safe and socially acceptable decisions concerning personal behaviour and social relations. This involves the realistic appraisal of the repercussions of one's behaviour, and concern for one's own and others' well-being (CASEL, 2021).

The EU Lifelong Learning Competence 'Personal, Social and Learning to Learn' (EU Council, 2018) includes three dimensions: Personal competence (to develop self-awareness and self-management skills to achieve one's goals, adopt a healthy and sustainable lifestyle, and achieve physical and mental health); Social competence (to use social awareness and interpersonal skills to establish and maintain healthy and collaborative relationships embracing human diversity); and the 'learning to Learn' competence (to pursue and persist in learning, and to organise one's own learning, including the effective management of time and information, both individually and in groups.

4.2   Resilience competences

Rutter (2013) points out that resilient individuals achieve fairly good outcomes, notwithstanding significant risk factors or adversities in their lives. Individuals, families, schools and communities all have qualities that contribute to the expression of resilience. These qualities or resources operate as protective factors, reducing the influence of risk factors on the one hand, and promoting health, well-being and quality of life on the other

(Simões et al., 2015). Some children and adolescents live in resourceful contexts that allow them to have life experiences and contexts that offer opportunities to develop and accumulate resources. These resources help them to face daily challenges or significant events and follow a positive and healthy path. Others, meanwhile, live in deprived contexts and experience situations that lead them towards complex trajectories that can compromise their well-being. In such cases, risk factors generally accumulate, increasing the likelihood of physical, mental or social problems. One of the most extensive studies on Adverse Childhood Experiences (ACEs) was the CDC-Kaiser Permanente study, which examined the impact of childhood abuse, neglect and family dysfunction (mental health issues, criminality, domestic violence, substance abuse and divorce) on health and well-being in adulthood (Felitti et al., 2019). The results of this study showed that the risk of a broad set of problems grows as the number of ACEs increases. These problems include poor academic and work performance, low health-related quality of life, substance abuse and dependence, sexual and intimate partner violence, teenage pregnancy, depression, suicide, as well physical health problems such as coronary heart disease. A recent systematic review and meta-analysis encompassing 23 studies on ACEs (11 in Europe and 12 in North America) confirms the significance of their impact on individual lives as well as social and economic systems (Bellis et al., 2019).

Despite these odds, research demonstrates that some children and adolescents manage to navigate adversity effectively and achieve their goals (Ungar and Theron, 2020). These positive outcomes occur when individuals have internal and contextual resources (i.e. protective and resilience factors), and manage to use these effectively. The main protective and resilience factors reported in two systematic reviews are presented in Table A1 (Annex 1). One of these reviews focuses on adversity in childhood (Fritz et al., 2018) and the factors that moderate or mediate its impact on mental health. The other (Meng et al., 2018) looked at resilience and protective factors associated with better outcomes in individuals with a childhood history of maltreatment. The outcomes included in this last review were: absence of psychopathology, school engagement, adaptive functioning, interpersonal relationships, life satisfaction, psychological well-being, perceived competence, and self-concept.

4.3   Impact of social and emotional and resilience competences

Social and emotional and resilience competences are crucial elements in the school curriculum for all students across all academic years. These competences are associated with positive development during the first two decades and throughout one's life. Children and adolescents who are more socially and emotionally competent present better emotional, social, behavioural and academic outcomes (Barry et al., 2017; Domitrovich et al., 2017; O'Conner et al., 2017). Several meta-analyses reveal the positive impact of these interventions in several domains of human functioning. The effects range from gains in social and emotional competences, prosocial behaviour, positive attitudes, self-image and well-being, to a decrease in internalising and externalising problems, and improvements in academic achievement. In most studies, these results show small to moderate effects that continue for 6 to 18 months after the intervention, as shown in Taylor et al. (2017). These interventions are effective for all students (Domitrovich et al., 2017), including students from different ethnic backgrounds, genders (Liu et al., 2020; O'Conner et al., 2017b), urban-rural contexts (Moy et al., 2018) and students with low socio-economic status (O'Conner et al., 2017b). Table A2 (see Annex 1) summarises the main meta-analysis results conducted in the field over the last 10 years.

In a significant portion of these cases, the effect sizes are small or moderate, particularly with regard to certain behavioural domains. However, as Jones et al. (2017) point out, this should be expected, since these programmes target social and emotional competencies

and not necessarily other behavioural domains. Furthermore, even small effects are fairly significant. Research shows that the change processes associated with different school-based SEL programmes seem to be similar, and relate to two different domains: students' competences and a positive learning environment (Domitrovich et al., 2017). Positive changes in these domains lead to other outcomes further on, namely positive behaviour change, academic improvement, and better mental health (Jones et al., 2017).

As Domitrovich and colleagues (2017) indicate, social and emotional education is a crucial element in universal school-based interventions: research shows that social and emotional competences are critical for positive and healthy growth, are predictors of central life outcomes in adulthood, can be promoted through sensible and cost-effective interventions, and play a critical role in behavioural change across different life domains. As such, the time and space that are dedicated to promoting well-being and mental health through social and emotional education are not a 'luxury or optional extra', but an evidence-based path to promoting effective learning and well-being, and preparing ethical and competent future citizens (Weare, 2015).

4.4 How do SEE and resilience interventions promote mental health and prevent problems?

The seminal meta-analysis of school-based universal interventions by Durlak and colleagues (2011) proposes a set of processes through which social and emotional education impacts and changes behavioural expression (see Figure 2). The authors point to person-centred and environmental-centred processes which lead to this change. In the person-centred or individual factors, several social and emotional competencies are outlined. Children and young people who are more self-aware of their emotions, values, strengths and weaknesses, and have higher self-efficacy, are more likely to respond successfully to daily or significant challenges. When they can set adequate goals, and self-motivate and self-organise to achieve them using good problem-solving skills, they achieve better outcomes.

Interpersonal and social domains are also relevant to this process of behavioural change. Relationship skills such as the ability to communicate effectively, to develop and maintain positive relationships, to resist negative peer influences and to seek support when needed, are essential to performing adequately at home, at school or in the community. Being able to see others' perspectives, be empathic towards others, identify group and contextual norms, recognise demands, and profit from opportunities, are also critical skills in navigating significant life contexts. Durlak et al. (2011) show that prosocial attitudes, interpersonal relationships, as well as problem-solving and conflict resolution skills, are some of the competences that act as a mechanism for the prevention of aggression. Durlak et al. (2011) also found that social and emotional education programmes may impact executive cognitive functions such as inhibitory control or planning as a result of better self-regulation. Recent studies also point to these kinds of cognitive gains (Crooks et al., 2020; Lemberger-Truelove et al., 2021).

Durlak et al. (2011) also identify various contextual mechanisms through which change can occur. These range from contextual norms (peers and adults) and structures, to caring teacher-student relationships and teaching methodologies. Contexts that relay high expectations and offer support to achieve planned goals, and which are safe, organised and promote positive behaviour, contribute to short- and long-term behavioural change. Caring teacher-student relationships are also critical for positive classroom engagement and academic achievement (Ansari et al., 2020), and are a protective factor against risk behaviours (Simões et al., 2012; Twum-Antwi et al., 2019). Positive classroom management and cooperative learning are two examples of engagement strategies that

promote behavioural change (Jones et al., 2017). As Ungar et al. (2015, p.71) point out, 'Good programs interrupt patterns of behaviour that are likely to lead to academic failure and disengagement from school by changing a student's social ecology… earlier is always better, but it is never too late to begin to make a difference'.

Figure 2. How social and emotional education promotes mental health and prevents problems
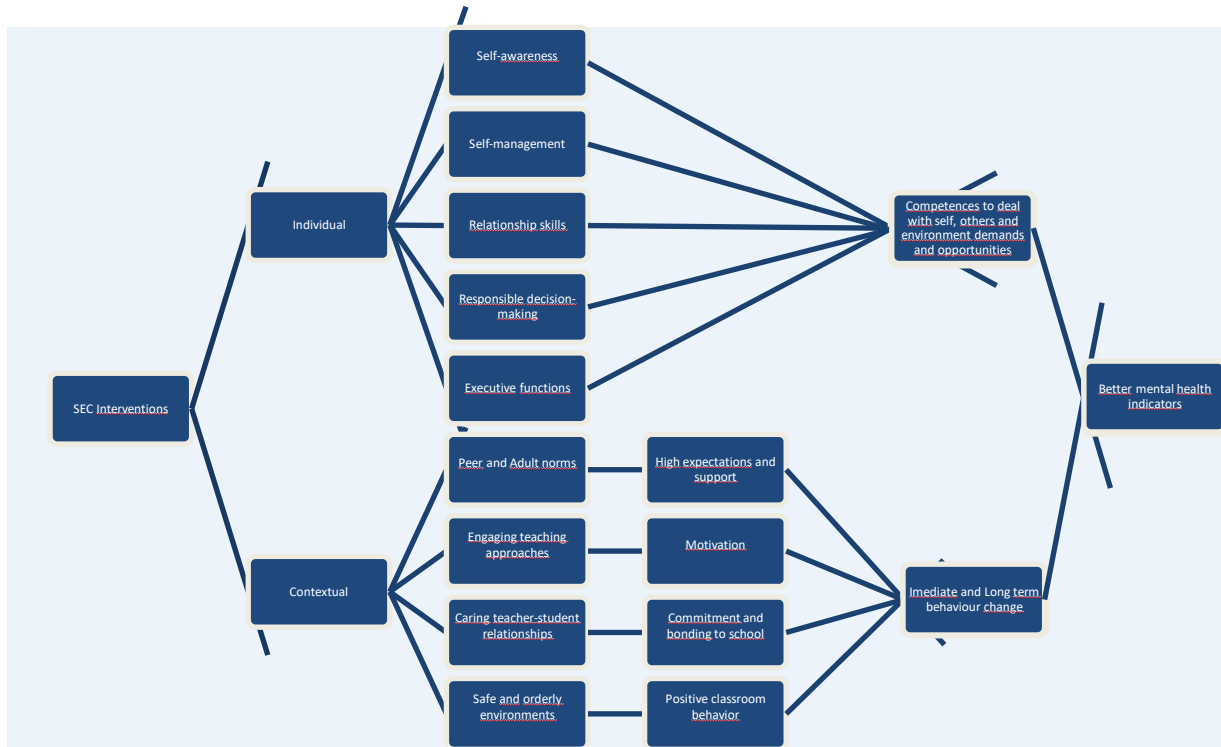
Developed by the authors, based on Durlak et al. (2011)

4.5 Features of effective social and emotional and resilience pro-grammes

Whole-school approach

School-based interventions that focus on, and engage with, the significant life contexts of children and young people, are more effective (Goldberg et al., 2019; Weare, 2010). In current systemic terminology, development is defined as a process through which new qualities arise due to dynamic interactions between the many layers of the person-environment system (Lerner et al., 2015). As such, the development and consolidation of new competences requires the involvement of various levels of the school system (student, peers, adults, classroom, playground), as well as the community in which the school is embedded, and families. The promotion of these competences should be part of the curriculum, school activities and school culture, rather than merely being an activity in certain classes or in a few sessions across the school year (Weare, 2010). Effective social and emotional programmes tend to be part of the school system and of daily activities (Nielsen et al., 2019). O'Conner et al. (2017) indicate that the school system should encompass a vertical and a horizontal alignment in which programmes cross contexts and grades, with the goals for each group reflecting developmental benchmarks, functioning as building blocks for subsequent acquisitions. A consensus exists that programmes should have a long-term duration and a spiral developmental approach, increasing their complexity over time and recapping on previous content (Weare, 2010). Some authors

suggest using a continuum of approaches, from evidence-based programmes delivered in the classroom to specific evidence-informed practices and strategies that can help to transpose SEE to the school ethos (Jones and Bouffard, 2012).

Teacher and classroom strategies as central elements
Several studies show that teachers are a fundamental element in the promotion of SEE and resilience at school (Durlak et al., 2011; Fenwick-Smith et al., 2018; Liu et al., 2020). The meta-analysis by Durlak et al. (2011) revealed that the impact of teachers as the main implementers of social and emotional interventions in the classroom was more effective than that of external professionals. Sklad et al. (2012) also showed that programme effectiveness did not improve with the participation of researchers or psychosocial professionals. Teacher education is, however, a prerequisite for effective intervention. Successful programmes should incorporate teacher development and training on SEE and resilience promotion, as well as in classroom management and positive and supportive teaching methods (Domitrovich et al., 2017; Liu et al., 2020; Nielsen et al., 2019; O'Conner et al., 2017a). Such education is even more important, since it represents a personal growth opportunity for teachers who sometimes do not feel supported in their own mental health needs or confident in taking on this challenge, or may regard such work as an extra burden (Weare, 2010). Common and straightforward classroom strategies that capture students' attention and engagement are often the backdrop for the success of such programmes. These strategies include being available, accessible and actively listening to students, modelling emotions adequately, reacting with empathy, respect and fairness, showing interest in the student's situation and advocating for them (O'Conner et al., 2017a; Ungar et al., 2014).

Programmes and components
Various social and emotional programmes have been developed, implemented and evaluated over recent decades. In Europe, these have followed two trends: some countries have imported evidence-based programmes such as PATHS, Second Step or FRIENDS, while other countries have created and implemented their own programmes (Humphrey, 2018). Many of the latter programmes resulted from EU-funded partnerships between European countries (see Boxes 7 and 9) Programmes follow various approaches, such as mindfulness, psychoeducation, social support (Liu et al., 2020), mental health promotion, youth-positive development, social and emotional learning, life skills, promotion of strengths, character education, or bullying prevention (Goldberg et al., 2019). Some authors claim that research is still needed into which fundamental elements of programmes lead to desirable outcomes (Domitrovich et al., 2017).

An interesting approach was taken by the MindOut programme, an Irish intervention for adolescents (Barry et al., 2017). After 10 years of implementation, a revised version of the programme was developed through the consultations with students, teachers and professionals, to better address the needs of the target population. The students identified the following main themes: friendships (communication, romantic relationships, conflicts); feelings (self-awareness, dealing with anger, depression); bullying (cyberbullying, discrimination, exclusion); mental health (symptom recognition, self-harm, eating disorders); education (sexual health, substance use, transition to active life); school (exams, study strategies, school-life balance); and peer influence (relationships, substance use, image, social media, sports). They also highlighted aspects related to the programme's structure and implementation (new topics and scenarios that were more relevant for young people); activities (increasing the diversity of teaching activities, more interactive activities); programme delivery (in a comfortable environment); and programme structure (longer and more detailed) (Barry et al., 2017). Interestingly, some of these recommendations are part of the SAFE approach, recognised as an important feature of effective social and emotional programmes (Durlak et al., 2011).

Box 7. EU-funded projects in social and emotional education and resilience

RESCUR (A Resilience Curriculum for Schools in Europe) is a universal resilience-focused programme, funded by the EU and developed by a European consortium (Malta, Croatia, Greece, Italy, Portugal and Sweden), which targets children from 4 to 12 years old and covers six main themes: developing communication skills; establishing and maintaining healthy relationships; developing a growth mindset; developing self-determination; building on strengths; turning challenges into opportunities. Its contents are presented in three manuals: early years, early primary, and late primary. The curriculum focuses on skills development through experiential and participative learning activities in the school setting. It has been translated into 11 languages and evaluated in various countries across Europe, with promising results (Cefai et al., 2021; Simões et al., 2021)**.**

PROMEHS[17] (Promoting Mental Health in Schools) (2019-2022) is a universal mental health promotion programme developed by an EU-funded consortium, providing a multilingual mental health curriculum across the school years (see Box 3)**.**

UPRIGHT[18] (Universal Preventive Resilience Intervention to promote Mental Health for Teenagers) (2018-2021) is funded by the Horizon 2020 Research and Innovation programme. The project aims to build a culture of mental well-being at schools in five European regions, through the co-design, implementation and evaluation of a training programme on resilience in young people, with the participation of students, school staff and parents. The programme is based on four main components: coping, efficacy, social and emotional learning, and mindfulness. It has developed a School Resilience Scale for Adults, which comprises five constructs (positive relationships, belonging, inclusion, participation, and mental health awareness), which is being validated in four European countries (Morote et al., 2020).

SEEVAL[19] (Social and Emotional Education – Building inclusive schools and ownership of values) is a three-year Erasmus+ KA 3 Policy Reform Project (2020-2023) on the development of a whole-school approach to Social and Emotional Education in secondary schools. Following a needs analysis, the partnership is currently developing a set of activities to promote students' social and emotional education, which will be implemented in secondary schools in Austria, Bulgaria, Greece, Italy and Romania. The activities will be developed by trained classroom teachers in collaboration with the students themselves, with the support of the project partners.

Developed by the authors

Box 8. Zippy's Friends in Europe

Zippy's Friends is a school-based social emotional education programme for 5-7-year-olds, taught to the whole class by the classroom teacher. It focuses in particular on teaching young children how to cope effectively with difficulties, in preparation for later childhood and adolescence. A review by Fenwick-Smith et al. (2018) included four studies carried out in Europe (Denmark, Ireland, Lithuania and Norway), which evaluated the impact of Zippy's Friends in primary schools. The four studies were implemented in multiple classrooms and schools, and sought to improve psychological and emotional competence such as resilience, emotional regulation and relationship by moderating the negative effects of stress and increasing coping skills. The studies reported a positive impact in at least three of the following outcomes: resilience, emotional regulation, relationships and behaviour, empathy, and emotional and psychological symptoms. The teachers adapted activities during implementation according to the needs of their class, while maintaining the fidelity of the programme. Teachers were supported by programme staff. This adaptation by teachers was considered an effectiveness factor by the authors.

Adapted by the authors from Fenwick-Smith et al. (2018)

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[17] www.promehs.org
[18] https://uprightproject.eu/
[19] https://seeval-project.eu

Implementation

Implementation is a critical factor in the success of social and emotional education and resilience programmes (Barry et al., 2017; Durlak et al., 2011; Murano et al., 2020). Effective implementation requires a set of steps, with supervision throughout the process (O'Conner et al., 2017b): 1) follow a well-thought-out plan; 2) begin small and commit to expanding via continuous improvement and support to the main intervention; 3) assess the fidelity of implementation to better understand what has emerged during the intervention, and to improve programme delivery; and 4) evaluate the programme results. Implementation is generally assessed according to fidelity, dosage, quality, reach, the responsiveness of participants, programme differentiation, comparison conditions, and adaptation (Humphrey, 2018; O'Conner et al., 2017b). Anyon et al. (2016) found three influential factors in fidelity: the compatibility of the intervention with staff members' views about behaviour change and management; the school organisation's capacity to fit the intervention into the system; and the intervention support system (training and supervision).

Weare (2010) refers to a potential conflict in implementation between strict programme implementation and adaptation to the context. In general, schools in the US follow prescribed programmes in which fidelity and assessment aspects are guaranteed. Meanwhile, in Europe, there is a tendency to prefer more open and flexible frameworks that allow for tailoring to context, but which may compromise comparisons between interventions. Research shows that programme adaptation can be a positive feature (Fenwick-Smith et al., 2018; Wigelsworth et al., 2016), presenting better results than programme fidelity as long as there is enough confidence and knowledge about the intervention (Wigelsworth et al., 2016). For instance, the Zippy's Friends programme, which has been extensively applied across European countries, was adapted and implemented successfully in different contexts (Liu et al., 2020) (see Box 8). As Nielsen et al. (2019, p. 419) point out, 'successful implementation is about much more than the activities in the specific program, it is instead about elements in synergy and professional learning processes over time, supported by well-designed teacher professional development'.

Box 9. Evaluations of social and emotional education programmes in the EU

Pannebakker et al. (2019) evaluated the impact of a social and emotional education programme 'Skills 4 Life' on mental health and self-esteem, self-efficacy and social interaction among 12-14-year-old secondary school students in the Netherlands. A cluster-randomised, controlled study was conducted in 38 schools (66 classes). The authors reported that the programme was effective in improving students' self-efficacy, depressive symptoms and psychological problem behaviours at the 20-month follow-up. The effect was most evident among students at lower educational levels who were most at risk of mental health problems. **Nielson et al. (2015)** implemented a social and emotional education programme 'UP' within the framework of the Health Promoting Schools. UP employs a whole-school approach aimed at promoting mental health by developing social and emotional competences. It consists of four components: activities for students; staff training in skills development; the participation of parents; and activities in the daily life of the school. The programme was implemented in two Danish schools among 589 students aged 11-15 years. The authors reported an increase in students' social and emotional competences following the implementation of the programme. **Simões et al (2021)** evaluated the impact of a universal resilience programme, RESCUR Surfing the Waves, on students' academic, behavioural and socioemotional outcomes, making use of a quasi-experimental design. The programme was implemented as part of the curriculum for 1,084 students aged 3-15 years, in various schools across Portugal. The authors found an increase in programme students' prosocial behaviours and well-being, and a decrease in mental health difficulties. Both teachers and students consistently reported positive behavioural changes in resilience competences following the implementation of the programme.

4.6 Mental health literacy

Mental health literacy (MHL) is a fundamental aspect of mental health promotion and mental ill health prevention and treatment. According to Kutcher et al. (2013, p.84), MHL focus on four main aspects: 'First, it encompasses the capacity to understand what constitutes positive mental health and strategies to achieve positive mental health. Second, it includes knowledge of mental disorders based on evidence-based research. Third, it promotes appropriate attitudes towards those living with mental disorders. Finally, it enhances the capacity to seek mental health care from appropriate health care providers should that be required'. MHL appears to be associated with mental health status, acting as a protective factor against mental health problems in young people (Riebschleger et al., 2017). In the case of young people with mental health difficulties or those with parents who have mental health problems, MHL may offer the advantage of healthier outcomes through early identification or early seeking of help (Kelly et al., 2007).

A thematic analysis of the literature by Riebschleger et al. (2017) identified five main themes to be considered as content areas for MHL aimed at children and young people: gaining an overview of mental health problems and recovery; reducing the stigma surrounding mental health issues; promoting resilience-related competences; increasing help-seeking skills; and identifying risk factors for mental health problems Another review by Bale et al. (2018) adds more specific areas of MHL content for children and young people: the ability to recognise mental health difficulties, focusing on the more common, namely depression and anxiety; knowledge of coping and preventive strategies (e.g. positive lifestyle, support networks); understanding their well-being needs in order to manage their own mental health and be aware of the experiences of significant others; and awareness of the support available (e.g. significant and trustable adults, professional help)[20]. Nevertheless, the authors highlight that one question that remains unanswered in this field is the specific needs of younger children, namely primary school children, due to a lack of studies.

Various studies have already established the impact of MHL interventions, particularly on adolescents. A recent small-scale systematic review (Seedaket et al., 2020), covering seven papers based on RCTs and involving almost 10,000 adolescents, found improvements in mental health knowledge and positive attitudes. Change in help-seeking efficacy was found in only one of the four studies that measured this component, with the authors suggesting that brief interventions may not be enough to promote meaningful changes in MHL. The review also highlights the importance of MHL teaching methods for adolescents, which should be interactive, making use of group discussions and media such as videos and movies. The use of media in interventions appears to be an important vehicle for transmitting MHL

Two recent systematic reviews have investigated the impact of MHL on the teachers and professionals involved. A review by Yamaguchi et al. (2020) analysed the effectiveness of MHL on teachers, while O'Connell et al. (2021) analysed the effectiveness of training on professionals who were in contact with children and young people. The results of both reviews are fairly similar, due a significant number of the same studies being included in both reviews. The findings point to a significant improvement in knowledge, a reduction in stigma-related attitudes and behaviours, and increased confidence in helping students.

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[20]From October 2021 onwards, a Mental Health High School Curriculum will be implemented for all 13 to 15-year-old students attending church schools in Malta. The curriculum, which is based on the Mental Health Curriculum (Kutcher et al., 2013), will be implemented by trained schoolteachers as part of mainstream social and emotional education. It consists of six modules: mental health stigma, understanding brain function, information about mental health difficulties, the lived experiences of people with mental health difficulties, seeking and finding support, and positive mental health and healthy lifestyle.

These results should be interpreted with caution, however, due to the low overall quality of the studies.

Various authors (Kutcher et al., 2016; Wei et al., 2015) indicate a growing interest in understanding how to achieve positive mental health among school children. Bale et al. (2018), for instance, mention a number of areas that need to be addressed, such as keeping in touch with support networks; remaining physically active; engaging regularly in relaxing activities; avoiding substance use; and avoiding stressful situations. Another example is Bjørnsen et al. (2018), who looked at a positive MHL programme that focused, among others aspects, on emotional life, sleep hygiene, stress management, relaxation techniques, body image, self-esteem, decision making and self-awareness.

Box 10. Extracurricular activities and mental health (adapted from Oberle, 2020)

> Oberle (2020) examined the relationship between adolescents' recreational time and participation in extracurricular activities after school, and their positive (optimism, satisfaction with life) and negative (anxiety and depressive symptoms) mental health and well-being. In a study involving 28,712 students aged 12 years old in Canada, they found that those who participated in extracurricular activities (sports, arts, community programmes) spent considerably less time in recreational screen-based activities, and had higher levels of satisfaction with life and optimism, and lower levels of anxiety and depressive symptoms. On the other hand, a longer time spent in front of screens was related with lower levels of satisfaction with life and optimism, and higher levels of anxiety and depressive symptoms. Students enjoyed the greatest levels of mental health and well-being when they participated in extracurricular activities and spent less time on recreational screen-based activities.

Adapted by the authors from Oberle (2020)

Box 11. A universal preventive programme to improve mental health literacy

> As part of the Saving and Empowering Young Lives in Europe (SEYLE) study, Wasserman et al. (2015) evaluated the Youth Aware of Mental Health programme (YAM), which involved 11,110 students aged 14-15 years, recruited from 168 schools in ten European Union countries. YAM is a European-based universal preventive programme to improve mental health literacy, enhance coping skills, and reduce suicidal behaviour among students aged 13–17 years. The topics range from relationships with peers and adults, to mood changes and coping with stressful situations. Experiential learning and peer support are two key elements of the programme. No significant differences were found between the intervention and the control group at a three-month follow-up, but at the 12-month follow-up, a significant reduction in suicide attempts and severe suicidal ideation was seen among the YAM participants compared with the control group.

Adapted by the authors from Wasserman et al. (2015)

Research highlights the importance of a healthy lifestyle to positive mental health (Hosker et al., 2019). Physical activity has a positive impact on the reduction of depression and anxiety symptoms (Pascoe et al., 2020). Evidence from cross-sectional and longitudinal studies show that physical activity is associated with lower levels of mental ill health (i.e. stress, negative affect, depression, and total psychological distress) and higher levels of well-being (i.e. self-image, satisfaction with life, happiness and psychological well-being). Substance use is also associated with various mental health problems in young people (Gray and Squeglia, 2018). Various studies highlight the impact of psychological distress or mental health difficulties on later substance use (Fluharty et al., 2018), while others address the impact of substance use on mental health problems such as depression and suicide (Gobbi et al., 2019). Short sleep duration is associated with poor mental health outcomes, and longer sleep duration is associated with better emotional regulation and higher levels of well-being (Chaput et al., 2016).

Several school-based mental health and resilience interventions focus on, or include a component of, mindfulness (Sapthiang and Gordon, 2019). Mindfulness-based

interventions for children and young people appear to promote a number of positive outcomes related to their cognitive (working memory, attention, academic skills), social (social skills, prosocial behaviour) and psychological functioning (emotional regulation, self-esteem, mood enhancements) (Donald et al., 2019; Dunning et al., 2019; Meiklejohn et al., 2012; Zenner et al., 2014). Studies have also found decreases in fatigue, stress, anxiety and depression (Kallapiran et al., 2015; Mckeering and Hwang, 2019; Meiklejohn et al., 2012). Other positive outcomes include an improvement in concentration, behaviour management and sleep quality, and a decrease in anger (Mckeering and Hwang, 2019), as well as in disruptive behaviour (Klingbeil et al., 2017). A systematic review of school-based mindfulness interventions (Mckeering and Hwang, 2019) shows that, among early adolescents, these interventions appear to be more effective in the reduction of mental health problems than in the promotion of positive mental health.

Research in this area highlights the importance of MHL in universal mental health promotion and the prevention of mental ill health. Understanding and recognising mental health symptoms and seeking help when these problems arise is also fundamental to addressing and preventing more serious problems in the future. The adoption of a healthy lifestyle is the centrepiece of this field, highlighting the interdependence of the physical, social and mental health components in the positive development of childhood and young people.

5. Classroom climate

In contrast to the broader school climate, the classroom climate refers specifically to the learning and social environment developed by teachers and students, influenced by other systems such as the whole-school climate, parents and the local community. It is a unique developmental context comprising learning, social and organisational interactions (Hamre and Pianta, 2001). It consists primarily of physical and emotional safety (such as empathic and supportive interactions, intrapersonal competencies of students and teachers, and fairness of classroom rules), the quality of the interpersonal relationships (student teacher and peer relationships), and the learning environment (such as the learning expectations and cooperative learning) (Schweig et al, 2019). The sense of safety, the level of support provided, the caring relationship between the teacher and the students, as well as supportive and collaborative relationships among the students, are key conditions that impact the learning process in the classroom (Thapa et al., 2013; Wang et al., 2020).

Recent conceptualisations of the classroom climate emphasise the teacher-student relationship and interactions (e.g. Hamre et al., 2013; Hamre and Pianta, 2001). These comprise three key elements: instructional support (quality and constructive feedback promoting high expectations and facilitating critical thinking and deep learning, challenging and relevant tasks); socioemotional support (warmth, safety, connectedness and responsive teacher interactions); and classroom organisation and management (fair and consistent classroom rules, positive behavioural support, instructional and preventive management strategies, focus on self-control) (Wang et al., 2020). These relational processes help to create an optimal classroom environment in which students have the opportunity to engage in various learning activities as well as positive interactions with teachers and peers, and to practice their social and emotional competences. As a result, their basic psychological needs (relatedness, competence, autonomy) are fulfilled, contributing to learning engagement, social and emotional competence, positive relationships, and psychological well-being (Wang et al., 2020).

5.1 Evidence

In a systematic review of 14 papers on positive classroom climate in early multicultural childhood education in the US, *Khalfaoui et al. (2021)* identified a number of relational-based pedagogical practices that contribute to a positive classroom climate. These consist of increased instructional time, provided through a caring and flexible pedagogical approach; supportive teacher-student interactions; supportive peer interactions and friendships; children's engagement in classroom activities; teacher education in creating emotionally supportive environments; and teacher-family relationships based on trust. This study is of particular interest, as it was carried out in multicultural classrooms, which is the reality faced by many teachers across Europe today.

In an extended study of optimally functioning primary school classrooms making use of participant observation, interviews and focus group discussions, *Cefai (2008)* found that classrooms that operated as caring classroom communities promoted academic learning as well as mental health, well-being and resilience. The climate in such classrooms was characterised by a strongly relational, emotional, inclusive and collaborative climate, incorporating the following processes:

- A sense of connectedness and belonging in which students are closely connected and attached to their teachers and to each other, and enjoy a sense of pride and belonging to their group;

- Warm and nurturing teacher-student relationships, with a close bond to the teacher, who is responsive to the needs of the children according to their developmental stages. Teachers showed a particular responsibility towards the welfare of the children not just as learners, but as young human beings left in their care;
- Prosocial peer relationships, with students expressing care for each other (e.g. ensuring that no one is left out during playtime; buddies for peers with disabilities), sharing with each other and resolving conflicts constructively;
- Inclusion of all students, with adequate support for all students irrespective of individual or cultural differences; teacher attention and responsiveness; and peer support (e.g. mentoring, buddies during play);
- Student engagement in authentic and meaningful learning activities, with a focus on engagement and learning rather than just performance; learning activities that are interactive, practice-based, enjoyable, and adapted to the students' needs and interests. In most instances, assessment was formative;
- Collaboration, including collaborative learning with frequent, small cooperative group work, and peer mentoring, as well as collaborative teaching and close collaboration between teachers and parents (mostly on a day-to-day basis);
- Positive belief and high but realistic expectations for all students, including vulnerable and marginalised ones;
- Voice and choice for students, with students having choices about activities and participating in decisions about academic learning and social behaviours.

Wang et al (2020) carried out a systematic review and meta-analysis of classroom climate, academic achievement and psychological well-being across the primary and secondary school years. They reviewed 61 carefully selected cross-sectional and longitudinal peer-reviewed studies (73,824 participants) published between 2000 and 2016. The authors found that the classroom climate (construed primarily in terms of instructional support, socio-emotional support, and positive classroom management and organisation) was positively related with social competence and academic achievement and negatively related with internalising and externalising behaviours, with no major differences across the school years. More specifically, there was a small-to-medium positive association with social competence, motivation, engagement and academic achievement, and a small negative association with socio-emotional distress and externalising behaviours. The relationship between classroom climate and socioemotional distress varied according to certain dimensions of the classroom climate. Socio-emotional support had a stronger impact on decreased socio-emotional distress than instructional support or classroom management, indicating that positive classroom relationships and interactions are particularly important for psychological well-being and mental health. This may be particularly important in adolescence, when mental health issues (internalising and externalising) become more apparent, with positive classroom relationships operating as protective factors against mental health issues (cf. Aldridge and McChesney, 2018; Thapa et al., 2013).

The study found that all three dimensions of classroom climate were associated with socio-emotional competence, academic achievement and internalising and externalising behaviours. This underlines the importance of responsive and quality instruction, positive classroom relationships and fair, instructional classroom management. These findings also indicate that classroom teachers need to pay attention to all three elements of the classroom climate since they are interdependent, influencing one another – and all of them impact student outcomes. One salient indication in this regard is that academic learning does not only require high quality instruction, but also adequate social and emotional support and positive classroom management and organisation. Another interesting finding is that the impact of the classroom climate on motivation and engagement was stronger in classrooms containing more ethnic/racial minority students. The authors conclude that the multidimensional classroom climate (instructionally supportive, socio-emotionally

supportive, with positive classroom management and organisation) addresses the psychological needs of children and young people for relatedness, competence and autonomy (Deci and Ryan, 2020), leading to positive academic, social and psychological outcomes. Students thus need classroom climates that support their psychological needs in order for them to thrive both academically and socio-emotionally

5.2   Indicators of a positive classroom climate

Cefai et al. (2021) have developed a set of evidence-informed indicators of a positive classroom climate that promotes students' social and emotional competences, well-being and mental health. These cover areas such as safety, classroom relationships, culturally responsive pedagogy, student engagement and collaboration, instructional and socio-emotional support, democratic ways of working and positive classroom management (Cefai, 2008; Cooper and McIntyre, 1996; Hamre et al., 2013; Schweig et al., 2019; Thapa et al., 2013; Wang et al., 2020). These underline the importance of teaching methods that emphasise supportive, inclusive and collaborative relationships between teachers and students (as opposed to traditional, top-down relationships, with students seen as passive receivers of instruction), and between peers (as opposed to competing with each other or engaging in bullying). Such practices benefit students' participatory academic engagement, sense of ownership of the learning process and their willingness to support one another. As such, they have a strong effect on the ways in which their self-concepts develop, both as learners and as members of the classroom/school community. More specifically, a positive classroom climate conducive to student well-being and mental health is characterised by the following nine indicators:

- *Cultural responsiveness and inclusion*: the curriculum is adapted and accessible to all students in the classroom, with pedagogy, resources and assessment of activities that match the diversity of students' strengths and needs. Students with individual educational needs and disabilities are actively engaged in the classroom's learning and social activities, and teachers are committed to actively removing linguistic, cultural, social and all other barriers to learning.
- *Sense of safety: T*here is a focus on mutual respect, understanding and support, and teachers avoid communication based on fear and anger. Clear procedures are laid down for dealing with incidents of violence and bullying in the classroom, with students knowing what to do when they are bullied by their peers, or if they witness peer bullying.
- *Positive classroom management*: Students are encouraged to take more responsibility for their behaviour, have a direct input into the rules of the classroom, and have a right of reply in incidents of conflict. Classroom management is instructive, consistent and fair towards all the students, with role models for expected behaviours.
- *Caring teacher-student relationships*: Teachers are committed to knowing the students well, to attending to their learning and social and emotional needs, to recognising their strengths and achievements, to providing them with frequent opportunities to express their feelings and concerns in a safe environment, and to dealing with conflict with students through understanding and respect.
- *Supportive peer relationships*: Students demonstrate care and concern for each other, support each other against bullying and violence, resolve conflicts and disagreements with each other constructively, and include peers with disabilities and those from different social and cultural backgrounds in their work and play.
- *Collaboration:* There is a collaborative approach to teaching and learning, with frequent and regular teacher-student consultations and discussions during learning activities; students working collaboratively in small groups and mentor each other, there is collaborative assessment including self- and peer-assessment, and students appreciate each other's strengths and achievements.

- *Active student engagement*: Students are actively engaged in interactive and meaningful learning activities that address their needs and interests. There is a focus on learning and engagement rather than just academic performance, and assessment is formative, inclusive and collaborative.
- *Challenge and high expectations for all students*: Teachers have high but realistic expectations for all students, including those with individual educational needs. Students are encouraged to believe in themselves and in their capability to learn and achieve. They are supported in identifying and making use of their strengths, and recognised for their effort and achievements. Competition, comparisons and ranking are discouraged in learning.
- *Student voice*: There an explicit commitment to a relational and democratic teaching environment, with students supported in becoming more autonomous in their learning, expressing their opinions and suggestions, being actively involved in constructing meaning in their learning (rather than being passive recipients), and participating actively in the assessment of their work[21].

5.3   Teacher education

Dusunberry et al. (2015) indicate that one of the most common classroom climate strategies is to train teachers to develop appropriate competences such as supportive instruction, positive classroom management and emotionally supportive practices. These complement the three key multidimensional elements of the classroom climate identified by Wang et al. (2020). Various studies have identified the positive impact of teacher education on classroom climate (Collie et al., 2012; Jennings et al., 2017; McNally and Slutsky, 2018). McNally and Slutsky (2018) found that educating teacher with regard to classroom interactions that sustain an emotionally supportive climate was associated with emotionally supportive classroom relationships and behaviours and a decrease in behavioural problems. Educating teachers in relation to their own mental health and social emotional competences, such as empathy, relationship building, culturally responsive teaching, collaborative working, and constructive conflict resolution, is particularly crucial in enabling teachers to promote a positive classroom climate (Cefai et al., 2018; Jennings et al., 2017; Schonert-Reich et al., 2015). Furthermore, professional learning such as social and emotional development, stress management and mindfulness programmes reduces teacher burnout, and increases teachers' self-efficacy and overall well-being, leading to effective, enhanced teacher-student relationships (Twum-Antwi et al., 2019) (see Chapter 6).

Teacher education will also help address potential teacher resistance to child-centred, non-directive and constructivist approaches to teaching and learning, particularly as a result of traditional approaches based on top-down, teacher-centred contexts that cast students in passive roles. Teachers coming from such a background may find the demand that they share ownership and empower students in the teaching-learning process highly threatening to their powerful status in the traditional teacher-student relationship (Cooper and McIntyre, 1996).

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[21] The checklist for the formative evaluation of the classroom climate completed collaboratively by the teacher and the students may be accessed from Cefai et al (2021).

6. Whole-school ecology

This chapter discusses how the whole-school layer, including policies, practices and relationships, contributes to the promotion of mental health and well-being. It describes how a whole-school climate permeated by connectedness and a sense of belonging lies at the heart of a whole-school approach to mental health and well-being. It examines how, within a whole-school approach, schools can effectively create and maintain safe places at school that prevent bullying and help to curb bullying at an early stage. This is followed by three sections on the respective engagement of students and teachers, as well as parents and the local community, in the promotion of mental health and well-being.

6.1 Climate of connectedness and sense of belonging

The school climate refers to the norms, interpersonal relationships, teaching and learning practices, and organisational structures of the school community. A sustainable, positive school climate includes norms, values and expectations that support members in feeling socially, emotionally and physically safe. Students, educators and families work together to develop and contribute to a shared school vision. Educators model and nurture an attitude that emphasises the benefits of, and satisfaction from, learning (National School Climate Council, 2007, p.4). Aldridge et al. (2020, p.131) operationalised school climate in terms of the following six constructs:

- *Teacher support*: the quality of student–teacher relationships and perceptions among students that their teacher both values and supports them;
- *Peer connectedness*: the quality of student relationships, including relationships across different groups of students;
- *School connectedness*: the degree to which students feel a sense of attachment, belonging and connectedness to the school;
- *Affirming diversity*: the degree to which students of from different backgrounds and with differing experiences are acknowledged, accepted, included and valued;
- *Clarity of rules*: the extent to which students feel that the school rules are clear and appropriate; and
- *Reporting and seeking help*: students' awareness of school procedures for reporting issues, and their willingness to make use of these.

In Chapter 2, we saw how a positive school climate characterised by warm interpersonal relationships and connectedness among and between students, teachers and parents, physical and emotional safety, and support for diversity, had a strong impact on students' mental health. A positive school climate promotes positive mental health and well-being, decreases mental health issues as well as violence, bullying and substance use, enhances academic motivation and achievement, and prevents early school leaving (Aldridge and McChesney, 2018; OECD, 2020a; Thapa et al., 2013, Wang and Degoll, 2016).

School-wide values, expectations and norms concerning the behaviours of all members, informed by policies, structures and rules developed collaboratively, are important to ensuring that all members of the school community work coherently towards common goals (Aldridge and McChesney, 2018; Barry et al., 2017; Oberle et al., 2018; Weare and Nind, 2011). These include policies and practices regarding safety and bullying, diversity and inclusion, behaviour, and mental health, supported by a focus on connectedness, collaboration and prosocial behaviour across the whole school. In their review, Aldridge and McChesney (2018) found that social connectedness and relationships, and the consequent sense of belonging, appeared to be one of the strongest factors in relation to mental health, well-being and the prevention of risk behaviours (see also Carney et al.,

2018; OECD, 2020a; Prati and Cicognani, 2021). In a recent study involving over 5,500 secondary school students, Singh et al. (2019) found that a nurturing school environment characterised by supportive student relationships with teachers and peers, a sense of belonging, and active participation in school, resulted in lower predicted rates of depressive symptoms, experiences of bullying and the perpetration of violence. The quality of these relationships was the strongest predictor of these outcomes.

These findings support a socio-ecological approach to mental health promotion and well-being that focuses less on organisational policies and structures (though these also need to be in place), and more on the relational processes that take place within the community. These include supportive and caring relationships among the various members at both vertical (teachers-students, administration-staff, staff-parents) as well as horizontal levels (collegial relationships among the school staff, students' peer-connectedness) (Brown and Shay, 2021; Thomas et al., 2016). The sense of connectedness that emerges from such relationships contributes to a sense of belonging and community, which operates as a factor promoting the mental health and well-being of all school children (Aldridge and McChesney, 2018; Oberle, 2018; Thapa et al., 2013, Wang and Degoll, 2016), as well as being a protective factor for marginalised children, moderating the negative impacts of socio-economic status (OECD, 2020; Thapa et al., 2013). The findings from the latest PISA results (OECD, 2020a) (e.g. a decrease in the sense of belonging over the last 15 years) and from the WHO HBSC study (Inchley et al., 2020) (e.g. overall decline in mental health and social well-being, decrease in liking for school), underline the need for schools in Europe to create more connected classrooms and schools which foster a sense of belonging and community among students. Both studies show that students from socio-economically disadvantaged schools in various Member States reported a weaker sense of belonging and lower levels of support from school peers and friends. This calls for a strategic focus to enhance the school experience of students with lower socio-economic status, in order to reduce social inequalities in education and promote the mental health of young people.

Box 12. Mental health and supportive school environments in middle schools

Oberle et al. (2018) carried out a population-level, longitudinal study on optimism and middle school students' relationship experiences at school – namely, peer group belonging, peer victimisation, and supportive relationships with school staff. They found that greater peer belonging, fewer experiences of peer victimisation and higher levels of staff support in school, were linked to greater optimism, above and beyond the effects of gender, age, and SES. School-wide levels of peer belonging and staff support (indicators of a supportive school climate) were predictors of optimism, while school-wide peer belonging was associated with increases in student optimism. The authors concluded that positive relationship experiences at school are key contributors to positive mental health, over and above the absence of negative relationship experiences (i.e. victimisation), and that a school with a positive social climate contributes positively to students' current and future mental health, over and above individual relationships with peers and school staff.

Adapted by the authors from Oberle et al. (2018)

6.2   Safety and bullying at school

School and classroom climates are key elements influencing bullying, which need to be addressed through anti-bullying interventions. Elements of the school climate that affect bullying can be delineated into dynamics, attitudes and informal norms in favour or against bullying that are shared by peers, teachers and school staff, parents and the local community. Accordingly, the majority of anti-bullying interventions include strategies to change dimensions of the school climate. Several of these have obtained encouraging effects.

Generic interventions aimed at promoting students' mental health and well-being can have a positive impact in terms of bullying prevention, as a result of changes in the school climate. An example of this is the whole school intervention 'Utrecht Healthy School', implemented in Dutch secondary schools between 2007 and 2010 (Busch et al., 2013). The intervention is based on the whole-school approach model described by the European Network of Health Promoting Schools (Barnekow Rasmussen, 2005; Cheshlarov et al., 2002). The Utrecht Healthy School programme did not focus primarily on bullying, but aimed to promote healthy behaviours among adolescents These ranged from healthy nutrition, physical exercise and sexual health, to reducing risky and unhealthy behaviours (e.g. substance use, gaming, screen time and internet use), as well as bullying. The programme focused on changing the school climate by involving the whole school community, including students, teachers and school staff, parents and the local community (as well as experts and other schools). Interventions involved the curriculum and peer-education activities, as well as school policies to promote healthy behaviours and prevent bullying. At the end of the three years, a significant reduction in several unhealthy behaviours was reported among the 336 students at the intervention school, including reductions in bullying perpetration among both boys and girls, and in victimisation among girls. This study shows the relevance of addressing the school climate in order to prevent bullying, by means of universal interventions with a minimal focus on bullying.

Interventions that are systematically developed to target bullying include actions to change the school climate, starting from the implementation of anti-bullying policies at the school level. For instance, the KiVa programme adopts the whole-school approach, with the objective of influencing the whole-school ecology. It places a particular focus on bystanders in bullying. KiVa involves all actors within the school system (students, teachers and school staff, parents) using a wide range of actions and tools (including electronic tools). These are implemented at school, classroom and individual levels. Its aim is to change the key components of the school climate: the attitudes of teachers/school staff and bystanders, school informal norms, and peer relationships. The data regarding the effectiveness of this programme in reducing bullying perpetration and victimization have been reported elsewhere (Chapter 2), but a recent study also provides some evidence that KiVa can also be effective in improving the victims' plight by reducing their negative perceptions of the school climate (Juvonen et al., 2016). In a sample of 7,010 Finnish students between the 4th and 6th grades, students at the 39 schools in which Kiva was implemented over 12 months (vs. 38 control schools), perceived a more caring climate after the intervention. This feeling was stronger among those students who were bullied most before the intervention, and thus the ones who suffered the most from bullying. Among 6th graders, the most victimised students at the KiVa schools also reported the greatest reduction in depression and the greatest improvement in self-esteem. Aside from their positive effects on bullying perpetration and victimisation, anti-bullying interventions that focus on changing dimensions of the school climate can also promote the well-being and mental health of children and young people who are the targets of bullying, in particular high-rate victims.

A whole-school anti-bullying programme specifically developed to change the school climate is the Bully Proofing Your School programme (Garrity et al., 2000). One of its main components is to create a positive school climate by promoting a 'caring majority' in the school that works to alter bystanders' behaviour. The other two core components seek to heighten awareness about bullying, and teach students protective skills against victimisation. Interventions include teacher education, curriculum activities implemented once a week by classroom teachers, the mental health of school staff, informing parents and providing counselling to parents of both perpetrators and victims, and teaching students avoidance and assertiveness strategies, as well as when and how to intervene when witnessing episodes of bullying. Full implementation of the programme spanned three years. The evaluation of the programme indicates that in the three primary

experimental schools (vs. three control schools) the programme led to reductions in both bullying perpetration and victimisation, an increased perception that bullying was discouraged at school, and a weak increase in the perception of safety at the school (Menard and Grotpeter, 2014). In the meta-analytical study by Gaffney and colleagues (2019a), this programme led to the highest reduction in bullying victimisation after NoTrap!, illustrating the value of focusing on the school climate to prevent bullying. Nevertheless, the authors highlighted that the positive effects of the programme weakened later on, when the schools implemented the programme without assistance from expert staff (Menard and Grotpeter, 2014). This indicates the need for schools to continue to monitor the implementation of the intervention, and to develop instruments and tools to support schools in becoming autonomous with regard to the implementation process.

Changing the school climate, particularly the school organisation and teachers' attitudes to and relationships with students, appears to be a core element for follow up interventions with bullied students as well as interventions addressing discriminatory types of bullying (bullying that targets members of minority groups in society). In a recent study in Norway by Tharaldsen (2020), experts from the national school and health systems and the wider community, as well as teachers/school staff, participated in focus groups to discuss follow-up work with bullied students, with the aim of also mitigating the negative consequences of victimisation in relation to mental health problems. The need to facilitate an inclusive learning environment and a positive classroom climate were highlighted by the participants as key elements for the follow-up work with bullied students, along with providing emotional support to these students at school, collaborating with the students' parents, and organising (within the school, and in collaboration with the wider community) systems to support teachers in this work.

School climate is also likely to be a key element that needs to be addressed in future interventions aimed at addressing discriminatory bullying, in particular ethnic bullying (Elamée, 2013). Recent research within the European context indicates that prejudices, as well as perceiving that cultural diversity is not accepted at a school, are associated with a higher risk of becoming a perpetrator of discriminatory bullying, in contrast to having a visible and influential status among peers (Caravita et al., 2020). Perceiving a negative school climate in terms of low acceptance of diversity can be a risk factor for perpetrating bullying towards migrant peers, in particular among those students belonging to the ethnic majority group who have more opportunities for contact with migrants, as is the case in multi-ethnic schools (Caravita et al., 2021). Students themselves also explain ethnic bullying with reference to negative attitudes towards ethnic minority members that are shared by teachers (Mazzone et al., 2018). In a study of Swedish students, Özdemir and Özdemir (2020) found that the ways in which students perceive the inter-ethnic climate in school and teachers' reactions to ethnic victimisation were associated with their involvement in ethnic victimisation. These results indicate that interventions that address ethnic bullying also need to include components that are specifically aimed at changing the school climate, as this is one of the key mechanisms underlying this phenomenon.

6.2.1   Adaptation and individualisation of interventions to prevent bullying

In view of its systemic nature, both in terms of individual behaviour and as a group phenomenon, highly influenced by factors at individual, classroom, school and community levels, bullying provides a prototype for interventions that seek to join together the three levels of prevention (universal, selective and indicated), and that need to be adapted according to the axes discussed in Chapter 2. International data, including various meta-analytic studies, indicate that anti-bullying interventions have a positive impact on the school environment, reducing both the perpetration and the victimisation by bullying. Nevertheless, contextual and individual factors moderate these effects and call for

adaptation of the interventions with respect to geographical area, student age, programme components, and individual and contextual characteristics.

Geographical area: The positive effects of programmes aimed at preventing bullying, which mostly adopt a whole school approach, have been found to be larger in Europe, where the rates of bullying are lower in comparison to other geographical areas (Gaffney et al., 2019a; 2019b). However, the effectiveness of interventions that adopt the whole-school approach (e.g. KiVa) varies between countries, underlining the need at individual country level to adopt programmes that have been developed and/or already validated in those areas, possibly with a different mix of components in terms of universal, selective and indicted interventions, according to context (Gaffney et al., 2019b).

Age of students: In anti-bullying prevention programmes, the whole-school approach has been found to be more effective among younger students up to 7th grade (Yeager et al., 2015). In older grades corresponding to the adolescent years, when peers become a more relevant source of socialisation, the whole-school approach may be not enough, and may potentially lead to negative side-effects. At this age, the implementation of additional peer education or peer mediation components (such as those in the NoTrap! Intervention) can be useful, in particular to reduce victimisation. The use of online settings can be also helpful, particularly among adolescents. Programmes that target adolescents may also benefit from techniques and activities that are less oriented towards facilitating basic social skills, and are instead based around the developmental tasks of this age group. Adolescents may therefore be considered a particularly sensitive group requiring specific types of interventions at universal and selective prevention levels.

Components of preventive interventions: When implementing anti-bullying interventions, consideration should be given to the fact that the whole-school approach is more likely to decrease bullying perpetration rather than victimisation. It is therefore crucial to include peer education and support as a form of targeted prevention. The use of peer education tools (e.g. online forums moderated by peers, as in NoTrap!) can be included in curriculum activities, and needs to be integrated into teacher education to enable teachers to effectively supervise the peer educators' activities. Universal prevention, which is typical of the whole-school approach (e.g. through the defining of policies) is, however, effective in changing the attitudes of bystanders (see Saarento et al., 20915), thus mitigating the possible negative outcomes that result from witnessing situations of bullying. These include desensitisation and self-justifications of violence (Killer et al., 2019). The effects of universal interventions on perpetrators and victims can be enhanced through the implementation of targeted prevention strategies (e.g. empathic training) aimed at these subgroups of students, as well as specific groups at higher risk of involvement in bullying (e.g. ethnic minorities; Downes and Cefai, 2019). Among the strategies included in the whole-school approach, studies indicate that parent and teacher training on bullying, as well as teachers' supervision of hotspots, are particularly useful in reducing the perpetration of bullying (Gaffney et al., 2019a; 2019b; Saarento et al., 2015). These strategies may become standard elements of whole-school interventions aimed at preventing bullying, at the levels of both universal and selected prevention.

Contextual and individual characteristics: The data on the differential effects of the whole-school approach and of single intervention components on reducing bullying perpetration, victimisation and improving health outcomes among students, underlines the need to perform a preliminary analysis of the bullying situation in a specific school context before planning and implementing whole-school interventions. Standard measures (self-report questionnaires, checklists) may be used, which are either already available or can be developed from existing, validated instruments (e.g. the Revised Olweus Bullying Questionnaire; Gaete et al., 2021).

The adaptation and implementation of school-based interventions following these four axes, together with increased monitoring of the implementation, are therefore recommended to prevent bullying within a whole-school approach in the European context.

6.3   Student engagement

One of the key principles presented in the framework for the promotion of mental health and well-being at school is children's right to expression and participation. This is complemented by emerging research which shows that when children and young people are given a meaningful voice in the design, implementation and evaluation of mental health and well-being promotion in schools, such interventions are more likely to lead to positive student outcomes (Atkinson et al., 2019; Garcia-Carrión et al., 2020; Rampazzo et al., 2016; Thomas and Aggleton, 2016). Having a representative voice and actively participating help students to 'own' and identify with the interventions and foster a sense of belonging (Atkinson et al., 2019; Cefai et al., 2018; Kutsar et al., 2019), and to develop self-efficacy and a sense of control (Weare, 2017). Students need to be active partners, not only in the classroom but across the whole school context, including the planning, implementation and evaluation of policies and practices. They may also participate in the co-design and delivery of the interventions themselves, such as peer mediated support in mental health (Atkinson et al., 2019; Feis et al., 2019).

In a qualitative study involving Swedish students, Kostenius and Bergmark (2016) found that students' understanding of health and well-being and how health could be promoted in school, focused on appreciation in various forms, such as a sense of belonging, being cared for by others, being respected and listened to, and feeling valued and confirmed. Kostenius and colleagues (2019) undertook a similar study involving young people aged 15 to 21 in Sweden and Scotland, to find out how mental health could be promoted in school. Connectedness featured again as an overarching theme ('everyone being there for each other'). This encompassed three sub-themes: being in a safe, inclusive and well-informed space; meeting adults who are available, listening, and taking action; and feeling significant and of significance to others. Atkinson et al. (2019) argue that young people may be the ones best positioned to understand the pressures and social issues impinging on their own lives. A bottom-up, participatory approach to mental health and well-being, guided by the principles of empowerment, autonomy and democracy (Weare and Nind, 2011) positions students as active agents in the 'shared ownership' of the interventions rooted in the culture and ecology of the school context (Inchley et al., 2007).

Student representation and participation can take place through various mediums such as school councils, health councils (see Box 13), joint committees and collaborative action groups (see Box 14). It is important, however, that this participation is as broad and representative as possible. The voices of vulnerable and marginalised children who are more at risk of mental health difficulties, need to be actively represented throughout the whole school. This is particularly pertinent in the field of mental health and well-being where such children are more at risk and are less likely to feel connected, safe and have a sense of belonging (OECD, 2020a; WHO, 2020). Their participation and contribution will ensure that they become more connected to the school, and that materials and interventions are culturally responsive and address the needs of all children in meaningful, inclusive and equitable ways (Cefai et al., 2021).

Box 13. Students' councils and health councils, Estonia

In Estonia, the Network for Health Promotion oversees the establishment of 'health councils' in schools, which include students. The health councils' training comprises the teaching of general skills such as problem solving, decision making, cognitive skills to resist the influence of the media and other people, skills for developing self-control and self-esteem, skills for effective coping with

stress and anxiety, and general skills for establishing oneself. The council consists of representatives of the school administration, teachers of various subjects, students; professionals working with the school, parents, and the local municipality. The decisions made by the health council reach all students, teachers and parents. Cooperation between the school's health council, the student self-government body, the board of governors, the school's administration and the local municipality creates the synergy necessary for successful implementation of health promotion activities in the school setting.

From Rampazzo et al. (2016)

Box 14. Case studies of students engaged in mental health promotion in school

Atkinson et al. (2019) published a paper, co-authored with young people, about a mental health initiative in a secondary school in the UK led by students themselves (12–18 years). With the support of school psychologists and school staff, the students developed a whole-school, student-friendly mental health strategy. The students "advocated for young person-friendly, innovative and creative ways of communicating information about mental health (e.g. the use of technology and visual resources), which avoided stigma… as the project progressed, it became evident that applying even carefully selected adult mental health models to school contexts might not be appropriate" (p.3). The authors recommend the model 'Voice is not enough' as a potential model for developing future policy and practice. This model comprises: Space (children must be given the opportunity to express a view); Voice (children must be facilitated to express their views); Audience (children's views must be listened to); and Influence (children's views must be acted upon, as appropriate).

The **Peer Education Project** (Mental Health Foundation)[22] is a peer-led mental health programme in secondary schools that focuses on equipping young people with the knowledge and skills they need to safeguard their own mental health, and that of their peers. More specifically, it seeks to improve young people's understanding of mental health, risk and protective factors, how to maintain mental health and well-being, how to seek help, and how to support their peers. Working in pairs or small groups, the trained peer educators deliver five lessons to peer learners. The material can also be used for group, class or whole-school discussions about mental health.

Developed by the authors

Another important aspect of student participation is to involve student peers in the implementation of interventions. Engaging peers in the delivery of school-based programmes can improve mental health and reduce risk behaviours, as adolescents find peer-mediated interventions more engaging and convincing than those created by adults, while having the opportunity to observe their peers role-modelling the health behaviours directly and through social networks (King and Fazel, 2021; WHO/UNESCO, 2021). Furthermore, having student peers as delivery agents helps to reduce stigma while addressing issues of increasing demands and limited supply and resources (Feis et al., 2019; King and Fazel, 2021). Peer-mediated interventions include support or training given by trained and supervised students to peers on issues such as bullying, school transitions and mental health. This support may be organised as peer support, peer mentoring, peer counselling, befriending or a buddy system (Cowie et al., 2020). Peer-mediated support may be used for universal, selective or indicated interventions in both primary and secondary schools. Houlston et al. (2009) suggest that universal interventions are more widely used in primary schools, while targeted interventions are more common in secondary schools. In a systematic review of 11 studies on peer interventions, involving a total of 2,239 participants, King and Fazel (2021) found no strong evidence for their effectiveness in mental health promotion, with indications that they may be more beneficial for the trained peer leaders than for the students who receive the intervention. However,

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[22] www.mentalhealth.org.uk/projects/peer-education-project-pep

they conclude that this was a small-scale review, and that further research is needed to evaluate the effectiveness or otherwise of peer-led mental health initiatives in schools.

Box 15. Peer support to counteract bullying

> In the context of bullying, peer support mobilises the skills and values of young people in addressing the issue of bullying, in order to provide emotional support to peers before their distress escalates into more serious mental health difficulties. It can take the form of face-to-face sessions, support through landlines or mobile phones, social networking sites and online forums, or actively promoting cooperation and a sense of belonging across the whole school. Terms used include 'befriending', 'mentoring', 'buddy mentoring', 'cybermentoring' and 'buddying'. Peer supporters usually receive needs-based, goal-directed and experiential training. In the most effective schemes, they are supervised on a regular basis. In various programmes, they also engage in self- and peer-evaluation to assess their capacity to offer guidance and emotional support to peers who are being bullied.

Adapted by the authors from Cowie (2020)

6.4 Staff participation, education and well-being

As the primary delivery agents for the promotion of mental health and well-being at school, school staff need to be actively and influentially engaged, as well as adequately trained and supported, also paying attention to their own well-being and mental health. The main studies discussed in Chapter 2 underline clearly that teachers need to participate actively in the development, implementation and evaluation of initiatives and activities relating to mental health and well-being at school. A participatory, bottom-up approach positions teachers, together with administrative and support staff, students, parents, community stakeholders and professionals, as 'shared owners' of the project, 'rooted' in the culture of the school (Goldberg et al., 2019; Inchley et al., 2007; Rampazzo et al., 2016). This active participation ensures that any interventions and initiatives implemented at the school will reflect the needs of the school population, will be owned by the teachers, and will be implemented faithfully by committed and enthusiastic teachers (Weare and Nind, 2011).

In order for teachers to participate actively and effectively in this process, however, they need to receive adequate training and support in the various aspects of the whole-school approach, in both universal and targeted interventions, in initiative at the layers of both the classroom and the whole school, and paying attention to their own social and emotional competences (Goldberg et al., 2019; O'Connor et al., 2018; Rampazzo et al., 2016; Thomas and Aggleton, 2016). This comprehensive education will ensure that teachers are confident in their promotion of mental health, are equipped with the foundational knowledge underpinning mental health interventions and programmes, and that they subsequently become less dependent on pre-packaged approaches (Goldberg et al., 2010; Nielson et al., 2019; Schonert-Reich et al., 2015).

First, teachers need to appreciate the importance of the promotion of mental health and well-being as a key goal of education, and should have a good understanding of the social and emotional development and mental health of children and young people. They need to appreciate that the formal curriculum itself, implemented through a child-friendly, collaborative, culturally responsive and constructivist pedagogy, is an important tool in promoting students' mental health and well-being. They also need the knowledge and skills to promote mental health and well-being through the implementation of curricular/universal and targeted interventions, making use of interactive and experiential pedagogy and evidence-based practices.

Teachers also need to be equipped on how to create a safe and caring classroom climate conducive to mental health and well-being, paying particular attention to their own

attitudes, behaviour and role-modelling. They need to have the competences to build warm and caring relationships with students, colleagues and parents, to be empathic and open to diversity, to engage in constructive conflict resolution, and to regulate their own emotions and manage stress. Such competences enable them to create a strong classroom culture that promotes mental health and well-being as a daily classroom process. This entails experiential learning sessions to develop these competences, during which they may also work on their potential biases and prejudices in relation to mental health and diversity. Finally, teachers need to be able to work collaboratively with students, colleagues, parents and professionals to promote mental health and well-being and support students with mental health needs, to address bullying effectively, and to identify and respond to early signs of mental health difficulties in students (Goldberg et al., 2019; Jennings et al., 2017; Rampazzo et al., 2016).

This process needs to begin during initial teacher education, with the promotion of mental health and well-being becoming a mandatory area of the teacher education curriculum (Cefai et al., 2018; Schonert-Reich et al., 2015), followed by ongoing, school-based professional learning[23]. Professional networks, learning communities and collaboration platforms provide a collaborative learning environment in which teachers can share, discuss, receive feedback and improve their practice in mental health promotion (European Commission, 2015). The sharing of experiences and success stories by committed teachers who are actively engaged in mental health promotion in their schools would serve to reduce potential anxiety and resistance among colleagues (Nielson et al., 2019).

Professional development also needs to enable school leaders to drive the initiative and embed it into the structures and culture of the school. In collaboration with the other members of the school community, school leaders need to lay out the vision for a whole-school approach to mental health and well-being. They must assess the needs of the school and devise a plan of action, followed by whole-school implementation and evaluation. They also need to guide and support their staff in integrating mental health and well-being into the curriculum and the whole-school ecology, providing the necessary human and physical resources and education, while mobilising the active engagement and support of parents, the local and community and professionals (Durlak, 2015; Mahfouz et al., 2019; Samdal and Rowling, 2013).

Box 16. Teacher education in Norway

> In Norway, the learning environment and pedagogical analysis framework (LP) provides a working method in which teachers collaborate in groups according to specific themes to obtain an understanding of the factors that trigger, influence and maintain students' behaviour at school. LP is a system for the analysis of educational challenges, the improvement of learning and the tailoring of professional development at school. Teachers are responsible for identifying what needs to be done in order to develop a good learning environment. The model does not follow a traditional strategy in which only one specific method or particular intervention is tested in school. The measures implemented by teachers are to be developed at their respective schools, based on an analysis of the challenges and conditions in each classroom or school, in line with the results of research in the area.

From Rampazzo et al. (2016)

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[23] Some other studies have found that interventions by qualified experts, particularly targeted interventions, were more effective than those implemented by teachers (e.g. Franklin et al., 2017; Werner-Seidler et al., 2017; Wigelsworth et al., 2020). Overall, however, the evidence suggests that universal interventions (and, where appropriate, targeted interventions) may be effectively implemented by teachers as long as they are adequately trained and supported. As interventions become more specialised and targeted, teachers would need to collaborate closely with professionals and trained experts as part of a collaborative implementation team.

- Review current practices in terms of initial and continuing professional development, and carry out a consultation to define the training needs, tailored to the local context, for all school staff who interact with children and adolescents.
- Also involve representatives of other sectors in the training, such as social, criminal justice and youth organisations, and allocate appropriate resources.
- Ensure that training is also made available to the members of the families and caregivers of children and adolescents. Provide opportunities for meetings and training sessions involving both teachers and families, in accordance with a community-level approach.
- Ensure that particular attention is also paid to the positive mental health and well-being of teachers and school staff via continuous support and mentoring.

From Rampazzo et al. (2016)

A symbiotic relationship exists between the mental health of teachers and that of students. Teachers need to enjoy positive mental health themselves in order to promote the well-being and mental health of their students[24]. The classroom and school climates are strongly mediated by the relationships between staff and students, and between the staff themselves (Thapa et al., 2013; Thomas and Aggleton, 2016; Wang et al., 2020). Teachers' well-being, self-efficacy and job satisfaction have been identified as key factors mediating the teacher-student relationship (Twum-Antwi et al., 2019). In a recent study involving 25 schools in the UK, Harding et al. (2019) reported that higher teacher well-being was associated with higher student well-being and lower student psychological distress, particularly mediated by the quality of the teacher-student relationship. Conversely, higher levels of depressive symptoms among teachers were associated with poorer student well-being and psychological distress. Teachers' burnout contributes to students' apathy (Gibbs and Miller, 2014), but supporting teachers to address burnout promotes their well-being (Iancu et al., 2018) and consequently that of their students (Harding et al., 2019). Correspondingly, teachers' well-being is positively related to student learning and achievement: Briner and Dewberry (2007) found that teacher well-being accounted for about 8% of the variance in student performance. Socially and emotionally competent teachers report lower levels of stress and higher job satisfaction, and feel more confident and satisfied in their work (Jennings et al., 2017; Nielsen et al., 2019; Oberle et al., 2016).

In their review of resilience interventions in schools, Twum-Antwi et al (2019) found that professional learning such as social and emotional development, as well as mental health and stress management programmes (including mindfulness) were found to reduce teacher burnout and increase teacher self-efficacy, job satisfaction and overall well-being, leading to enhanced teacher-student relationships. The recent Eurydice report (2021) on teachers in Europe concludes that creating conditions for collegiality and collaborative work, increasing teacher autonomy, and providing meaningful professional learning opportunities, helps to reduce teachers' stress and improves their well-being. Various studies have also underlined how the school context itself may promote the mental health and well-being of teachers through collegial relationships, supportive administration, mentoring and coaching (Ingersoll and Strong, 2011; Mahfouz et al., 2019; Mansfield et al., 2016).

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[24]According to the recent Eurydice report (2021), almost 50% of teachers in lower-secondary schools in the EU experience stress in their work (variation between Member States ranges from 90% to 20%). Overall, 22% to 24% of teachers reported that stress had a negative impact on their physical and mental health. The health and well-being of teachers is generally linked to their working conditions, with key sources of stress including administrative work, excessive marking, responsibility for exam results, as well as classroom management, heavy teaching load, and addressing parental concerns.

Ungar (2012) underlined the school context as a resource for teachers' personal growth, while pointing out that the personal and ecological positions are not mutually exclusive and support each other. Cefai and Cavioni (2014) proposed an interactional perspective to teacher well-being, integrating the development of teachers' personal, social and emotional resources with a caring school context that promotes their well-being and provides support and protection against emotional labour and burnout. Beltman (2020) maintains that research evidence and recent systemic views support a broad framework for teacher resilience including both individual and contextual processes, together with strategies employed to maintain well-being and health and their consequent, positive outcomes. More specifically, the combining of personal (motivation, self-efficacy, sense of purpose, optimism, and social and emotional competence) and contextual resources (school leaders, colleagues, relationships with students, mentors, and school culture) leads to the adoption of resilience strategies (maintaining work-life balance, problem solving, professional learning, goal setting, setting boundaries, and reflection), resulting in positive outcomes such as well-being, commitment, agency and job satisfaction (Mansfield et al., 2016).

Box 18. Mindfulness-based interventions for schoolteachers

The Cultivating Awareness and Resilience in Education (CARE) programme (Jennings et al., 2017) is a mindfulness-based professional development programme for schoolteachers, designed to promote teachers' well-being, social and emotional competences, and to improve the quality of their relationships with students. In a cluster-randomised trial design study involving 224 teachers (each of whom received 30 hours of training) in 36 primary schools, Jennings et al. (2017) found positive effects on teachers' emotional regulation, mindfulness and psychological distress. In a review of 13 studies (mostly in the US) on the impact of mindfulness-based interventions for schoolteachers, Emerson (2017) reported a positive impact on emotional regulation and to a lesser extent on perceived stress, but not on professional self-efficacy; the author also raised concerns regarding the various limitations of the studies. Farias and Wikholm (2016) took a more critical stance on mindfulness in general, arguing that there is insufficient or inconclusive evidence for its benefits, particularly when compared with other interventions. They argue that it may benefit some but not others, and that for some it may actually have an adverse effect. They maintain that there is a need for more quality research on the impact of mindfulness.

Developed by the authors

6.5 Working collaboratively with parents and the community

6.5.1 Parents

Parental participation is considered an essential component of effective interventions to promote the mental health and well-being of school children (García-Carrión et al., 2019; Paulus et al., 2016; Weare, 2010; Weare and Nind, 2011). As Weare (2017, p.121) points out, 'work with parents, families and communities can add strength and depth to efforts to promote well-being, help young people experience a sense of coherence across their lives and feel a genuine sense of well-rooted, belonging which is highly protective for mental health'. The results of the meta-analysis of universal school-based programmes by Durlak et al. (2011) show that the interventions with more significant effect sizes were those that involved parent-delivered activities at home and teacher-delivered activities at school. The review by Baughman et al. (2020) on interventions in early childhood to prevent anxiety and depression shows the positive impact of interventions in mitigating the negative consequences of these problems, when parents were also actively involved. The knowledge and skills facilitated through parents' interventions allows them to undertake a more dynamic role in promoting their children's mental health (Rampazzo et al., 2016). They can act through different paths, such as reinforcement at home of the skills learned in the classroom; practice in real-life contexts; improved family dynamics;

better communication; and the moderation of negative mental health consequences (O'Conner et al., 2017; Philips and Bruckmayer, 2021).

Another important feature of several family-school interventions is their focus on parents' mental health and well-being (Twum-Antwi et al., 2020). As previously mentioned, such programmes promote a positive parenting style, but they also contribute to a reduction in parental stress as well as promoting mental health and resilience (Twum-Antwi et al., 2020). Parents and families' health and well-being are undoubtedly crucial factors in the mental health of children and young people. As Twum-Antwi et al. (2020, p. 1) note, 'the more resilient caregivers are, the more likely children are to experience the promotive and protective factors they require for optimal growth and development in both home and school settings'. As such, this twofold goal of parental interventions, namely the promotion of their own and their children's mental health, is essential for all parents and caregivers.

Establishing a relationship with the school is a challenging task for many parents (Damianidou and Phtiaka, 2018). Some parents feel afraid and pressured by the idea of having to participate in school life, particularly if they live in poverty, have low literacy skills, or belong to an ethnic minority. Parents may feel that teachers do not want to share children's information or are not available to listen to them effectively, or even that teachers expect them to conform to teachers' decisions (Damianidou and Phtiaka, 2018). These feelings can act as barriers to effective communication and participation. Other kinds of barriers, such as awareness of mental health problems, time, or personal or cultural beliefs about mental health support, can also prevent parents' participation (Kern et al., 2017). On the school side, teachers usually contact parents to report children's social, emotional or behavioural problems (Paulus et al., 2016). This can lead to feelings of embarrassment, inferiority, worry and accusations about their children's problems (Damianidou and Phtiaka, 2018; Weare, 2017). Nevertheless, teachers frequently misjudge these reactions as "the inertia of 'hard-to-reach' or indifferent parents" (Damianidou and Phtiaka, 2018, p.92). To address these barriers, it is necessary to involve parents in school life and every area of school-based mental health interventions, taking into account their needs, strengths, values, and culture (Kern et al., 2017; Weare, 2017).

The recent book by Paseka and Byrne (2020), 'Parental involvement across European education systems', provides an analysis of parental involvement in 11 European countries. In their conclusion, the authors answer four questions relating to the inclusion of parents in the education system and its comparability across countries and systems and policy challenges relating to parental involvement (Byrne and Paseka, 2020). The authors report that while over recent decades there has been a growing movement towards the inclusion of parents in their children's education, differences exist between European educational systems with regard to the individual and collective rights of parents as well as obligations. These differences have an impact on the research, practices and political discourses in the area. The authors conclude that participatory approaches in which parents have a voice appear to have the potential to reveal alternative ways in which parents can be involved (Byrne and Paseka, 2020).

Despite the importance of parental involvement, empirical evidence concerning techniques, strategies or activities to engage parents and establish and maintain a successful home-school relationship is scarce (Paulus et al., 2016; Weare, 2017). Nevertheless, it is possible to identify various effective actions from the literature. These are anchored in positive values such as trust, respect, safety, recognition, acceptance, empowerment and engagement, and involve the establishment of positive home-school relationships, the continuous exchange of information, and the provision of adequate support that considers families' needs and best interests (see Annex 2, Table A3).

6.5.2   Community

The importance of schools in providing community-based care for children's mental health and well-being is generally recognised and supported (Patalay et al., 2017). Schools provide an ideal setting for fostering the participation of young people, their families and community, in mental health interventions (Carta et al., 2015). Nevertheless, as Carta and colleagues observe (2015, p.19), 'it must be taken into consideration that schools in Europe are often underfinanced while being overburdened with duties and expectation from the society at large'. Schools are part of a more extensive community network that includes other stakeholders and organisations interested in children's and adolescents' mental health and well-being. Consequently, responsibility for young people's mental health needs to be shared among all the stakeholders. The European Framework for Action on Mental Health and Well-being (EU, 2016) draws attention to the importance of involving different sectors, besides health and education, in young people's mental health – namely, the social sector, criminal justice and youth organisations. School–community relationships should be reciprocal, introducing community resources into schools and providing opportunities for students to contribute back to their communities (Trach et al., 2018).

Research shows that many schools are highly dependent on community mental health services provided at school or in the community (Fazel et al., 2014). Communities are contexts that contain a considerable richness of opportunities for mental health promotion. Community programmes can help families and schools by offering opportunities for young people to acquire social and emotional competences through practical experiences (Ikesako and Miyamoto, 2015). Examples of such programmes are volunteering activities, service learning or mentoring programmes. Research shows a positive impact of these programmes on positive youth development and the prevention of problem behaviours (Gutman and Schoon, 2015). Community volunteering activities positively influence young people's social and emotional competences, but its effect is smaller than that of service learning. Service learning links community activities with classroom learning content (Gutman and Schoon, 2015). It is an experiential activity that involves active student engagement in deliberately planned events, focused on knowing and understanding the needs of their community with scheduled time for reflection (Trach et al., 2018). Successful service learning is associated with positive academic, social and emotional results for adolescents. The meta-analysis by Gutman and Schoon (2015) shows that service learning produces small-to-medium effects on social skills, motivation and self-perception, and medium effects on academic outcomes. Results also point to more positive effects among older students. The meta-analysis also found that mentoring programmes produce small but significant results. They appear to produce better results among at-risk children and adolescents, with community programmes showing larger effects than programmes implemented within schools (Gutman and Schoon, 2015).

The availability and accessibility of community programmes and specialised school-based or community-based services is crucial for young people. Nevertheless, it is not enough to develop and implement interventions that focus on fostering individual, family or community protective factors to promote mental health, prevent or address problems. As several authors point out, it is also imperative to develop actions to reduce the social risk factors or mitigate their effect. Khanlou and Wray (2014) talk about the importance of a whole-community approach in which, aside from the promotion of an individual resilience process ('beating the odds'), it is also fundamental to intervene with regard to social risks ('changing the odds'). According to the authors, 'a whole-community approach is one in which the critical domains of resilience, family, school environment and community are integrated in the mission of fostering resilience through collaborative partnership and engagement' (Khanlou and Wray, 2014, p.76).

An interesting project developed in this area is the 'Asset-Based Community Development

(ABCD) in Schools', implemented in England and involving undergraduate mentors from two local universities (Forrester et al., 2020). On the one hand, the project stimulates the recognition, expression, appreciation and utilisation of the mentors' own unique assets; on the other hand, it links this to the identification and exploitation of the school and community. The mentors share their skills with the group and support the students in identifying community assets, discovering a community issue in which their assets may be of value, and proposing and carrying out a project to solve the problem. The project's results appear very positive from the perspectives of the various stakeholders involved (students, teachers, community members), particularly in asset-building.

On the basis of the literature review, it is possible to extract three main areas of community action, directly or indirectly related to school, that have a potentially positive impact on the mental health of children and young people. First, communities can provide mental health resources to schools; second, communities can develop programmes and provide specialised community mental health services for students and their families; and third, communities can address social risk factors and promote social protective factors. These actions involve community-school exchange of resources, information provision, community mental health programmes and support groups, and engage community activities for youth, fulfilling basic needs and promoting positive community values and a health culture (see Annex 2, Table A4).

7. A Multi-tiered approach to mental health and well-being

This chapter discusses how a universal approach to mental health and well-being may be complemented by a targeted approach to providing support to school children at risk of developing mental health problems (focusing on a strengths-based, resilience perspective) and those already experiencing mental health problems, in collaboration with external support agencies within an intersectoral, transdisciplinary approach. The chapter begins by defining targeted interventions and how these relate to universal interventions within a whole-school approach.

7.1 Targeted interventions within a whole-school approach

An integrated approach to mental health and well-being in school provides targeted interventions for students at risk of (selective interventions) or experiencing mental health difficulties (indicated interventions), in collaboration with professionals and agencies. Such interventions do not replace universal interventions, but provide additional and more individualised and intensive support. Various reviews have found that universal interventions are especially effective for children considered to be at risk, and help to promote mental health and prevent mental health difficulties (e.g. Durlak et al., 2011; Sanchez et al., 2020; Weare and Nind, 2011). The results of a systematic review on the effectiveness of school-based mental health and behavioural programs for low-income urban youth showed that universal social and emotional interventions might be more effective for these young people than interventions targeting only these students (Farahmand et al., 2011). Several authors highlight the benefits of universal interventions (Domitrovich et al., 2017; Sanchez et al., 2018; Stockings et al., 2016) and their potential to prevent future problems, decrease stigma among wider population groups, as well as economic benefits. However, various authors refer to the need for a deeper understanding of how the effects of universal interventions are moderated by student characteristics such as gender, race/ethnicity, socio-economic status, disability, and sexual orientation/gender identity (Daley and McCarthy, 2020; Rowe and Trickett, 2018).

Universal interventions need, however, to be accompanied by targeted interventions for children and young people at risk, and there is evidence that an integrated approach is the most effective one for children at risk or those experiencing difficulties (Liu et al., 2020; Murano et al., 2020; Sanchez et al., 2018; Stockings et al., 2016; Werner Seidler et al., 2017; Weare and Nind, 2011). Weare (2017) mentions that evidence on mental health promotion in schools helped in the creation of a list of guidelines, among which is a balance between universal and targeted approaches. These approaches are complementary and mutually beneficial. For instance, Murano et al. (2020) found small-to-medium effects for universal intervention in the development of social and emotional competences and the reduction of behavioural problems in preschool students, and medium effects for targeted interventions aimed at students at risk. In their review of universal and targeted school-based interventions to prevent depression and anxiety among young people, Werner Seidler et al. (2017) found effects for both universal and targeted interventions, concluding that having both types of interventions in schools might be more effective. The authors also suggest a staged approach, with universal interventions being followed by targeted interventions for students at risk or experiencing difficulties. Stockings et al. (2016) underline the need of universal and selective interventions to prevent the onset of mental health problems, supported by indicated interventions for those experiencing difficulties. Furthermore, some at-risk students, such as those living in poverty and neglect or suffering from abuse, may not have access to universal interventions and thus could be better reached through targeted interventions (Boivin and Hertzman, 2012; Sanchez et al., 2018). In their meta-analysis of mental health services in primary schools, Sanchez et al.

(2018) found that half of children receiving targeted interventions came from low socio-economic background or ethnic minorities. School-based interventions can thus help to overcome disparities in access to mental health care, as these groups are less likely to make use of such services due to stigma, cost and accessibility (WHO, 2020; WHO Office for Europe, 2018).

Targeted interventions become more indicated as difficulties become more chronic and complex, forming part of a tiered intervention approach to mental health (Suldo et al., 2010). Selective interventions are targeted at students who may be at moderate risk of mental health problems, such as those from deprived background or with low SES, students with a migrant background including forced displacement, students exposed to abuse, violence, bullying or other forms of trauma, and students with learning difficulties or disabilities. Such interventions are more focused, and include cognitive behavioural interventions, mindfulness, coping skills, stress management, resilience education, and psychoeducational interventions (e.g. Caldwell et al., 2019; Dray et al., 2017; Werner-Siedler et al., 2017). These interventions are carried out in school (or sometimes in the community) in whole-classroom or small groups, usually led by trained school staff in collaboration with professionals, or by professionals from external agencies in collaboration with the school. Selective interventions also serve to build resilience by protecting children from mental health issues at a critical developmental phase, before mental health problems emerge (Woods and Pooley, 2016). Thus, they also serve to foster equity (Domitrovich et al., 2017; Fenwick et al., 2018; Stockings et al., 2016; Werner Seidler et al., 2017).

Indicated interventions are targeted at students who are already manifesting symptoms of mental health problems. These usually involve intensive and personalised one-to-one or small-group therapeutic interventions. They are usually led by inter-disciplinary and intersectoral teams that also include the family and the school staff. These students may need evidence-based therapeutic interventions that should be compatible with the universal intervention at their school. In their review of 81 universal and targeted interventions, Werner Siedler et al. (2017) reported that while universal interventions were primarily delivered by teachers, external professionals were more likely to deliver targeted interventions. Caldwell et al. (2019) similarly found that most targeted programmes were delivered by external professionals. Both external professionals and teachers may need to be actively involved to maximise the impact and ensure the effectiveness and sustainability of interventions; teachers also need to be adequately trained in providing support at this level (Williams et al., 2020). Indicated interventions may be held at school, in the community or in mental health services, but a school-based intervention with the participation and continuing support of teachers not only ensures that children and families will have access to these services, but that the children and families will be more likely to attend the intervention, and that there will less likelihood of labelling and stigma (Sanchez et al., 2018)

7.2 Selective interventions: promoting the mental health of marginalised and vulnerable students

The importance of schools in promoting resilience and mental health is evident with respect to all school children, but it is of particular importance in the case of vulnerable children and adolescents (Liu et al., 2020; Ungar et al., 2015). In the report 'Changing the Odds for Vulnerable Children: Building Opportunities and Resilience' (OECD, 2019, p.16), child vulnerability is defined as 'the outcome of the interaction of a range of individual and environmental factors that compound dynamically over time'. Individual factors include disability, mental health difficulties, a migrant background, belonging to an ethnic minority, being an unaccompanied minor, maltreatment or out-of-home care. Environmental factors may be categorised into two groups: family and community. Within the family, factors

include income poverty, maternal deprivation, parents' health problems and health risk behaviours, lower levels of parental education, intimate partner violence, and family stress. Community factors include low access to early childhood care and education, poor primary and secondary education, bullying and violence, and poor neighbourhoods (e.g. poverty, social isolation, unemployment, segregation, crime). Mental health interventions show that vulnerable children exposed to significant levels of adversity have better results than lower-risk children, and in some cases, are the only ones to benefit from these interventions (Ungar et al., 2014). Research also shows that targeted interventions have positive impacts on the mental health and well-being of vulnerable and marginalised children and young people (Liu et al., 2020; Murano et al., 2020; Sanchez et al., 2018; Stockings et al., 2016).

7.2.1   Diverse groups, individual needs

Within the broad group of vulnerable children and young people, several sub-groups can be identified, such as children and young people with a history of adverse events (ACEs); those with special educational needs (including social, emotional, behavioural or learning difficulties, disability or chronic illness); and those from ethnic minority or migrant backgrounds.

Children and young people within the first group have been confronted with traumatic experiences such as abuse, neglect, or the consequences of family dysfunction. These experiences significantly impact development (Hambrick et al., 2019). With regard to this, several authors underline the importance of 'trauma-informed' (Berger, 2019; Roseby and Gascoigne, 2021) or 'trauma-sensitive' approaches, schools or programmes (Gherardi et al., 2020), although these concepts are generally used interchangeably (Gherardi et al., 2020). According to SAMHSA (2014, p.9), 'A program, organisation, or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatisation'. This approach allows multi-tiered action, from universal interventions (e.g. professional training on trauma prevalence and impact) to selective (e.g. the development of social and emotional competences), and indicated interventions (e.g. individual or group therapy).

The second group encompasses children and young people with individual educational needs. Studies conducted in Europe show that children and young people with such difficulties are more often exposed to bullying, violence and harassment (Downes and Cefai, 2016; Møller Christensen et al., 2019). They are at an increased risk of facing mental health problems, which may not be recognised as such (McMillan and Jarvis, 2013). Consequently, the provision of information to educators, early identification of signs of mental health difficulties, and early intervention, are key recommendations to address the mental health of these students (McMillan and Jarvis, 2013). Daley and McCarthy (2020) conducted a systematic review on universal social and emotional interventions for middle and high school students, to examine how students with disabilities are considered in these interventions. The review left many open questions, namely level of participation by these students in such interventions, the amount of attention paid to these students' difficulties in programme design, the level of training and experience that professionals have with these students, and the accessibility of materials. McMillan and Jarvis (2013) recommend that schools should also invest in targeted interventions to promote mental health for students with disabilities, and should not rely solely on universal interventions that may not address the specific needs of these groups.

The third group, students with ethnic minority or migrant backgrounds, are similarly exposed to multiple negative experiences. Many minority groups live in deprived areas, in poverty, and face stigma and discrimination. Migrants and refugees have in their history adverse experiences that may occur before or during the transition to the new country. These may also continue when they arrive in the country of adoption. These 'new adversities' relate to language barriers, differences in cultural values and a lack of support networks (OECD, 2019; Slobodin and de Jong, 2015; Sullivan and Simonson, 2016)[25]. Again, schools represent one of the more obvious community settings for mental health interventions aimed at these children and young people (Eruyar et al., 2018; Slobodin and de Jong, 2015). These groups also underuse clinical mental health services, which reinforces the importance of community services.

Other vulnerable groups at substantial risk of mental health problems include LGBTQI students. A recent systematic review of qualitative research by Wilson and Cariola (2020) identified a set of themes related to significant risk factors and indicators of mental health problems. These students may face challenges such as rejection and isolation, discrimination, abuse, bullying and marginalisation, which are associated with negative outcomes such as depression, self-harm, and suicidality. The authors recommend the need for more information and support in schools and within the community, as well as inclusive policies, safe spaces, programmes and curricula that address diversity, as well as the need for peer and family acceptance and connection (Wilson and Cariola, 2020).

Lastly, students who attend high-achieving schools may also be at risk of mental health difficulties due to academic pressure, high expectations and fear of failure. Luthar et al. (2020) point out that high and ongoing pressure to excel is listed among the principal risk factors in relation to adolescents' mental health, along with poverty, trauma and discrimination. These students, who generally come from higher socio-economic status groups, are more likely to exhibit problems of internalisation and externalisation and be involved in drug and alcohol use, compared with normative samples (Luthar and Kumar, 2018).This underlines the need to 'upgrade' the status of 'soft skills', such as social and emotional education to one that is at least commensurate with that of academic achievement. This requires a raising of awareness regarding the need for a balanced education, and the development of educational evaluation systems that reflect such a balance, endorsed by governments in Member States.

One crucial aspect to consider in supporting the mental health and well-being of vulnerable and marginalised children is the heterogeneity of children and young people in all of these groups, and how best to address the needs of all of these groups of children. Narrow group interventions can facilitate cultural adaptations and community engagement but promote fixed identities, stressing the differences and distance between students. Broader programmes can mitigate differentiation, but risk not properly addressing the different needs of these groups. One possible solution to this dilemma may be the approach recommended by Weare (2010), in which universal and targeted interventions coexist to take advantage of the benefits of both interventions. Furthermore, targeted interventions need to be implemented as inclusively as possible (e.g. as part of the curriculum, delivered to the whole classroom by the classroom teachers where possible) to avoid potential labelling and stigmatisation. With regard to this, Wigelsworth et al. (2020) draw attention to the need of more robust evidence of the impact of universal interventions among the sub-groups described in this section They conclude that the evidence on the impact of social and emotional interventions among these groups is mixed, and that in order to obtain

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[25] The EU Council (2019) Recommendation on a comprehensive approach to the teaching and learning of languages recommends the use of innovative and inclusive language teaching methods in order to facilitate the proficiency in the language of schooling among students with diverse backgrounds.

conclusive results about differential effects, longitudinal studies are required to observe the effects through the course of their lives.

Box 19. A selective prevention strategy for groups at moderate risk

Building on the principles of health promotion and the international right to health, a range of key underlying principles can be developed to inform a selective prevention framework and strategy for mental health promotion of groups of moderate risk in school. These include:

- Making the target groups subjects not simply the objects of policy, through direct stakeholder representation and consultation as to the design of interventions and supports
- Cultural competence of professionals including teachers as a dimension of the right to health
- Community outreach as a dimension of the right to health
- Building community leaders among children and youth
- A strategy to develop community-based spaces of assumed connection and shared meaning for cooperative tasks between different social groups
- Involving sports, arts and nature-based activities through a relational, mental health promotion perspective

Adapted from Downes and Cefai, 2016

Box 20. Community outreach to groups at moderate risk

A distinctive feature of a selective prevention focus is that of community outreach. An interesting exploratory study in a community context involved 30 children aged between 7 and 12 in Paris (Fonseca, 2015). The intervention took place over seven months in three social centres in Paris. These socio-educational centres were also attended by a large number of children from Muslim populations. The intervention focused on corporeal activities, routine, space to talk, thinking, and group work. Activities were bodily focused, meaning that movement was always a big part of the proposed games. Some relaxing activities were also included. This exploratory study found gains regarding behavioural problems, emotional symptoms and prosocial behaviour, as well as psychomotor skills.

Adapted from Downes and Cefai, 2016

Table 2 presents the key recommendations from the literature to prevent mental health problems in vulnerable and marginalised students. The table structure is based on the Foxcroft prevention taxonomy (Foxcroft, 2014), which proposes an integration between the universal-selective-indicated categorisation with other prevention approaches, namely environmental, developmental and informational prevention. Environmental prevention encompasses interventions to limit inappropriate behaviours (e.g. legal restrictions). Developmental prevention comprises actions to promote healthy behaviours and prevent risk behaviours (e.g. developing social and emotional competencies). Informational prevention uses communication to raise awareness and expand knowledge about health-related behaviours (e.g. mass media campaigns). In this table, we have broadened the prevention areas to address not only health-related behaviours but also the behavioural difficulties associated with the groups mentioned above. Also, we have extended the environmental area to include actions regarding physical and social environments that promote solidarity, mutual respect, caring relationships, positive expectations, opportunities, social justice, access and participation (Hart et al., 2016; Khanlou and Wray, 2014).

7.3 Indicated interventions: supporting children with mental health needs

The prevalence of mental health difficulties varies according to the diagnostic classifications and assessment tools used, ranging from 10 to 20% (Polanczyk et al., 2015; WHO, 2020).

Many of these students are reached effectively by universal and/or selective interventions, but children and young people with chronic or complex needs may require more intensive and personalised support. Schools provide a unique setting for the provision of such mental health support through an integrated, intersectoral, multi-agency approach. In collaboration with health and social services, they can provide an accessible, non-stigmatising context in which the needs of the most vulnerable children and young people and their families may be effectively addressed. Such interventions have been found to be effective in reaching out to and engaging families in difficulties, reducing mental health issues, and enhancing participation in education (Sanchez et al., 2018; Williams et al, 2020).

Various reviews and meta-analyses have found that school-based programmes intended to reduce mental health problems such as depression and anxiety are effective, even though in most instances the effect sizes were small to moderate (see also Chapter 2). In a systematic review of 57 US school-based mixed interventions to reduce depressive symptoms in young people (carried out between 1990 and 2017), Aurora et al. (2019) found that the majority of selective interventions (60% of studies) and indicated interventions (16% of studies) found to have a positive impact, even if those effect sizes were small. In a similar review of 42 USA-based experimental studies on school-based programmes to prevent depression and anxiety in young people, Feiss et al. (2019) reported that the interventions were generally effective in reducing symptoms, and that targeted interventions were more effective in reducing depression than universal ones, similar to the findings of Werner-Siedler et al. (2017). Similarly, the review by Sanchez et al. (2018) found that the greatest effect in decreasing mental health was achieved by indicated interventions, followed by selective and universal interventions respectively[26].The review by Stockings et al. (2016) reported that the impact of selective and indicated interventions was short-term, suggesting the need for repeated exposure to such interventions across the school years. However, in a large-scale meta-analysis of 108 experimental trials including both universal and targeted interventions, Caldwell et al. (2019) found that targeted interventions on their own (45% of studies) did not have an impact in reducing anxiety or depression. The meta-analysis indicated that targeted interventions in schools need to be part of a multi-tiered, systems-based intervention.

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[26]Similarly, in their review of 91 studies on addressing trauma in school, Stratford et al. (2020) called for more rigorous evaluation of practices and policies that adopt a whole-school approach and can be implemented by non-clinical but adequately trained school staff.

Table 2. *Multi-tiered interventions in mental health and well-being in school*

Intervention	Universal	Selected	Indicated
Environmental	- Whole-school approach with a universal focus on mental health promotion - Focus on school and community culture and climate, and providing a nurturing and safe school environment - Create adaptable and accessible accommodations for a wide range of students - Encourage everyone to communicate openly and frequently - Resource allocation for inclusive teaching practices - Give access, voice, and ownership to staff, students and the community - Promote effective and compassionate discipline policies (restorative practices) - Promote positive relationships with parents and community services - Promote well-being in the school community	- Develop a trauma-informed school approach (SAMHSA, 2014), respecting the following principles: 1. Safety; 2. Trustworthiness and transparency; 3. Peer support; 4. Collaboration and mutuality; 5. Empowerment, voice and choice; 6. Cultural, historical, and gender Issues - Develop a participatory approach to help families overcome feelings of hopelessness and isolation - Targeted interventions to build resilience resources to deal with stigma and bullying - Promote a variety of support services for vulnerable students, family members and school staff - Promote a support network for parents (educators, relevant community stakeholders and associations)	- Use data to identify vulnerable students and establish outcomes and strategies for continuous positive growth - Individualised mental health intervention and professional treatment - Support parents with children with severe disabilities and complex needs (e.g. looking after the young people while parents take a break)
Developmental	- Develop a strengths-based approach for all students and staff - Promote social and emotional competences - Promote resilience through formal and informal professional and family networks - Promote appropriate interventions to meet the needs of the class while considering the diversity of the students. - Promote community-based initiatives that re-inforce self-esteem, positive relationships with adults, prosocial behaviour and prevent risk behaviours	- Provide tiered interventions for all students based on their needs - Promote growth in the areas of social, emotional and cognitive development affected by the adverse experiences - Develop interventions to empower these students: - Small group sessions - Nurture groups - Play-based approaches - Simulation games - Creative expression interventions, writing, drawing and dramatic interventions - Mindfulness and relaxation techniques	- Trauma-based individual, group and family therapy for students with more intense and disabling problems, complex or critical needs delivered by specialists: - Cognitive behavioural therapy - Play-based therapies

		- Emphasise both academic and non-academic goals - Adapt programmes in coherence with students' and families' needs, beliefs, practices, and identities - Improve parenting skills - Professional development for staff on the prevalence and consequences of trauma, SEN, and trauma-informed education competences - Use the wraparound process for students with emotional/behavioural difficulties, their families, teachers, and other caregivers: (a) identify the basic needs, interests and limitations of families and service providers; and (b) develop a plan to address those aspects using natural community supports - Engage programme staff with the same ethnic, linguistic or national backgrounds, or with similar experiences	
Informational	- Raise awareness about mental health (e.g. photo exhibitions, roundtables) - Educate about mental health (knowledge, attitudes, emotions, and behaviours) - Provide a perspective on the complex challenges faced daily by vulnerable students - Organise cultural events and awareness-raising campaigns to create a culture of human rights	- Involve vulnerable young people and their families in awareness activities - Promote information on the services available to support their needs	Promote information on specialised therapeutic services

Developed by the authors

In their literature review of school-based mental health programmes aimed at preventing, reducing or addressing mental health issues among adolescents, Williams et al. (2020) found mixed and limited evidence of the effectiveness of single-faceted school-based anxiety and depression programmes. They recommend that student participation may be facilitated by ensuring that programme content is meaningful and acceptable to the students, that the use of clinical and medical language is limited to reduce stigma, that student choice and control are increased, and that trust and confidentiality are given priority. Building relationships between external professionals and agencies, parents and school staff, engaging parents and school staff in the intervention, and a shared understanding of roles and support from the school administration, are also key issues in ensuring the sustainability of an intervention. Schools also need to consider the feasibility of interventions in terms of resources, time and disruption to timetabling. Peers also need to be engaged in the design and implementation of programmes, not only improve the mental health of their peers, but also to reduce stigma.

Box 21. Outreach to families with chronic needs

Individual outreach to families with chronic needs is a distinct strategic dimension of an indicated prevention approach to mental health promotion in school. A number of examples are available of multidisciplinary, community-based family support centres in European contexts. Eurochild (2011) describes one-stop multidisciplinary, community-based family support centres (SPIL) in Eindhoven, the Netherlands. These centres are linked to primary schools and childcare centres, in order to be as close as possible to families and to identify children at risk of mental health as early as possible. The multifunctional centres provide a range of health, education and social services to marginalised families, including parenting support, youth health care and social work, among others.

Adapted from Downes and Cefai, 2016

The review by Williams et al. (2020) suggests that collaborative teamwork between the key stakeholders (school staff, professionals and parents), together with active consultation with the students themselves, is crucial for targeted interventions to be effective and sustainable. Thomas and Aggleton (2016) refer to various evaluations of multidisciplinary mental health interventions in schools, which identified the factors which led to positive outcomes. These factors include involving students as active participants in the development of the interventions; ensuring all students are aware of the range of services available and where to find them; delivering interventions in an area of the school familiar to students, where they feel safe and comfortable; ensuring health professionals are visible and available to students and build trusting relationships with them; making sure interventions are welcoming, student-friendly and non-judgmental; that support is provided at an early stage; and that interventions complement other existing mental health and well-being initiatives. Multidisciplinary, inter-agency work in schools also has a positive impact on the professionals themselves, such as increasing teachers' understanding of services in relation to students' needs, and enhancing their confidence in supporting students, encouraging shared expertise and resources, mutual respect and support, as well as enhancing the sustainability of interventions by increasing their efficiency and cost-effectiveness (Thomas and Aggleton, 2016)

The review by Rampazzo et al. (2016) of policies and practices regarding the mental health and well-being of children and adolescents in 11 Member States found that while some European countries had developed multidisciplinary teams in and around schools for children and young people with the highest needs, intersectoral collaboration was weak. For instance, 25% of the policy and programmes reviewed contained no intersectoral collaboration element, while 10% offered no information on this aspect. Many of the examples of good practice identified were not part of a formal policy framework. They concluded that there is a need for a framework for intersectoral collaboration at multiple

levels, with a clear definition of roles and responsibilities, supported by legislation where necessary. More specifically, the authors recommend that the mental health and well-being of children and young people needs to be considered when defining and implementing policy in different sectors, including the health, education and social sectors. They also recommend that intersectoral collaboration on the mental health and well-being of children and young people, including cross-sectoral budgeting and sectoral responsibilities, needs to be regulated by national and regional legislation; that resources are provided per sector to finance contributions towards the mental health of children and young people, while adequate and shared financing by the various sectors involved is provided for. In addition, evaluations of the effectiveness of school based interventions should be carried out, with the aim also of increasing cost-effectiveness in each sector. The authors emphasise that all relevant stakeholders need to be provided with the necessary support and training, including the training of school staff in promoting mental health and supporting students with mental health difficulties, as well as addressing their own mental health. They recommend a review of current practices in initial and continuing professional development to define training needs, tailored to the local context, for all school staff who interact with children and adolescents.

Box 22. Case study of policy on intersectoral collaboration (from Rampazzo et al., 2016)

In Iceland, the Regulation on Specialized Services by the Municipalities for Pre- and Compulsory Schools (2010) states that municipalities are to ensure that appropriate specialist services are provided in pre- and primary schools. Municipalities must also determine the form and facilitate the implementation of interventions in schools and are responsible for rendering and financing the service. Municipalities shall specify in their school policies how the objectives of this Regulation will be met. In the delivery of specialist services, municipalities must focus on prevention, among other things, in order to effectively contribute to the welfare of students, as well as early assessment and counselling for learning difficulties and social and psychological problems. Municipalities must initiate collaboration on behalf of individual students with specialist services within the community that provide state-based assessment and intervention services. The municipalities must also ensure the mutual exchange of information between service levels in consultation with parents, and set standards regarding how these services are used. School principals must initiate collaboration between specialist services within the municipality, as well as social services, child protection and health authorities, for individual students with targeted needs.

Adapted from Rampazzo et al., 2016

8. Conclusions and recommendations

Awareness is increasing across the EU and its Member States that schools need to go beyond narrow sectoral goals such as academic achievement, and should contribute actively to promoting the mental health and well-being of children and young people. This movement for the promotion of mental health and well-being in schools is driven by children's rights to quality education, health care, well-being, protection and participation, as well as the emerging evidence on the key role of schools in promoting the mental health and well-being of children and adolescents during a critical developmental phase. In addition, it is driven by evidence from international and European comparative studies on the mental health challenges facing many young people at school today, as well as recognition of the role of education in fostering equity and social inclusion by supporting marginalised and vulnerable children who are at greater risk of mental health difficulties[27]. The increasing awareness and recognition of the importance of mental health promotion and well-being in schools does not, however, appear to be prevalent across educational systems, and has not been accompanied by the policies and practices required to put this goal into practice. Although numerous instances exist of good practices and initiatives in both policy and practice at EU level as well as at the level of Member States and local schools, there appears to be a lack of priority given to the promotion of mental health in schools, and a lack of strategic focus at national, regional and school levels regarding the integration of the promotion of mental health and well-being as key learning objective.

In view of the evidence supporting the social, emotional and academic benefits of mental health promotion in school for children and young people, as well as the increasing mental health needs of children and young people across Europe, the following recommendations are made for the effective promotion of mental health and well-being and the prevention of mental health difficulties in European educational systems.

8.1 Mental health promotion as a mandatory key learning goal in 21st-century education

In line with the policy presently being developed by the European Commission on the achievement of the European Education Area by 2025 (including the Pathways to School Success and the setting up of an expert group to develop proposals on strategies for creating supportive learning environments to support well-being at school), a supporting Communication would secure the promotion of mental health and well-being as a major educational objective across Members States, integrated into the curriculum and supported by a whole-school approach. Such an initiative is supported by the emergence of consistent evidence that schools can effectively promote the mental health and well-being of children and adolescents and prevent the emergence of mental health issues during critical periods in their development. It also resonates with the rights of children and young people to physical and mental health, quality education, protection and participation, and would help in the realisation of the corresponding Sustainable Development Goals. An EU-wide initiative in this respect would also help to clarify concepts and facilitate the consistency of terminology and an overall framework for the promotion of mental health and well-being in schools. It would also help to reduce the stigma and discrimination that surrounds mental health within various sections of European society.

[27] The evidence-based realisation that mental health promotion in school is cost-effective and offers substantial economic returns in the long term (Belfield et al., 2015; Chisholm et al., 2016), is another reason why more attention is being given to the promotion of mental health and well-being in schools.

8.2   Mainstreaming mental health and well-being into the formal curriculum and pedagogy

A strategic approach to encourage schools to broaden their agenda and include mental health and well-being as a key learning objective is to emphasise its inextricable link with academic learning and curriculum design and pedagogy, challenging the false dichotomy between mental health promotion and academic learning. Teaching practices that foster connectedness and a sense of belonging, a constructivist collaborative pedagogy involving active student engagement, instructional and restorative behaviour management, culturally responsive and inclusive practices, and role-modelling of social and emotional competences, are the building blocks of both academic learning and social and emotional competences and well-being. These practices fall within the remit of all schoolteachers, and an emphasis on such 'mainstream' practices may help to reduce resistance on the part of teachers towards mental health promotion, providing a 'royal road' to the prioritisation of mental health promotion and well-being in school.

8.3   Adapting the metrics of school success to prioritise mental health and well-being

Another important way to encourage schools to prioritise mental health and well-being, and to provide a more balanced and meaningful education, is to increase the currency of mental health and well-being in education. It is difficult for mental health and well-being to develop and flourish in systems that are bent exclusively or primarily on academic achievement as the measure of their success. Education systems need to support the change towards 21st-century schools and the positive development and well-being movement by expanding the metrics they use to evaluate school performance. Including students' mental health and well-being as a common indicator of school effectiveness and success will ensure these factors will feature prominently in the schools' agenda. Any such evaluation, however, should avoid the trappings of traditional assessments, which lead to labelling, ranking and comparisons, in favour of formative, inclusive and whole-school assessment (see the NESET report by Cefai et al., 2021). This shift in educational priorities also requires the development of educational evaluation systems that are endorsed by the governments of Member States.

8.4   Adopting a systemic, whole-school approach to mental health and well-being

School-based interventions to promote student mental health and well-being are more likely to be effective if they are organised within a systemic, whole-school approach. Whole-school interventions have a more positive impact on student outcomes than individual components such as standalone or single-component interventions, provided they are implemented well, integrated into the fabric of the school context, and sustained over time. A whole-school approach mobilises the various resources of the whole school community, including the active engagement and voices of students, staff, parents, professionals and the local community, towards a collaborative effort to promote the mental health and well-being of all the community. Universal interventions, such as mental health promotion for all students at school at both curricular and classroom climate levels, are complemented by a whole-school ecology framework that is embedded in the culture and ethos of the school and supported by targeted interventions for students at risk of, or experiencing, mental health difficulties.

8.5 Relatedness and connectedness at the heart of mental health pro-motion

While structures and policies are essential tools that facilitate the implementation of a whole-school approach to mental health and well-being, they need to be framed within an ethic of relatedness and care. A sense of belonging and connectedness, fostered by respectful, caring, and supportive relationships among the various school members across the whole school, create healthy spaces in which individuals can growth and thrive. Such an environment will also help to prevent unhealthy practices at the school that may compromise the mental health and well-being of the school's members. These include peer bullying; coercive classroom management based on fear and punishment; unequal or unfair treatment; and undue pressures on students to achieve, leading to stress and anxiety. Similarly, such environments work as an antidote against stress and burnout among the school's staff.

8.6 A bottom-up, participatory approach including a representative stu-dent voice

In line with European schools' culture of autonomy, empowerment, democracy and ownership, a whole-school approach to mental health and well-being needs to adopt a bottom-up, participatory and flexible approach that fits with the ecology of the school and the local community. A bottom-up approach also helps to ensure that any initiative is culturally appropriate and addresses the diverse needs of the school population. It will be also an investment in the development of feasible and contextually relevant interventions, developed for the local context by the stakeholders on the ground themselves. School staff, students, parents and the local community need to be actively involved in the planning and implementation of programmes and initiatives.

Parents and the local community are key resources for schools in the promotion of mental health and well-being. Their active involvement will ensure that interventions are relevant and adapted to the local context, that parents and the community will provide instrumental and moral support for school initiatives and interventions, and that they will adopt the appropriate interventions within their own community. Schools may thus serve as lifelong, community-based centres for promoting the well-being of the whole community.

A strong and meaningful student voice, both inside the classroom and across the whole school, is vital for students to identify with and 'own' the interventions. This includes the co-design of materials; participation in delivery and implementation, both in the classroom and outside; participation in decision making; and contributing to peer interventions. It is important that the student voice is representative, and includes the voices of marginalised and vulnerable children, including those with mental health needs.

8.7 Developing a mental health curriculum for school children in Europe.

All school children, from the early years to high school, need to be exposed to a curriculum that equips them with the resources and competences they need to take active steps to maintain their mental health and well-being, as well as that of others. The curriculum should include social and emotional education, resilience building, and mental health literacy (including addressing stigma and prejudice), adapted to the schools' context and needs. It may be integrated into other existing and related curricular areas and initiatives such as social and emotional education and Health Promoting Schools, and may make use of existing practices, expertise and resources. This may make it easier for mental health to find its way into the curriculum, but care must be taken to retain the focus on the

promotion of mental health and well-being. In this respect, there need to be more collaborative efforts between schools and academic institutions to develop and validate a mental health curriculum with an identity that is European in its diversity. The European Commission has led and funded various projects to promote mental health in schools, including curricular programmes developed and tested in schools across Europe. This report refers to a number of such projects, some still ongoing, as examples of good practice and promising tools for mental health promotion in European schools. Such initiatives need to be sustained and strengthened through further projects and actions.

8.8 School-based intersectoral support for students with mental health needs

Mental health is a multifaceted phenomenon, and schools need to work with other sectors and agencies to provide targeted interventions for students who are at risk of or experiencing difficulties, beginning as early as possible. Close intersectoral collaboration with health services, mental health agencies, social services and other related services, will ensure schools are able to address the mental health needs of students within a transdisciplinary, cross-sectoral approach that involves all stakeholders, including parents and the students themselves. It is essential that these intersectoral interventions are as accessible, responsive, appropriate and equitable as possible. The key role of schools in mobilising and coordinating support for students and families also ensures that services are more accessible and destigmatising, and can be linked with other support available at the school such as universal and selective interventions.

8.9 A strategic focus on the mental health needs of vulnerable and marginalised students

Students exposed to risk, disadvantage and marginalisation, such as those coming from low-SES background and migrant backgrounds, as well as children exposed to abuse, violence and bullying, and those who have experienced other forms of trauma, are more at risk of developing mental health problems[28]. Students who attend high-achieving, competitive schools may also be at risk of mental health difficulties, due to academic pressure, high expectations and fear of failure. Schools are in a unique position to prevent the onset of mental health issues and address the mental health needs of vulnerable students at a critical time before problems become more complex and chronic, through preventive selective interventions. Such interventions may include programmes tailored to the needs of the students, such as resilience or prevention programmes as well other forms of support at the school, within a whole-school approach (e.g. mentoring, extra-curricular activities). Such interventions also need to be implemented within an inclusive setting to avoid labelling and stigmatisation. Addressing the mental health needs of vulnerable and marginalised children and young people underlines the school's role in promoting equity and equality.

8.10 Involving the whole school community in tailoring interventions to prevent bullying

Bullying is a systemic phenomenon that includes both individual behaviours and experiences as well as group dynamics, which are affected by factors and relationships within the whole-school ecology and the larger community. Involvement in bullying

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[28]Children affected negatively by the COVID 19 pandemic (academically, psychologically, financially) may also be included in this group.

increases the risk of mental health problems for victims, perpetrators and bystanders. Interventions to prevent bullying within a whole-school approach should thus be implemented in all schools by means of priority actions at the level of universal prevention. Joined-up actions involving selective and indicated preventions also need to be implemented, targeting at-risk groups and individuals, to increase the effectiveness of interventions. The selection and implementation of interventions and their components (e.g. peer education) need to be tailored to the specific needs of individuals (e.g. those of adolescents and minority groups), as well as the school, community and geographical area. Such a process requires an assessment of the bullying phenomenon in the school/area in which it occurs, and the constant monitoring of programme implementation and the work of the large network that connects the school with experts, political leaders and members of the wider community. From an operational perspective, teachers and school staff should be also targeted by the intervention and should be its main delivery agents, with the support of professionals. Targeting parents in interventions is also recommended, and this should be further strengthened in existing programmes. Besides being the target of intervention actions to prevent bullying, the voices of students need to be actively listened to, and their active involvement given weight according to their age.

8.11 Prioritising teacher education in the promotion of mental health and well-being

Teachers are the primary delivery agents of mental health interventions – not only in universal interventions and, in many instances selective interventions, but also by providing their support to students with mental health needs as part of an intersectoral, transdisciplinary team. Adequate teacher education in mental health promotion both during initial teacher training and through continuing professional development, is crucial to the success of mental health promotion in schools. National frameworks for both teacher education institutions and educational authorities need to outline the key educator competences necessary for the effective delivery of mental health and well-being in schools. Teachers require training not only in the delivery of mental health interventions at classroom and whole-school levels, but also in engaging in relational, child-centred, collaborative and constructivist pedagogy. They also need to develop their own social and emotional competences as educators, such as empathy, relationship building, collaboration, and constructive conflict resolution. Mentoring programmes, professional networks, learning communities and collaboration platforms provide a collaborative learning environment in which teachers can share and improve their practice in mental health promotion. Professional development needs to be organised with the involvement of the teachers themselves, according to their needs.

8.12 Addressing the mental health and well-being of adults who work with children

The mental health and well-being of adults such as those in the school administration, the school staff, as well as parents and carers, has a direct impact on the mental health and well-being of students, and should therefore be targeted for intervention. Teachers require active support from local authorities, the school administration and their colleagues in order to deal effectively with the challenges and stresses of their profession, and to take care of and maintain their health and well-being. Similarly, schools not only need to encourage parents to share responsibility and collaborate actively with them in mental health promotion, but should also empower them in parental education and support them in taking care of their own well-being.

8.13 Strengthening evidence and evidence-based practice

Most of the reviews examined in this study underline the various methodological limitations of the studies, and emphasise the need for more rigorous research to provide stronger evidence on the effective promotion of mental health and well-being in school. The need for more evidence is particularly evident in the case of the multi-layered and complex whole-school approaches that pose particular challenges in terms of implementation and sustainability. Further research is also recommended with regard to ways in which the formal curriculum and pedagogy can facilitate and optimise both mental health and academic outcomes. Evidence is also lacking, particularly in the European context (in contrast to North American and Australian contexts), in relation to which universal, selective and indicated interventions work, and for whom. Rigorous evaluation of existing and developing interventions in European schools would strengthen the evidence base and provide schools across Europe with a repertoire of evidence-based interventions from which to choose and adapt according to their needs. Evaluations must, however, include local interventions developed and implemented in European schools. Investing in evidence-based interventions also helps to cut costs and drive funds to where they are more likely to make a difference in children's and young people's lives. Providing a stronger evidence base for school-based mental health promotion would also make it easier for mental health promotion and well-being to make deeper inroads into educational systems across Europe.

8.14 Conclusions

The recommendations made in this chapter require the transformation of traditional education systems and teaching practices in schools. They entail significant and widespread changes in the way education systems are conceived, designed and operationalised, with significant shifts in roles and power relationships. Such a change may be potentially threatening to some educational authorities, school staff, parents, professionals and others in the wider community, who may find their understandings, expectations and sense of identity being challenged. As suggested in these recommendations, a combination of legislation, advocacy, policy development, education and training, the provision of multi-level support and intersectoral collaboration will therefore be required to help schools adopt this approach and to implement it in the everyday life of the school. A bottom-up, participatory process involving the whole school community would ensure that any changes made would be meaningful, well implemented and sustained in the long term.

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Annex 1

Table A1. *Protective and resilience factors*

Domain	Subdomain	Factor
Physical		Optimal birth outcomes
Individual	Cognitive	Cognitive reappraisal
		Mental flexibility
		Rumination (low)
		Social information processing
		Adaptive functioning skills
		Intelligence
	Emotional	Distress tolerance
		Aggression (low)
		Expressive suppression (low)
		Self-regulation
		Find positive meaning in the trauma
		Hope expectancy
		Spirituality
	Interaction/attachment	Secure attachment
		Disconnection/rejection (low)
		Other-directedness (low)
		Social competence
	Personality/Self-concept	Self-esteem
		Self-efficacy
		Emotional regulation
		Well-adjusted temperament
		Extroversion, agreeableness, conscientiousness
Family	Family structure	Income level
		Stable living situation
		Living with parents
		Relatedness to mother
	Family support	Maternal warmth
		Family cohesion
		Positive family climate
		Immediate family support
		Sibling warmth
		Extended family support
	Parenting style	Positive parenting
		Parental involvement
	Peers/friends	Social support
		Positive peer context
		Friendship
Community/Society	School	Caring teachers
		School safety
		Educational support
		Sense of school membership
	Community	Community support
		Caring adults
		Social engagement
		Social cohesion
		Living in a neighbourhood with few problems
		Informal social control in the neighbourhood

Developed by the authors from the analysis of the literature.

Table A2. *Meta-analyses on the effects of social and emotional competence school-based interventions*

Authors	Year	Study Type	Type of Interventions	Population/Grade	Positive Outcomes
Durlak, Weissberg, Dymnicki, Taylor and Schellinger	2011	Meta-analysis 213 studies 270,034 students 2007	Universal	Pre-K-12	• Social and emotional skills • Attitudes • Behaviour • Academic performance
Sklad, Diekstra, Ritter and Ben	2012	Meta-analysis 75 studies Intervention group size = 543 students (SD = 1,119.83) 1995-2008	Universal	Primary or secondary school	• Social skills • Antisocial behaviour • Substance abuse • Positive self-image • Academic achievement • Mental health • Prosocial behaviour
Wigelsworth, Lendrum, Oldfield, Scott, Bokkel, Tate and Emery	2016	Meta-analysis 89 studies 1995-2013	Universal	Pre-K-12	• Social-emotional competences • Attitudes towards self • Prosocial behaviour • Conduct problems • Emotional distress • Academic achievement • Emotional competence only
Boncu, Costea and Minulescu	2017	Meta-analysis 37 studies 32,742 students 2008-2015	Universal	Children and adolescents	• Social and emotional skills • Externalising problems • Internalising problems • Prosocial behaviour • Attitudes
Taylor, Oberle, Durlak and Weissberg	2017	Meta-analysis 82 studies 97,406 students 1981-2014	Universal	Pre-K-12	Follow-up outcomes (6 months to 18 years post-intervention) • Social and emotional skills • Attitudes • Well-being
Corcoran, Cheung, Kim and Xie	2018	Meta-analysis 40 studies 16,000 students 1970-2016	Universal	Pre-K-12	• Academic achievement • Reading (N = 57,755) • Mathematics (N = 61,360) • Science (N = 16,380)
Goldberg, Sklad, Elfrink, Schreurs, Bohlmeijer and Clarke	2019	Meta-analysis 45 studies 496,299 students 1998-2017	Universal and targeted	Primary or secondary school	• Social and emotional adjustment • Behavioural adjustment • Internalising symptoms
Murano, Sawyer and Lipnevich	2020	Meta-analysis 48 studies 15,498 students 2017	Universal and targeted	Pre-school	• Social and emotional skills • Problem behaviours

Developed by the authors

ANNEX 2

Table A3*. Parental engagement actions for schools and parents[29]*

Stages	What can schools do	What can parents do
Connect	- Establish a solid school-home relationship based on trust and reciprocal respect - Provide a safe and welcoming school environment - Actively consult students and their families when developing mental health programmes - Encourage initial parental engagement through monetary incentives, testimonials, advertisement and engagement packages - Allocate funds to recruit the hardest-to-reach parents - Promote teachers' cross-cultural competence	- Be attentive to school initiatives - Be available to participate in school initiatives - Be open to new information
Attend	- Empower families by offering different approaches (e.g. conversation with individual parents and carers, presentations at parents' evenings, informative flyers, parenting education courses and designated family link workers) - Provide information on all intervention components and key features for success - Consider the families' best interests in defining goals and quality criteria - Integrate the families' values and culture into decision-making processes - Provide opportunities for meetings and training sessions involving teachers, families and students - Provide individualised support for families experiencing significant barriers to participation - Allocate funds to retain the hardest-to-reach parents	- Make the necessary efforts to attend school initiatives and complete school programmes - Be open to attitudinal and behavioural change
Participate	- Promote home-school collaboration and provide support to promote parents' participation - Regularly invite parents to school and keep them up to date with their children's progress - Increase families' awareness about school and community mental health services - Involve parents (mothers and fathers, and parenting dynamics) in all aspects of mental health provision	- Early identification and communication of their child's difficulties - Home–school collaboration through extension activities - Involvement in the planning and delivery of specific programmes - Volunteering in classrooms or on school boards - Participation in school activities (e.g. careers day, preparing

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[29] Table A3 presents a list of actions that schools can carry out to enhance parents' engagement. The table structure is based on the CAPE model of parental engagement (Piotrowska et al., 2017). The CAPE model is a conceptual framework that looks at parental engagement as far more than just attendance. CAPE is an acronym obtained from the different stages encompassed in the model: Connect, Attend, Participate and Enact. Connect, the first stage, refers to the recruitment and enrolment of parents. Attendance relates to the permanence of parents in the programmes, i.e. retention. Participate, the third stage, refers to involvement or active participation (e.g. participation in discussions, completing home activities). Enact, the final stage, is associated with transferring knowledge and skills to the parent-child relationship (Piotrowska et al., 2017).

	- Ensure that parents' views, wishes and feelings are taken into account - Address parents as experts with specialised knowledge of their children - Keep parents informed throughout the process about decisions relating to their children - Avoid the expert posture, avoid blaming parents for their children's mental health problems	holiday festivities, assisting in classrooms, parents' evenings, field trips, participating as an audience member) Maintaining home-school communication
Enact	- Highlight family strengths and build on them - Promote acceptance, confidence and a sense of self-efficacy - Combat stigma relating to mental health problems and services - Empower parents to seek effective mental health interventions - Help families to develop their own parenting skills and attitudes	- Respond to children's behaviour in emotionally knowledgeable ways - Model prosocial behaviours and use positive reinforcement - Spend quality time with children - Create opportunities for children's active decision making, participation and self-efficacy development - Focus on children's strengths - Listen and understand the causes of behaviour instead of acting severely or inconsistently - Use adjusted parent-child causal attributions - Collaboration and continuing home-school communication (e.g. through home-school notes, email, text correspondence or face-to-face)

Developed by the authors from the analysis of the literature.

Table A4. Community mental health actions

Domains	Actions
Provide mental health resources to schools	▪ External community health professionals (e.g. nurses, psychologists, psychiatrists, lay counsellors, trained peer workers) can visit and deliver services regularly at school for students, families and school staff ▪ Mental health literacy programmes ▪ Parental interventions (e.g. psychoeducation, SEL, resilience) ▪ Stress management interventions ▪ Psychological consultations and treatments ▪ Psychosocial rehabilitation ▪ Participation of mental health professionals as invitee lecturers at schools ▪ Disclose information at schools about community mental health programmes and services, and how to access them
Develop community programmes and provide community mental services for young people	▪ Recreational, sports and after-school programmes ▪ Community-based creative activities or programmes (music, dance, singing, drama, visual arts) ▪ Outdoor adventure programmes ▪ Volunteering activities (tidying up natural or community spaces to protect the environment, minor repairs to public buildings, support for disadvantaged groups, collaborating in the organisation of neighbourhood parties, fundraising) ▪ Service learning ▪ Tutoring and mentoring community programmes ▪ Community support groups ▪ Involve community members (young people, families, professionals and community members) in the creation of community programmes ▪ Enhance access to services and foster partnerships within the local community (e.g. integrate youth organisations, churches, community centres and health facilities) ▪ Reach vulnerable adolescents who tend to remain outside the system
Address risk factors and promote social protective factors	▪ Address mental health risk factors (e.g. neighbourhood safety, housing conditions, unemployment) ▪ Address inequalities, paying special attention to vulnerable groups (minorities; refugees; other culturally, socially or economically disadvantaged groups) and involve them in the search for solutions ▪ Identify and address community conditions that can improve mental health (e.g. through an asset-based community development approach) ▪ Raise mental health awareness (e.g. through radio programmes, giving voice to discriminated groups) ▪ Promote "cultures of health" (through building social networks, solidarity and collective efficacy, mutual responsibility for the community's well-being and social justice)

Developed by the authors from the analysis of the literature.