Addressing Youth Depression in Africa – school mental health literacy in a low income setting: innovation; achievement; failure?

October, 2017
Dr. Stan Kutcher
ABSOLUTE DALYS ATTRIBUTED TO MENTAL, NEUROLOGICAL & SUBSTANCE USE DISORDERS, BY AGE, 2010

Note: DALYs = disability-adjusted life years.
Untreated mental illnesses are strong independent predictors of reduced life expectancy due to associated medical conditions, such as diabetes, heart diseases and stroke, respiratory conditions, and suicide.

PRIMARY INVESTMENT IN GLOBAL MENTAL HEALTH MUST BE IN YOUNG PEOPLE

• 70% mental disorders can be diagnosed prior to age 25
• Most are high volume/low intensity disorders of mild to moderate severity and thus respond well to treatment in PRIMARY CARE
• Effective interventions are available for scale-out that can be relatively easily applied, are inexpensive and strengthen systems of care – must involve both education and health
• When widely applied they can be expected to bring a substantial ROI – both at point of impact but extended over the life span
• Pay a POPULATION DIVIDEND: decrease early mortality; increase labour force participation; improve productivity
HORIZONTALLY INTEGRATED PATHWAY TO MENTAL HEALTH CARE

Primary Care Provider

Family
- Early Adversity
- Heritability

School
- Educate
- Identify
- Triage/treat
- Refer
- Support

Specialty Mental Health Care
- CAP

Educate
Advise
Monitor
Identify
Diagnose
Treat
Refer
Support

Mental Health Care for Youth

Schools

Radio

Clinics
DEPRESSION will soon be the No.1 burden of disease in the world for young people.
• Significant difference for knowledge scores between baseline and endline radio listening assessments for both Malawi ($t(1600.045 = 9.426, p < .001$) and Tanzania ($t(1411) = 8.236, p < .001$) among youth populations.
• Significant difference for attitude scores between baseline and endline assessments for radio listening in both Malawi (t(1495.659) = 3.499, p < .001) and Tanzania (t(954.618) = 8.606, p < .001) among youth populations.
Significant improvements (p<0.001) in youth advising other youth in help seeking for mental health needs as a result of radio program exposure. Malawi results are based on three years of radio program exposure and the Tanzania results are based on one year of radio exposure.
• Self reported help seeking in BOTH countries improved significantly (p<0.001) as a result of the radio program. The Malawi improvements were based on three years of radio exposure and the Tanzania data was based on only one year of exposure.
SCHOOL-BASED MHL: classroom plus
Within School Activities:

1) Headmaster supported resources provided

2) Teacher training (3 days plus refresher) on the use of the African Guide (adapted from the Mental Health and High School Curriculum Guide – Canada) resource

3) Teachers apply the Guide resource using their own pedagogic skills

4) Embed radio programs into school activities through Radio Listening Clubs

5) Peer Educator training for senior students (Malawi in some schools only)

6) Foster linkages between schools and local community health centers – Hub and Spoke model – Headmasters role and operational application
RADIO PROGRAM LISTENING CLUBS
MALAWI EDUCATORS

- Significant improvement in MH knowledge and attitudes (decreased stigma)
A school mental health literacy curriculum resource training approach: effects on Tanzanian teachers’ mental health knowledge, stigma and help-seeking efficacy

<table>
<thead>
<tr>
<th>Table 1 Effect of AG curriculum resource training on teachers’ scores at pre- and post-training, n = 38</th>
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<tbody>
<tr>
<td>Knowledge</td>
</tr>
<tr>
<td>Mental health specific</td>
</tr>
<tr>
<td>14.16 (2.18)</td>
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<tr>
<td>16.68 (2.23)</td>
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<td>1.14</td>
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<tr>
<td>Curriculum specific</td>
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<tr>
<td>5.61 (2.01)</td>
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<td>6.66 (1.24)</td>
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<tr>
<td>Overall</td>
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<td>19.76 (3.57)</td>
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<td>23.34 (2.63)</td>
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<tr>
<td>Attitudes</td>
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<td>Towards mental health</td>
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<td>41.39 (8.38)</td>
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<td>46.08 (7.02)</td>
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<td>0.61</td>
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<tr>
<td>Comfort</td>
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<td>Addressing mental health</td>
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<td>13.25 (1.86)</td>
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<td>13.72 (1.34)</td>
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<td>&gt;0.05</td>
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<td>Data are mean (SD)</td>
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<td>* p value &lt;0.05</td>
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<td>** p value &lt;0.01</td>
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<td>*** p value &lt;0.001</td>
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TANZANIA EDUCATORS

- Improvements in identification and/or advising students, friends, peers, or family members to seek professional help for a mental health problem or sought professional help themselves.
Malawi Educators Assessment: Student Outcomes

- Positive improvements in:
  - Attitudes towards mental illness
  - Behaviours towards others
    - Emotional difficulties
    - Help-seeking for self
    - Help-seeking for others

• 95% of teachers reported that they had identified students who had a mental disorder or mental health problem.

• The number of students identified for mental health care totaled over 500 from <30 schools.

• 73% of teachers reported that they advised students to seek professional help for a mental disorder or mental health problem.
The number of students teachers advised to seek help for a mental health problem totaled over 375 with most teachers reporting between 1 and 5 students were so advised.
84% of teachers reported that they had identified students who had a mental disorder or mental health problem.

The number of students teachers identified for mental health care totaled over 200 from <20 schools.

79% of teachers reported that they advised students to seek professional help for a mental disorder or mental health problem.
The number of students who may have a mental health disorder or mental health problem identified by teachers was over 200. Most teachers identified between 1 and 5 students to seek professional help for a mental disorder or mental health problem. The chart shows the frequency distribution of the number of referalls made by teachers, with the majority falling in the 1 - 5 referall range.
The African Guide: One Year Impact and Outcomes from the Implementation of a School Mental
Health Literacy Curriculum Resource in Tanzania

Figure 1: Impact of the AG Over a One Year Period

10:50 DOI: 10.11114/jets.v5i4.2049
MALAWI PEER EDUCATORS

• Significant improvements to knowledge; non-significant improvement in attitudes
ENHANCING COMMUNITY CLINICAL CARE
The Hub and Spoke Model
Linking Schools to Health Care Centers
MALAWI HEALTHCARE WORKERS

- Significant improvements in MH knowledge and self-reported competency
TANZANIA HEALTH CARE WORKERS

- Significant improvement in MH knowledge and self-reported competency

*Figure 1: Comparison of mean pre- and post-test mental health knowledge scores for Primary healthcare workers (n=96)*

*Figure 2: Comparison of mean pre- and post-test confidence scores for Primary healthcare workers (n=92)*

Knowledge Assessment for Trainers and Clinical Staff: Tanzania

$t(95)=8.253, p<.001; d=1.08$

$t(91)=5.333, p<.001; d=0.73$

Error bars represent +/- 1 SD.
Youth who visited clinics in Tanzania

237 Youth Depression and Outcomes Measurement Tools applied

16.96% screened positive for Depression

12.5% diagnosed with Depression and treated

87.5% were not diagnosed with Depression

83.04% did not screen positive for Depression

3.29% of the sample were diagnosed with a mental disorder other than Depression and treated
Clinical Outcomes Youth Depression: Malawi

- 93% of those diagnosed with Depression were treated
  - 95% with EH
  - 66% with fluoxetine
- CGI assessment (8-12 weeks)
  - 42% much better
  - 42% better
  - 16% somewhat better

Kutcher et al. Malawi Medical Journal, in press.
Breaking down the silos

- Schools necessary but not sufficient (education plus culture shift)
- Reaching students and teachers – both concurrently
- Community biases/ stigma – innovative reach using youth voices
- Healthcare provider: knowledge; competencies; stigma
- Access to effective care: hub and spoke model - relationships
- Sustainability - if it works, how can it continue?
Evaluating Community Health Care Providers Capacity in the Identification, Diagnosis and Treatment of Adolescent Depression in Malawi

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**Depression in Adolescents in Malawi: Clinic Outcomes of the Pathway to Care Model**

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Abstract
Despite the need for improving mental health literacy (MHL) among young people in low- and middle-income countries little research is available. Schools are an ideal location in which to address mental health literacy. A Canadian school-based mental health literacy resource was adapted for application in sub-Saharan Africa called the African Guide (AG). The AG is a classroom ready curriculum resource addressing all aspects of mental health literacy. Herein we provide teacher reported activity impacts and MHL outcomes from the implementation of the AG in Tanzania. Following training, survey data addressing teacher reported AG impact and MHL outcomes was collected at three time points over a one year period. Over a period of one year, 32 teachers from 29 different schools reported that over 4,600 students were taught MHL; 150 peer teachers were trained on the AG; 390 students approached teachers with a mental health concern; 450 students were referred to previously trained community care providers for diagnosis and treatment of Depression; and most students were considered to have demonstrated improved or very much improved knowledge, attitudes and help-seeking efficacy, with similar outcomes reported for teachers. Results of this study demonstrate a substantial positive impact on MHL related activities and outcomes for both students and teachers using the AG resource in Tanzania. Taken together with previously published research on enhancing MHL in both Malawi and Tanzania, if replicated in another setting, these results will provide additional support for the scale up of this intervention across sub-Saharan Africa.

Keywords: school mental health, Tanzania, adolescents, teachers, mental health, Africa, depression

1. Introduction
Mental health literacy is a complex construct that addresses four separate but integrated components. These are: how to obtain and maintain good mental health; understanding mental disorders and their treatments; decreasing stigma related to mental disorders; enhancing help-seeking efficacy (knowing when and where to seek help for a mental disorder and improving one’s own self-managed mental health care) (Kutchert, Bagnell, & Wei, 2015; Kutchert, Wei, & Conigliaro, 2016; Kutchert, et al., 2016; Kutchert, Wei, & Hashish, 2016). Mental health literacy is considered to be the foundation for mental health promotion, prevention, early identification and improved access to effective care and for young people it may be most appropriately addressed in school settings (Kutchert, Wei, & Conigliaro, 2016; Kutchert, Wei, & Hashish,
A school mental health literacy curriculum resource training approach: effects on Tanzanian teachers’ mental health knowledge, stigma and help-seeking efficacy

Stan Kutcher1, Yifeng Wei2, Heather Gilberds3, Omary Ubuguyu4, Tasiana Njau4, Adena Brown5, Norman Sabuni6, Ayoub Magimba7 and Kevin Perkins4

Abstract

Background: Mental health literacy (MHL) is foundational for mental health promotion, prevention, stigma reduction, and care. School supported information pertaining to MHL in sub-Saharan Africa is extremely limited, including in Tanzania. Successful application of a school MHL curriculum resource may be an effective way to increase teacher MHL and therefore help to improve mental health outcomes for students.

Methods: Secondary school teachers in Tanzania were trained on the African Guide (AG) a school MHL curriculum resource culturally adapted from a Canadian MHL resource (The Guide) for use in Africa. Teacher training workshops on the classroom application of the AG were used to evaluate its impact on mental health literacy in a sample of Tanzanian Secondary school teachers. Pre- and post training assessment of participants’ knowledge and attitudes was conducted. Help-seeking efficacy for teachers themselves and their interventions for students, friends, family members and peers were determined.

Results: Paired t tests (n = 37) results demonstrate highly significant improvements in teacher’s overall knowledge (p < 0.001; d = 1.14), including mental health knowledge, (p < 0.001; d = 1.14) and curriculum specific knowledge (p < 0.001; d = 0.63). Teachers’ stigma against mental illness decreased significantly following the training (p < 0.001; d = 0.61). Independent t tests comparing the paired sample against unpaired sample also demonstrated significant differences between the groups for teacher’s overall knowledge (p < 0.001). Teachers also reported high rates (greater than ¾ of the sample) of positive help-seeking efficacy for themselves as well as for their students, friends, family members and peers. As a result of the training, the number of students teachers identified for potential mental health care totaled over 200.

Conclusions: These positive results, when taken together with other research, suggest that the use of a classroom-based resource (the AG) that integrates MHL into existing school curriculum through training teachers may be an effective and sustainable way to increase the MHL (improved knowledge, decreased stigma and positive help-seeking efficacy) of teachers in Tanzania. As this study replicated the results of a previous intervention in Malawi, consideration could be given to scaling up this intervention in both countries and applying this resource and approach in other countries in East Africa.

Keywords: Mental health literacy, School-based intervention, Knowledge, Stigma, Tanzania, Adolescents, Teachers, Mental health, Africa

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INTerventions

ORIGINAL RESEARCH PAPER

Improving Malawian teachers' mental health knowledge and attitudes: an integrated school mental health literacy approach

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Background. Mental health literacy is foundational for mental health promotion, prevention, stigma reduction and care. Integrated school mental health literacy interventions may offer an effective and sustainable approach to enhancing mental health literacy for educators and students globally.

Methods. Through a Grand Challenges Canada funded initiative called 'An Integrated Approach to Addressing the Issue of Youth Depression in Malawi and Tanzania', we culturally adapted a previously demonstrated effective Canadian school mental health curriculum resource (the Guide) for use in Malawi, the African Guide: Malawi version (AGM). We evaluated its impact on enhancing mental health literacy for educators (teachers and youth club leaders) in 30 schools and 15 out-of-school youth clubs in the central region of Malawi. The pre- and post-test study designs were used to assess mental health literacy - knowledge and attitudes - of 218 educators before and immediately following completion of a 3-day training programme on the use of the AGM.

Results. Results demonstrated a highly significant and substantial improvement in knowledge ($p < 0.001$, $d = 1.16$) and attitudes ($p < 0.001$, $d = 0.70$) pertaining to mental health literacy in study participants. There were no significant differences in outcomes related to sex or location.

Conclusions. These positive results suggest that an approach that integrates mental health literacy into the existing school curriculum may be an effective, significant and sustainable method of enhancing mental health literacy for educators in Malawi. If these results are further found to be sustained over time, and demonstrated to be effective when extended to students, then this model may be a useful and widely applicable method for improving mental health literacy among both educators and students across Africa.

Key words: Adolescents, Africa, Depression, educators, global mental health, knowledge, Malawi, mental health literacy, stigma.

Introduction

Globally, up to 14% of the burden of disease is attributable to mental illnesses, with the onset of most mental disorders occurring before the age of 25 (Patel et al. 2007; Prince et al. 2007). Youth in particular are at...
Malawi Educators’ Assessment of Student Mental Health Outcomes

Abstract

Purpose: This paper presents teacher perceptions of life improvements achieved by students following the application of a school-based curriculum mental health literacy resource in Malawi.

Methods: Life improvement metrics were generated based on educators’ self-reported questionnaires obtained as part of the midterm evaluation of a larger youth Depression intervention project. These metrics include a stigma reduction variable, an improved behaviour at school variable, and a mental health related help-seeking variable.

Results: Most teachers (81.3%) reported a positive change in their students’ attitudes toward mental illness following exposure to the mental health literacy curriculum resource. Ninety-six percent of teachers reported improvement in student behaviours at school, and all teachers reported one or more mental health care related help-seeking behaviours among students.

Research Limitations: The sample size was relatively small and recruited from only two districts in Malawi. This is a pilot field implementation and will need to be expanded with larger numbers into a greater number of school districts in order to improve the robustness of the findings.

Originality/value: To our knowledge this is the first study to examine teachers’ perspectives on student life improvement metrics related to mental health literacy in sub-Saharan Africa. This method of measuring the impact of school-based interventions on students in African schools may be a useful and culturally meaningful approach to youth mental health assessment.

Keywords: Mental health, Mental illness, Knowledge, Attitudes, Stigma, Help-seeking, Help-seeking efficacy, Mental health literacy; Life improvement metrics

Introduction

Depressive disorders account for 4.46% of all disability adjusted life years (DALYs) worldwide [1]. In Africa, these disorders contribute 1.2% to the overall burden of disease [1]. The lifetime prevalence of Depression in Sub-Saharan Africa is reported to be between 3.1 and 9.7% [2] and the onset of Depression frequently occurs during adolescence (prior to age 23), where it is linked to numerous adverse personal, social, vocational and academic outcomes, as well as increased early mortality and higher risk for suicide [3-8].

Depression in Malawi is common, with rates ranging from about 20 to 30 percent in clinical populations [9,10]. In young people rates vary between 10 and 20 percent [11-13]. While rates for Tanzania are not available they are not expected to significantly differ from those in Malawi as studies from Nigeria and Kenya, other similarly low income Sub-Saharan African countries, have reported in-school youth depression rates as ranging between 21 and 26 percent respectively [9,10,14-16].

Effective treatments for young people with Depression are known but are largely unavailable to young people in Sub-Saharan Africa. Reasons for the inaccessibility of adolescent mental health services include: lack of training of health providers in diagnosis and treatment of Depression; lack of public awareness about Depression; high levels of stigma and low levels of mental health literacy (MHL) in both young people and teachers; a lack of available mental health treatments such as cognitive behavioural therapy and appropriate medications [16-18]. Since MHL is foundational as a method for addressing Depression through mental health promotion, prevention and treatment applications [19], and given that many young people attend school, schools provide an unparalleled opportunity to enhance the MHL of students and teachers.

The understanding of MHL has expanded in recent years from its original definition of “knowledge and beliefs about mental disorders which aid their recognition, management and prevention” [20] to a more comprehensive framework, grounded in the World Health Organization [21] approach to health literacy, to encompass: 1) enhancing capacity to obtain and maintain good mental health; 2) enhancing understanding of mental disorders and their treatments; 3) decreasing stigma related to mental illness; 4) enhancing help-seeking efficacy [22-24].
Key Learning Points:

1) Simple within schools only approach inadequate for addressing mental health- community; schools; clinics – integrated approach

2) Simple solution based messages (eg: HIV/AIDS; hygiene) not appropriate for complex topic such as mental health

3) Single focus (such as teacher led education) not sufficient – radio listening clubs for youth engagement to encourage and support learning

4) Importance of demonstrating outcomes – not just outputs – HOW HARD THIS IS TO DO IN LOW RESOURCE SETTINGS

5) Cross – sectorial collaboration (Education/Health) essential
Sobering Considerations: sustainability

When the project ended the innovation ended, even though highly successful.

1) Sustainability framework/resources developed - Master trainers groups/Nursing education BUT no continued investment to maintain.
2) MOH engaged – MH policy development input (awaiting output) – MOE not engaged sufficiently so no application into teacher training or ongoing educational directions.
3) Cross-sectorial collaboration (Education/Health) occurred during the intervention but did not continue following – no structures after project.
4) International interest but no local movement (WHO/World Bank; MHIN).
What We Know & Need to Know:
Promoting Mental Health, Reducing Stigma,
Providing Psycho-Social Support in
Low Resource Countries
Initial Findings of a Review of Research, Reports & Resources
An Overview

- Need clarity on what we mean by Mental Health
  - in HRC mental Health includes Positive Mental Health, MH Problems, Interactions with other problems, Mental Disorders/Illnesses and Sub-Populations
  - in LRC’s should we focus on Promoting MH Literacy, Reducing Stigma and Providing Psycho-Social Support?
- Need to clarify what is achievable in a Low Resource Contexts
Mental Health: Which Parts are Relevant to LRC’s

The wide scope of mental health:

- **positive mental health** includes “well-being”, emotional health, mindfulness, critical thinking, self-esteem/knowledge, social attachment, life goals, social & emotional learning, spirituality, yoga, brain development, self-regulation, etc.

- **mental health problems** includes resilience, difficulty in life-stage transitions, bereavement, stress, divorce of parents, social isolation/loneliness, parental unemployment, parental mental illness etc.

- **Interactions with other problems** includes bullying, addictions, discrimination based on race or sexual orientation, child neglect, child abuse, sexual abuse, trafficking, economic disadvantage, trauma from violence, disaster, cultural oppression, colonialism etc.

- **mental illness** includes depression, anxiety, suicide, autism, intellectual disability, learning disabilities, ADHD, eating disorders, OCD, phobias, schizophrenia, self-harm, mood disorders, etc.

Or should we focus on **mental health literacy** (basic knowledge, skills, beliefs, help-seeking behaviours, **reducing stigma** and **providing psycho-social support**
Mental Health Literacy

Mental health literacy includes key/basic knowledge, attitudes & behaviours (help-seeking)

There are four domains:
1) understanding how to obtain and maintain good mental health;
2) understanding mental disorders and their treatments;
3) decreasing stigma against mental illness; and
4) enhancing help-seeking efficacy

A systematic review (1) identified several levels at which interventions and strategies to reduce stigma can be implemented: intrapersonal, interpersonal, organizational/institutional, community and governmental/structural level. Although a lot of work has been carried out on stigma and stigma reduction, far less work has been done on assessing the effectiveness of stigma-reduction strategies. The effective strategies identified mainly concentrated on the individual and the community level. Three methods of stigma reduction have the best empirical support (2), and a three-pronged approach that includes all methods is the most effective (a) Education: to dispel myths about mental illness, (b) Protest: to suppress discriminatory attitudes and challenge commonly held stigmatizing images, such as in popular media and (c) Contact: to put a human face on mental illness. A review of school-based interventions (3) found they should (a) involve experiential activities to evoke feelings, (b) be implemented multiple times within and across the school years, (c) use agents familiar with students and (d) promote empathy

(2) Ontario Centre for Child & Youth Mental Health (2012) *Effective stigma reduction strategies in child and youth mental health*, Author
Psycho-Social Support

Psychosocial support is a holistic activity of identifying those children and adolescents whose family and community safety nets are failing, and providing them with the psychological, medical, social, educational and legal assistance to protect them from further harm and to build their resilience. It should be recognised as a key component of MH promotion.

**Child-centred targeting:** Psychosocial support should be accessible to all children in need rather than be targeted at children who fit a particular label or category. Need can be determined by the social situation of children, their mental and emotional status, or by their behaviour (for instance children who have dropped out of school, girls who are involved in transactional sex, young people who take drugs, children living with handicapped caretakers, children who are excluded from community life, boys who engage in violent behaviour etc.)

**Effective psychosocial support:** Governmental and non-governmental organisations providing psychosocial support should be thoroughly trained in working with traumatised and mentally disturbed children. They should have the capacity to act decisively on child protection issues and to provide holistic support, meeting the psychological, developmental, and physical needs of vulnerable children and adolescents.

So Many Interventions: Which for LRC’s?

Schools acting with the direction and support of government ministries, school boards and working collaboratively with other agencies and professionals as well as parents and young people, can make a substantial contribution to enhancing the mental health of youth. This may include but not be limited to the following: developing mental health awareness, knowledge, skills and beliefs among students, educators and parents; creating supportive social and physical school environments; helping to deliver programs that can assist in the identification, triage and referral of young people at risk of mental disorder; providing "on site" services to address mental health problems; providing on-going liaison with health care providers to meet the needs of youth receiving care for mental disorders; promoting staff wellness and more.
So Many Interventions: which ones for LRC’s?

**Policy:** whole of government policy on MH, inter-ministry policy/coordination on youth, schools, Ministries of Ed, H, SS, LE & other ministries on policies on SMH, local education authorities policies on SMH, school procedures, discipline/student conduct policies, parental involvement & appeal policies, student engagement policies, etc.

**Instruction/Education:** Curriculum Design/ Learning Objectives, Instructional programs/supplements on different aspects, Teaching Learning Methods/ Classroom Management, Student Assessment & Evaluation, Teacher Education & Development, Web-based MH Learning, Parent Involvement in MH Instruction, Peer-based Instruction, Awareness & Information Classroom Programs using Celebrities, Survivors or Community or PH Personnel

**Services:** Early Identification, Screening & Referral Services, Brief Counselling Services, Motivational Interviewing, Student Assistance Programs, Case Management & Coordination, School Support during Treatment incl. cooperation with family-based programs, School Support for Re-integration, Individual Ed Programs for students with MH problems, School Clinics in or linked with schools, Crisis Response & Follow Up Services for Students, Parents, Staff, Role of Physicians, Clinics, Hospitals, Social Workers, Guidance Counsellors, Police Officers, School Psychologists, Classroom Teachers, Trained Peer Helpers, Trained Volunteers re SMH services

**Social Support:** School Discipline/Conduct, Whole School Climate Programs, Anti-stigma programs & campaigns, Anti-harassment, bullying policies, programs & campaigns, After school programs that promote MH, Student Friendship Programs, Student Leadership/ Advocacy Programs, Peer Helper Programs, Mentoring Programs, Inter-generational activities, Parent Information Activities, Parent Involvement & Volunteer Programs, Parent Education, Training & Support Programs, Working with Community & Self-help Organizations, Web Awareness Programs for Parents & Students, Working with Local Media, Staff Wellness & Occ. Safety/Health Programs

**Physical Environment & Resources:** Safe Transportation to school, Student friendly places within school, Stress-reducing/green school grounds
Multiple Dimensions of “Knowledge” Within a systems approach

Implementation, Maintenance, Sustainability, Diffusion & Scaling Up
(Use of situational analysis, implementation planning tools/models, implementation quality, mechanisms, local drivers & barriers, diffusion theory, scaling up models etc.)

Relevance & resources available to different country, community & neighbourhood contexts
(high resource, low resource, emergencies, rural, religious, disadvantaged, private/affluent, urban, indigenous, etc.)

Ecological approaches, systems thinking, organizational development models & management theories
(Systems modelling, professional bureaucracies, organizational readiness/cultures, the adsorptive capacity of schools, structures, routines, informal networks within large organizations, role of middle managers (HP or Disease Managers) & front-line managers (school principals) in managing boundaries etc.)