The role of educational institutions in promoting and protecting mental health across childhood, adolescence and youth

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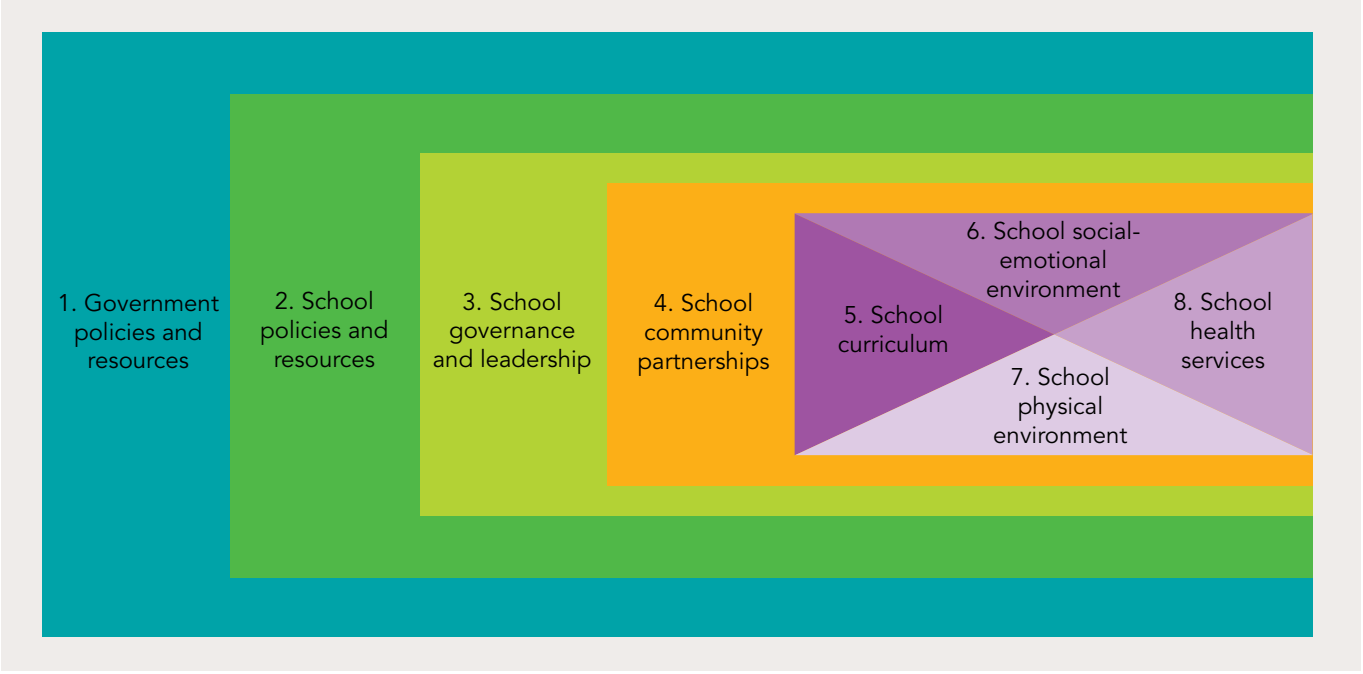
In the face of deep inequality, growing unemployment, high rates of crime and violence, and the social and economic fallout from the COVID-19 pandemic, mental health trajectories for young South Africans look bleak. But what if our educational institutions were a powerful protective factor for child, adolescent and youth mental health? How are they currently promoting and protecting the mental health of South African children and adolescents? And how could mental health support and services at different developmental stages be strengthened or better linked to broader structures?

In this chapter we describe the current and potential role of educational institutions in promoting and protecting mental health in the South African context through four key stages: early childhood education (ECE), primary school, secondary school, and tertiary education. Within each stage, we consider the current policies, provisions and subsequent challenges that exist. Using case studies as exemplars, we highlight potential opportunities for intervention at different levels within the education system to address gaps in psychosocial provision and support. We close the chapter by discussing several key cross-cutting issues that influence implementation and intervention responses.[1]

Why use educational institutions to support young people's mental health?

Educational institutions are precious resources for mental health. In addition to the growing numbers of children attending early childhood development (ECD) centres, there is a near universal reach in primary and secondary schools, and increasing enrolment in tertiary education programmes.[2, 3]

Figure 20: Relations among global standards for health promoting schools (WHO)



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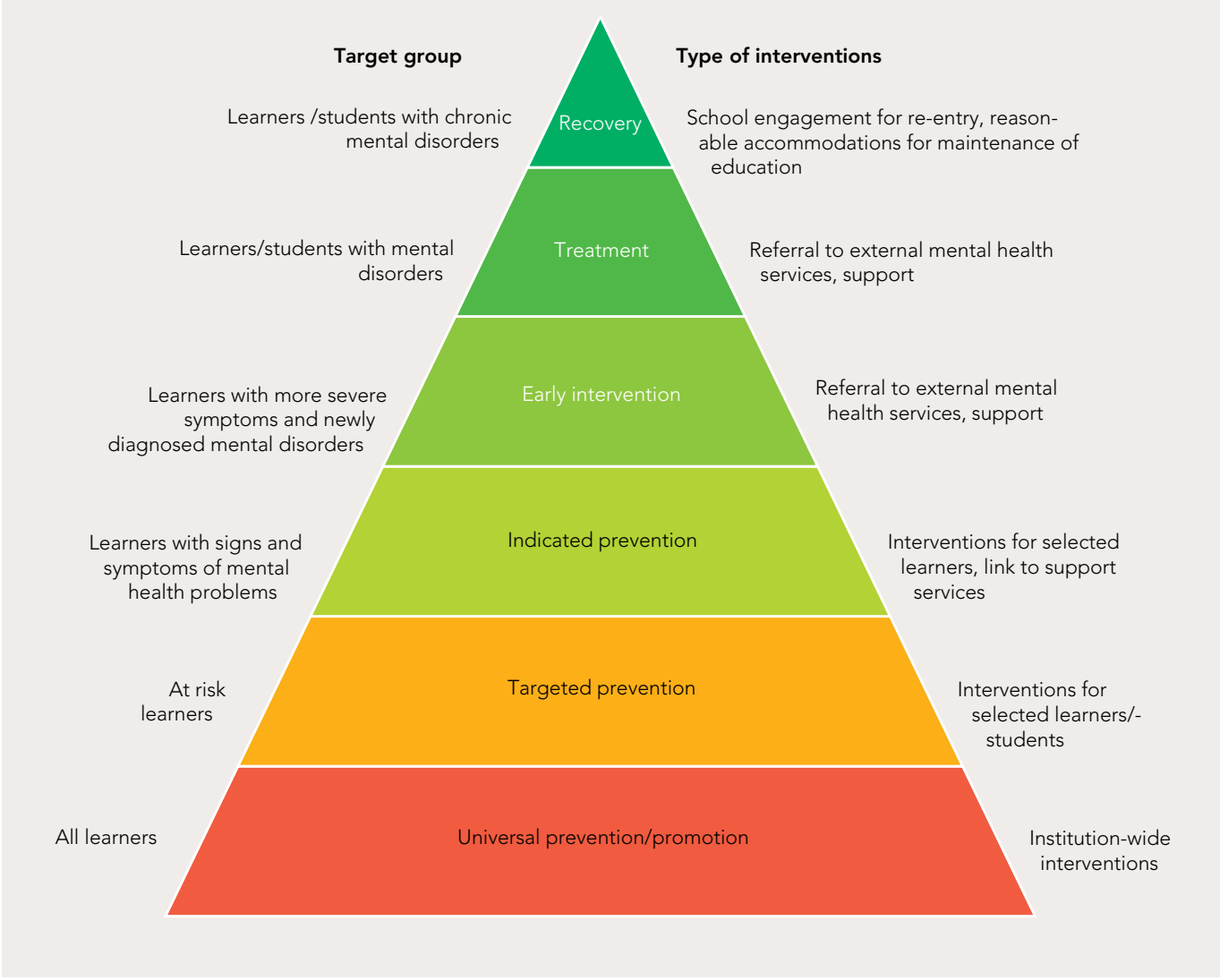
These institutions have existing infrastructure, are networked locally and provincially, and offer opportunities for staff to be further trained in aspects of child and adolescent learning and development.[4, 5] They are generally well connected to communities and facilitate contact between teachers, learners, parents and caregivers, and other community organisations and services. They are more accessible, and less stigmatised, than specialised mental health services. School connectedness – or the extent to which learners feel accepted, valued, respected, and included in the school – has been found to promote a sense of belonging, positive self-esteem, internal regulation of emotions, positive attitudes toward school, and motivation to achieve.[6] Schools can provide support to learners living in fragile families, and supportive child-teacher relationships can be protective for mental health.[7-9] School-based interventions can be delivered effectively by mental health professionals, teachers, paraprofessionals, lay counsellors and/or peers.[10]

However, intervening through schools and other educational institutions can be challenging, as these environments exist within complex systems involving multiple stakeholders, and with a different primary purpose. Structural issues such as poverty, violence, and social and gender inequality greatly influence how educational institutions operate, which in turn affects child and adolescent mental health.[11] In some cases, schools can be environments where children and adolescents are exposed to negative influences, including abuse and violence from peers and teachers.[12] Education systems are often overburdened and have limited capacity to provide comprehensive mental health responses, such as integrating mental health programming into school routines, coordinating with health and social services, communicating with parents and caregivers, and managing ethical issues such as informed consent and confidentiality.[1, 13] More recently, due to the COVID-19 pandemic, there has been an unprecedented loss of in-person learning time

Figure 21: Optimal mix of services in educational institutions



due to school closures. This led to the swift adoption of an educational model that relied heavily on remote learning, despite most learners having limited access to online platforms.

Why is it important to provide a continuum of care?

Mental health support in schools should respond to children's context, age, and developmental stage, and be provided along a continuum of care that covers promotion of positive mental health, prevention of mental health conditions, and access to treatment and recovery services.

Health promoting schools

Mental health service delivery benefits all learners and should be positioned within a Health Promoting Schools (HPS) framework.[14, 15] An HPS is an educational institution that strives to improve the health of learners, staff, families, and other community members through the creation of a healthy living, learning and working environment. The World Health Organization's (WHO) HPS approach describes how improving health in an educational environment relies on strengthening the curriculum, the physical and psychological environment of the school, and school health services.[16] These activities are supported by broader actions such as effective partnerships between schools and communities, sound school governance, policies and resources, and strong government policies and resources (see Figure 20).

Promotion, prevention, early intervention, treatment and recovery

To be effective, promotive and preventive efforts need to be introduced across the full population before mental health conditions emerge. Early interventions, required by a subset of children or adolescents, need to take place when symptoms of a condition first become apparent, and can have positive, lifelong impact on a child's health and well-being.[17] Treatment and recovery services need to be available for an even smaller group: those living with mental health conditions. In Figure 21, types of preventive and treatment-related services, the target group for each level, and the role of educational institutions is further described.

What are the challenges and opportunities for intervention at different stages of education?

This section briefly outlines the mental health profile of learners as they pass through the education system and describes current and potential interventions to promote and protect child and adolescent mental health in South Africa, including both prevention and treatment. This is presented for each educational stage, bearing in mind that there is much overlap in the risks to mental health that learners face at each stage and the types of responses that are appropriate.

Early childhood education

In South Africa, ECE forms part of a broader package of ECD programmes which aim to promote the cognitive, emotional, social and physical development of children from birth to nine years old. ECE, until April 2022, was the responsibility of two departments: the Department of Basic Education (DBE, managing Grades 1 – 3) and the Department of Social Development (DSD, managing preschool to Grade R). Preschool programming, including Grade R, has subsequently moved from being managed by DSD to DBE.

What are the mental health concerns and risk and protective factors?

Early signs and symptoms of depression, anxiety, attention deficit/hyperactivity disorder, and behaviour and affect dysregulation can begin to emerge at a young age.[18, 19] Risk factors include exposure to early adversities such as violence, maltreatment, household stress or trauma, poverty, and poor nutrition.[18, 20] Protective factors such as early identification of mental health problems and access to mental health support can have a positive, lifelong impact on a child's health and well-being.[17]

Case 11: Developing emotionally supportive classrooms

The Irie Classroom Toolbox is a teacher-training programme that aims to reduce corporal punishment and class-wide child aggression in preschools. The programme focuses on creating an emotionally supportive classroom environment, preventing and managing child behaviour problems, teaching social and emotional skills, and individual and class-wide behaviour planning. The programme is delivered to teachers of children aged 3 – 6 years by facilitators over a five-day period and eight in-class support sessions. The programme was assessed using a cluster-randomised control trial in Jamaica that found that the Irie Classroom Toolbox was effective in reducing the use of violence against children by teachers, improving child behaviour and inhibitory control, and teacher well-being in the longer term compared to controls.[28]

Case 12: How play can promote self-regulation in children

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Imagine that you are observing young children on a playground. Some children are climbing and swinging from bars on a jungle gym, two other children are trying to figure out how to make a house out of materials around them, and a few children are playing 'three toti' (three tins) where they aim to knock down a stack of empty pilchard tins. This may seem frivolous, but it's quite the opposite. Children learn important skills during play, skills that support their academic *and* non-academic learning. For example, a child's ability to self-regulate is a crucial determinant of how they navigate the social world, cope with stressful situations, manage their emotions and mentally course-correct where necessary. This all has significant bearing on their long-term mental well-being and ability to thrive.[88, 89] We know from the literature that play is one of the best ways that young children practice and develop self-regulation skills.

> *A child's greatest self-control occurs in play* – Vygotsky, 1978

Much of our framing of the central role of play in children's development comes from Vygotsky's[90] notion that children naturally set themselves appropriate challenges and thereby establish their own 'zone of proximal development' during play, in which their learning is optimised. Vygotsky also suggested that play makes a critical contribution to the development of symbolic representation and language skills which underpin self-regulation. Play is really the first medium through which children explore the use of symbols and spoken language. Specifically, very young children begin to represent ideas as they talking to themselves while they play. This type of self-talk promotes language development and gives children a greater repertoire of ways to express their behaviour and emotions.

Types of play that promote self-regulation

Play offers children an ideal context in which to activate, practice and master many of these skills and processes. It is through the activation of these pathways or mechanisms that play can facilitate the development of self-regulation in young children. Let's take a look at how this works, drawing on two of the most popular forms of play in childhood – pretend play and games with rules.

Pretend play

Make-believe, imaginative or fantasy play is often seen as a natural and joyful experience, but it can be a particularly powerful medium for the development of self-regulation. Pretend play allows the expression of both positive and negative feelings, and the modulation of affect through role-taking.[91]

When children take on roles in pretend play, they must navigate and negotiate differences and align their desires with others which forces them to flex their inhibitory control.[92] Perhaps the most powerful aspect of role-taking is how it nudges children into taking on the perspectives of the character they are playing. In doing so, they are required to represent the mental states of another person or character which can help them become aware that to understand other people's perspective, they need to see the world through the eyes of that other person (a concept called 'theory of mind'). Children also need to follow social rules when playing a role, even if these rules are implicit. For example, their behaviour will follow the norms and rules of being a doctor caring for a sick patient, or a policeman making an arrest, all of which involve the use of internal mental representations, inhibitory control, and perspective-taking in order to keep the pretence going.[93]

Collaborative pretend play can be particularly beneficial to language development as it involves rich conversational exchanges between players, both in the creation of the game and in acting it out.[94, 95] This includes internal conversations known as private speech,[96, 97] which also help strengthen children's ability to self-regulate.[98]

Games with rules

In pretend play most rules are implicit, while games with rules contain a set of clear and explicit rules that must be followed by players and are usually established at the start of the game. Children tend to progress from more pretend play between ages 3 – 6 towards more games with rules from age 7 – 12.[90] These games with rules tend to activate several core self-regulatory processes and executive functions, including working memory, executive attention and inhibitory control.[99]

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As an example, a game like 'Simon Says' taxes children's executive functions, particularly inhibitory control and attention, as they need to control an impulse or emotion to follow instructions that are not preceded by the code words 'Simon Says'. 'Freeze' games are similar, where the listener is required to exercise inhibitory control and stop dancing as soon as the music stops. In both these examples, working memory is also required for the child to hold the rule in their heads. The activation and taxation of working memory can also be increased in other word memory games, such as the indigenous Setswana game 'Tsamaya oreka Omo' (Go and buy Omo), where children begin with the statement, "I went to the shop and I bought Omo (washing powder)." Each player must then recall all the previous items before adding an item of their own to the shopping list, while simultaneously clapping and slapping their thighs.

Implications for parents and practitioners

Self-regulation enhances children's ability to cope with various stressors. Therefore, providing them with opportunities via play to exercise these skills is critical. Parents and early childhood development practitioners can help by providing structured and unstructured time for pretend play and games with rules and by providing multifunctional props or toys (these can be made from recycled materials) that can prompt children to create imaginary scenarios. It is important to let the child lead, and adults can help by asking questions, describing their perspective, or asking children how they feel. At times it might be helpful to suggest a new rule, element, or scenario to add complexity to the game, but child autonomy and ownership of the process should be maintained.

How can ECE centres promote and protect mental health?

ECE centres can support mental health in early childhood by:

- Promoting child functioning and well-being through curricula, pedagogical approach and school environment.
- Acting as hubs to screen for developmental or behavioural disorders.
- Linking children at risk of mental health problems (for example, those with early signs of behavioural problems) to local DSD or Department of Health (DoH) practitioners for additional support.
- Providing caregivers with information and linking them to services and support networks as required.

What is the current policy response in South Africa?

The National Integrated ECD Policy 2015 provides an overarching framework to strengthen ECD services at each level of government, including a description of programme components, roles and responsibilities, and the establishment of a coordinating structure.[21] Part of this framework focuses on emotional well-being; however, it is predominantly geared towards screening for families at risk and supporting caregivers to promote healthy and safe home environments, and not on the role of ECE centres settings. The Integrated School Health Programme (ISHP) includes provisions for health screening, services, and education of Grade R learners. At this stage, mental health is intended to be included in health screening; however, no clear referral pathways are described, apart from provision of information around sexual, physical, and emotional abuse.[22]

One of the key challenges in implementing current policy is that many ECE centres in South Africa operate in informal settings and are therefore unregulated and unsubsidised, which may introduce risks to child well-being and safety, in addition to providing care and education of inconsistent quality. Another key challenge is that very few ECE institutions are linked to child mental health services, despite the overarching intersectoral ISHP.

What are the promising opportunities for future service development?

Some promising early education-based models from low-resource settings include developing teachers' skills in fostering the socio-emotional development of young children and early identification of behavioural problems.[23, 24] Other potential approaches include provision of individualised child assessment and therapy, and family assessment and support.[25]

The ECE setting could be used as a platform to promote nurturing care and positive parenting and discipline techniques.[26] Psychosocial treatment for parental depression and specific mental health programmes focusing on parent–infant interaction have been found to help prevent impaired cognitive development and behavioural and emotional problems in disadvantaged children.[27]

Primary schools

Primary school education is the responsibility of the DBE. It starts in Grade 1,when the learner turns 7, and continues until the end of Grade 7. Primary schools have the highest rates of enrolment and most learners attend no-fee public schools.

What are the mental health concerns and risk and protective factors?

The most commonly reported mental health concerns during the primary school years are anxiety, depression, post-traumatic stress disorder, aggression, substance abuse, and conduct and attention deficit/hyperactivity disorders.[29, 30] High rates of bullying are also common,[31] particularly for boys.[32] Additionally, many learners are still exposed to corporal punishment,[33] despite it being outlawed in South Africa in 1997.[34] Corporal punishment has been linked to increased rates of anxiety, depression, aggression, and suicidal ideation.[33, 35, 36]

Primary schools can be a safe and supportive space for learners, which can encourage school attendance and improve feelings of belonging.[29, 37] However, the transition to primary school can be stressful and learners can struggle with associated changes such as new teachers, peers, rules and routines.[38]

How can primary schools promote and protect mental health?

Primary schools can support the mental health of learners by:

- Building a positive school climate, improving relationships within schools, creating an environment that promotes respect and values diversity, and reducing exposure to risk factors through modifications to the physical and psychological environment.
- Incorporating emotional well-being and building skills such as emotional regulation into the curriculum.
- Involving parents/caregivers in initiatives that promote mental health and well-being.
- Investing in staff well-being.
- Offering targeted support and appropriate referrals for those showing signs or symptoms of mental health conditions.

What is the current policy response in South Africa?

The framework of services that should be available through primary and secondary schooling in South Africa are detailed in key documents such as the ISHP, the National School Safety Framework (NSSF) and the Care and Support for Teaching Learning (CSTL) Programme (the last two of which are described in more detail in the secondary school section below). These are aligned with the South African Mental Health Care Act and the Child and Adolescent Mental Health Policy Guidelines.[39]

The ISHP positions schools as being important for addressing health challenges of learners, including mental health.[22] It includes provision for school children to be screened for mental health problems and provided with psychosocial support at foundation and intermediate phase.[22] Moreover, health education should be provided that focuses on related topics such as abuse (foundation phase), substance abuse and bullying (intermediate phase) and suicide (senior phase). Each school should be assigned to a primary health care facility with school health nurses acting as the primary referral agents. School-based support teams should be in place, comprising skilled teachers, health promoters (full-time members of the school health team or lay health workers based at facilities or part of primary health care (PHC) outreach teams), representatives of the school governing body, and non-governmental organisations.

Health education is a crucial component of the ISHP and is incorporated into the school curriculum and provided through Life Orientation. The subject of Life Orientation is intended to build learners' skills, knowledge, and values about the self, the environment, responsible citizenship, a healthy and productive life, social engagement, recreation and physical activity, careers and career choices. The content taught in lower grades serves as the foundation for later content introduced in higher grades.

In practice, the ISHP implementation is fragmented and inequitable. There are too few assigned health care workers and a lack of collaboration between health and education officials. [40] Recommendations for ensuring more effective implementation of ISHP include clarifying educators' role in the implementation of ISHP, providing training, introducing baseline standards for schools implementing the ISHP, and ensuring greater commitment to intersectoral collaboration.[39] This process includes establishing clear communication

Case 13: Universal intervention to reduce anxiety

An information motivation and behavioural skills (IMB) based intervention programme was delivered to primary school learners to reduces levels of anxiety. The programme consists of six modules focusing on emotions, emotional triggers, empathy skills, emotional regulation skills, and self-esteem. The programme is delivered to learners aged 10 – 11 years by research assistants over four weekly sessions delivered to whole classes. The effectiveness of the programme was assessed using a cluster randomised control trial in Malaysia that found the IMB-based programme was effective in reducing levels of anxiety when compared to a school-as-usual control group.[42]

Case 14: Whole-school health promotion

The Strengthening Evidence Base on School-Based Interventions for Promoting Adolescent Health (SEHER) is a whole-school health promotion intervention that aims to enhance the school climate and adolescent health and well-being.[67] SEHER is delivered by lay counsellors and teachers to Grade 9 learners (13 – 14 years) in Bihar, India. The intervention programme consists of three components: (1) whole-school activities, (2) group activities, and (3) individual activities. School-wide activities address a range of topics (hygiene, bullying, mental health, substance use, reproductive and sexual health, gender violence, rights and responsibilities, and study skills) each month. Group activities are delivered through peer groups and workshops. The peer groups consist of approximately 10 – 15 students from each class, who meet monthly to discuss the topic of the month and assist in organising various activities. Workshops focus on effective study skills for learners and on discipline practices for teachers. Lastly, problem-solving counselling is offered to learners who self-refer or who are referred by teachers. The effectiveness of the intervention programme was assessed through a cluster randomised trial. The intervention had beneficial effects on school climate, depression, bullying, violence victimization and perpetration, attitudes towards gender equity, and knowledge on sexual and reproductive health when delivered by lay counsellors, but no effect when delivered by teachers. This may be because lay counsellors were employed full-time to facilitate the programme, whereas teachers also had their full-time academic responsibilities to attend to.

systems within and between the DoH and DBE to engage all stakeholders, improving the management of financial, human and other forms of resources, and ensuring that they are equitably distributed and accounted for.

What are the promising opportunities for future service development?

Opportunities for future service development through primary schools include training health personnel to ensure effective implementation of school health policy at district and regional levels, and prioritising educator mental health through debriefing sessions and mentorship. Whole-school approaches that address the school environment have been shown to be effective in school-based bullying prevention and intervention.[41] Interventions that promote school connectedness (including a sense of belonging, school involvement and positive school climate) and offer structural dimensions, such as teacher support, have also been found to promote mental health during middle childhood.[27]

Secondary schools

Secondary school runs from Grade 8 to Grade 12, from the ages of 13 – 18, culminating in the National Senior Certificate (or Matric) exams. Compulsory education is completed at the end of the senior phase (Grades 7 – 9), and school dropout increases with age during the Further Education and Training band (Grades 10 – 12).

What are the mental health concerns and risk and protective factors?

Secondary school is a critical period for adolescent development, with half of mental health conditions emerging by the age of 14 years. Common mental health conditions that emerge during adolescence are anxiety; mood, attention, and behaviour disorders; substance use; and suicidality.[43, 44]

Specific risk factors for mental health conditions during adolescence include poor socio-economic status,[45] parental depression,[46] poor family functioning,[47-49] poor parental relationships,[50] poor interpersonal skills,[51] bullying[52] and low self-esteem.[53] Schools can be protective when they provide a safe environment (physical and emotional safety),[54] high connectedness,[55] nurturing relationships and interactions between learners and teachers,[55] and a supportive learning environment.[56]

How can secondary schools promote and protect mental health?

Secondary schools can support the mental health of adolescents in several ways:

- Committing to a whole-school approach to being a HPS and interventions should reflect this. Will and commitment are needed from leadership, at an individual school level, to instil an inclusive and healthy institutional culture.[16]
- Providing parents, caregivers and local community members with opportunities to participate meaningfully in the governance, design, implementation and evaluation of HPS initiatives.[16]
- Implementing national policies against substance use and bullying behaviour.
- Supporting the physical, social-emotional and psychological health and well-being of learners.

- Providing programmes to enable staff to support their own well-being and those of their learners.
- Ensuring learners can access support or treatment when needed. This can include links with after-school programmes that provide psychosocial support. After-school or community-based programmes are also a promising avenue for reaching out-of-school children, including children and adolescents who face hardships in accessing or completing formal school.[57]
- Providing platforms for peer-based and peer-led mental health interventions, as these have been shown to improve self-esteem in victims of bullying and positively improve learners' relationships.[58]

What is the current policy response in South Africa?

The ISHP, NSSF and CSTL programme outline a package of services that should be available through primary and secondary schools. At a secondary school level, the ISHP states that adolescents should be screened for mental health issues and provided with psychosocial support during the senior phase.[22] Health education should be provided through Life Orientation and additional life skills teaching should be provided in secondary schools where timetables may not provide adequate time to fully address health and social issues.[15] Additional on-site services include sexual and reproductive health services and provision of HIV counselling and testing.

The CSTL Programme, a Southern African Development Community initiative adopted by the Minister of Education in 2008, was initiated to coordinate and expand care and support activities that improve education outcomes across school stages.[59, 60] The initiative aims to remove health and social barriers that limit the potential of children. Key provisions include nutritional support, health promotion, infrastructure, water and sanitation, safety and protection, social welfare services, psychosocial support, material support, curriculum support, and co-curricular activities. At the school level, the essential package of services includes safety and protection policies against discrimination and bullying, identification and support of children who are exposed to abuse, and disaster risk reduction and sensitisation. Implementation of the CSTL at school level is facilitated through a school-based support team, which could take the form of a School Development Committee, a School Management Board, or Parent Teacher Association. These support structures include community development partners, community members and learners to promote child participation. As in primary schools, the NSSF, together with the Regulations for Safety Measures in public schools, require every school to put in place a school safety policy, a school safety plan, a policy on non-violent discipline, and a code of conduct for learners. School safety interventions are monitored by the Safe School Committee in every school.[61]

The Department of Basic Education's National Policy on the Prevention and Management of Learner Pregnancy[63] asserts the Constitutional rights of pregnant learners to continue and complete their basic education without stigma or discrimination. Schools are required to provide counselling and support to pregnant learners, allow a short- to medium-term absence from school and enable them to return to school and complete their education up to Grade 12. An implementation plan is expected in 2022.

Despite these promising policies to promote psychosocial development and well-being among secondary students, there are several key challenges in implementing the existing policies. There are high levels of school dropout, with vulnerable adolescents most at risk, and dropout rates tripling during the first year of the COVID-19 pandemic.[64] There is also lack of a conducive environment for screening and examining children properly, including mental health assessment, due to lack of privacy.[15] When a mental health issue is identified, support services are not always available to respond to identified health needs and follow-up is rarely conducted, as nurses generally visit schools once a year.[15] There is also limited resource allocation for implementation, poor delivery of school health services as well as a lack of

Case 15: A whole-school approach to safety promotion

The Safe School Programme, a Western Cape Education Department initiative, is a provincial level response that uses a whole-school approach to safety promotion and violence prevention.[62] This approach requires collaboration between principals, educators, school governing bodies and learners and cluster safety committees to develop, implement and monitor a sustainable integrated safety plan. The programme aims to promote safe learning environments and prevent violence through effective behaviour management, creative and constructive approaches to conflict resolution, mediation in school communities, gang prevention education, parent workshops, mentorship programmes, diversion programmes, youth development, victim empowerment, and multi-cultural education.

support from caregivers and communities, partly because caregivers are not certain of their role in the provision of school health services.

What are the promising opportunities for future service development?

Universal delivery of social and emotional learning programmes can promote positive mental health outcomes and reduce poor mental health and risk behaviours.[65] Interpersonal and social skills training can also assist in reducing violent and antisocial behaviour in youth.[66]

Tertiary education

Tertiary education institutions are the responsibility of the Department of Higher Education and Training (DHET). DHET focuses on post-school education, skills development, and vocational training.

What are the mental health concerns?

Mental health problems common among South African university students include mood and anxiety disorders, post-traumatic stress disorder, and hazardous substance use.[68-71] Findings from a study to establish the prevalence of common mental disorders (CMDs) among first-year university students in South Africa found that CMD prevalence rates are higher among students than in the general population.[69] The transition to tertiary education institutions can be stressful as it usually involves leaving one's family and home, adapting to a new social environment, increased academic and financial pressure, and more opportunities for substance misuse.[69]

How can tertiary institutions help?

Tertiary education institutions should focus on creating healthy, safe, secure, and inclusive environments that promote respect and value diversity.[69] Programmes should be implemented to enhance student health and wellness to increase the proportion of students who complete their degrees. Tertiary education institutions should also engage and collaborate with community-based services that can provide support and treatment to students.

What is the current policy response in South Africa?

There is no overarching policy response for mental health in higher education in South Africa. Mental health policies developed by South African universities generally include a commitment to providing professional, coordinated, accountable, fair and accessible services to students to support the prevention of mental health challenges and the promotion of mental health and wellness. Several universities have a designated primary healthcare entity for registered students that regulates mental health care services and treatments. These facilities offer assessment and intervention to those experiencing mental health challenges. They offer mental health awareness, promotion and prevention activities to the campus community, and aid in providing motivations for reasonable accommodation for students with mental health difficulties.[72-74]

The lack of a national policy related to mental health in higher education poses a significant challenge to the implementation of programming. Lack of guidance from national government means that if provincial governments implement appropriate services, they are required to develop their own evidence-based guidelines and implementation plans – a time-consuming and costly process. In addition, the lack of effective prevention and early detection of mental health problems amongst students can cause bottlenecks in service delivery at the primary health care level.[69, 75]

What are the promising opportunities for future service development?

Opportunities for developing services at a tertiary education level include linking to school-based programmes and improved access to adolescent psychiatric services. Other possibilities include adopting a public mental health approach to promoting student wellness with ongoing monitoring of the prevalence of mental health problems

Case 16: Digitally delivered psychological treatment

A web-based group cognitive behavioural therapy (GCBT) intervention was delivered to Stellenbosch University students to reduce symptoms of anxiety and depression during the COVID-19 pandemic, when access to traditional campus-based psychotherapy was restricted. The intervention was delivered remotely by graduate clinical psychology students (trainee psychologists) via Microsoft Teams in 10 weekly workshops of 60 – 75 minutes. Content is organised into five themes, with each theme spanning two workshops, and drawn from common elements identified from GCBT interventions that were shown to be effective among university students. The effectiveness of the intervention was assessed through a pragmatic open trial in South Africa that found significantly decreased symptoms of anxiety, depression and composite anxiety and depression in intervention participants compared to controls.[76]

Case 17: Supported Education programme

Supported Education (SEd) is a programme model developed in the United States to assist people with psychiatric disabilities achieve their post-secondary education goals and to improve retention rates for tertiary education students with psychiatric disabilities. SEd is built on a resilience-based framework where students are taught how to cope more effectively with the complexities of tertiary education learning, which are often associated with dropout. They are also taught how to use internal and external protective factors in the tertiary education environment to increase resilience.[77] SEd programmes also offer the following services to students: (1) career planning, which includes vocational assessment, career exploration, and course selection; (2) academic survival skills, which include information about the tertiary institution and different training courses, disability rights and resources, tutoring and mentoring services, and social support services; (3) direct assistance, which includes help with enrollment, financial aid, education debt, and contingency funds; and (4) outreach, which includes campus resources and mental health treatment. Research on the effectiveness of SEd programmes in high income settings has found higher levels of academic engagement in individuals with psychiatric disabilities, improved self-confidence and self-perception, and higher enrolment rates in tertiary education institutions.[77]

on South African university campuses. This approach would require accurate epidemiological data that could then be used to plan and support the delivery of preventive mental health services, and the adopting of alternative, sustainable counselling approaches, such as the use of group therapy and/or internet-based psychotherapy.[76]

How can we address cross-cutting issues?

There are several challenges as well as opportunities to improve mental health promotion and preventive services that cut across all levels of education.

Transitional periods

While the ISHP stipulates that mental health screening, assessment and education is incorporated into every school health package, from Grade R to 12, it provides limited focus on the transitions between the different stages of education.[39] Increased stress is characteristic of the transition, as learners are expected to adapt to new school, teacher and/or classroom demands, new peer groups, and, in some cases, the changing languages of instruction between phases. Various strategies could assist with transitioning processes. For example, within schools, efforts should be made to welcome and orientate new students by building relationships across grades, and information should be given to parents and caregivers on how best to support their child's transition from one school setting to another.[16] Regular meetings and information sharing between schools within the same geographic area could be beneficial. These meetings could provide opportunities for educators to share important information about children (e.g., health information or support services accessed) to ensure ongoing support, and to learn about the different programmes that each school stage offers and their connection with childcare programmes within the community.[78]

Racism and discrimination

In the South African context, learners' exposure to interpersonal and institutional racism is an ongoing challenge. Experiences of alienation, discrimination, and racialised bullying are common at formerly white schools and universities across the country. The negative impact of these environments on learners' mental health, self-esteem and sense of belonging was well described by the #yousilenceweamplify campaign on social media which gained national prominence.[79] Explicitly capacitating schools to address issues of discrimination is critical. Examples of programmes include Teaching for All, which has been widely rolled out in South Africa and aims to equip teachers and schools with training on how to "teach inclusively in diverse classrooms in diverse communities".[80]

Educator well-being

South African educators experience high levels of stress in their places of work and often do not feel equipped to deal with learner mental health issues themselves.[81, 82] This psychological load undermines educators' ability to respond to their learners and can interfere with positive educator-child relationships and effective social-emotional teaching.[83, 84] Student well-being could be positively influenced by improving educator well-being, through interventions such as task sharing that reduce job demands and increase job resources.[67, 85]

Disability

In South Africa, up to 70% of children of school-going age with disabilities are do not attend school. Of those who do attend, most are still in separate schools for learners with special needs. This situation prevails despite the push for the educational inclusion of learners with disabilities since the publication of Education White Paper 6 in 2001.[86] Providing basic and higher education, let alone mental health services, for children and adolescents with disabilities may be challenging, especially in remote areas where infrastructure and support are lacking. Children with disabilities are at increased risk of developing mental health disorders. It is therefore essential to include them in mental promotion and prevention programmes and to ensure early referral for treatment to prevent the development of a secondary psychosocial disability. Treatment should have an emphasis on recovery and provide consistent follow-ups from a multi-disciplinary team that spans the health and education sectors.

What are the priorities for further research?

Two priority areas of research are policy implementation and programme evaluation. While the ISHP provides a national roadmap, provincial policy and implementation plans are lacking and need to provide feasible, relevant and evidence-based frameworks for service delivery.[75] Situational analyses should be conducted to assess the current implementation of the ISHP and how it relates to child and adolescent mental health at a provincial, district and school level. This includes engagement with the users and providers to understand their lived experiences and perceptions of the mental health services that are currently offered through schools. This feedback should inform recommendations for policy and programming, and the research findings should be available for policy makers to spark discussion and encourage policy planning and implementation.[75]

Rigorous evaluation designs are difficult to implement in educational settings, as randomised control trials often require rigid controls to minimise confounding factors, which may not be feasible.[87] Possible strategies to mitigate this include effectiveness studies (evaluating an intervention under usual conditions) or quasi-experimental and well-designed observational studies which rely on naturally occurring variation among schools or settings.

Conclusion

Schools and other educational institutions have the potential to be a powerful resource for promoting and protecting child, adolescent and youth mental health in South Africa. While national policy exists to support the mental health of learners and students, the implementation thereof, at a provincial, district and institutional level, is weak and requires attention. The COVID-19 pandemic and its far-reaching consequences for our society add another layer of complexity that needs to inform future research, policy and programming.

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