



Mental health in schools: a manual



**World Health
Organization**

REGIONAL OFFICE FOR THE **Eastern Mediterranean**



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“Our love for children is undiminished. Their innocence and energy, their happiness and welfare must be protected and treasured. It is their laughter that I yearned for while in prison.”

Nelson Mandela



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Introduction

The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Indeed, “there is no health without mental health”.

Approximately 1 in 5 children display signs of poor mental health (UK Department of Health, 1995) and, at any given time, meet the criteria for a mental illness (Merikangas et al., 2010). About half of all mental illnesses begin in childhood and adolescence (Kirby & Keon, 2004).

Schools afford a great opportunity not only to identify and support children who are experiencing emotional difficulties but more importantly to promote overall emotional well-being and social and moral development. Schools are imperative in mental health promotion and prevention. As the majority of countries in the WHO Eastern Mediterranean Region have a large population under the age of 18 years, investing in the mental health of children has long-term implications for the development of these countries and their ability to have a productive and skilled workforce. In addition, several countries in the Region have experienced recent wars or political unrest, increasing the vulnerability of these children and their families to mental disorders.


School experiences are vitally important in both children’s intellectual development and their psychological well-being, and evidence increasingly illuminates the close connection between emotional health and academic achievement; hence, schools enhance school achievement by attending to issues such as self-esteem and social well-being (Hattie, 2008; Rutter, 1991). In addition to school success, children and adolescents who experience positive emotional and social well-being report greater satisfaction with their family and their relationship with friends (Gutman & Feinstein, 2008). Conversely, children with emotional problems are more prone to academic failure and quitting school, making them vulnerable, targets for child labour, substance abuse, criminal involvement and violence, as well as unemployment. Thus, schools have a critical role to play regarding student mental health.

Teachers have a significant responsibility for educating their students, and teaching can be both rewarding and challenging at the same time. Learning about school mental health will help teachers and not just be one more thing to do. Teachers often report that they need support in fostering wellness in their classroom and in identifying and supporting students with mental health challenges. When teachers feel better equipped to support student mental health, it is easier for them to manage difficult classroom behaviour and also to promote students’ academic success (see Appendix 1 for more information on teacher wellness).

Effective social and affective education is directly beneficial to academic attainment and improves teacher effectiveness and satisfaction, such that promoting mental health in the classroom is consistent with and supports the academic mission of schools (Weare, 2000). Even in developed countries such as Canada, a need was found for more teacher training about mental health and for a more proactive approach towards mental health in schools (Roger et al., 2014).

Why should schools be invested in the mental health of their students?

- Investing in mental health results in improving academic achievement rates and decreasing grade retention and dropping out. For instance:
 - children's well-being is linked to their academic achievement (Gutman & Feinstein, 2008);
 - student effort (i.e. the level of school attachment, engagement and commitment) is highly correlated with more positive academic outcomes (Stewart, 2007);
 - school programmes that focus on social, emotional and academic learning from kindergarten through high school have been found to improve school attitudes, behaviour and academic performance (Zins et al., 2004).
- Social development, including meaningful peer relationships that promote psychological well-being and life skills, can improve academic achievement and motivation, while negative peer pressure or social disapproval towards school work might lead some students to drop out of school (Stewart, 2008; Nichols & White 2001).
- Students spend a significant amount of time at school (Rutter has estimated approximately 15 000 hours from kindergarten to completion) and are therefore accessible for mental health promotion, prevention and intervention.
- Strengthening student protective factors and resilience within schools reduces negative risks and outcomes for vulnerable children.
- Promoting school mental health helps decrease violence and juvenile crime.
- Schools play a significant role in the early recognition and identification of children with mental illness and also in altering the school experience of these students to yield better outcomes.

- 
- School is a more familiar and less stigmatizing or threatening environment for students in need of help compared to hospitals and medical offices.
 - Working with children who have mental health problems can be very challenging and stressful to teachers (Hanko, 1993). Enhancing student emotional health can improve satisfaction and retention among teachers.
 - Schools influence the adoption of healthy behaviours (healthy diets, physical activity, etc., instead of substance abuse, delinquency, etc.) which improve quality of life across the lifespan.
 - Children often establish deep and lasting relationships with teachers, school staff and peers at school: these relationships are also protective and supportive.
 - Children learn to express themselves and actively participate in social activities at school and community projects: these experiences enhance their social connectedness and sense of belonging as well as their self-confidence and motivation for productive participation in society in the future.

Target audience of this manual

This manual is primarily intended for those involved in the educational process including teachers, school administrators, nurses, social workers and school counsellors, in addition to educational policy-makers and nongovernmental organizations. This manual can be used together with supporting tools that are part of this package including slides and handouts. Additional resources are also available in the following appendices: Teacher wellness (Appendix 1); Risk and protective factors for mental illness (Appendix 2); Bullying prevention and intervention in schools (Appendix 3); Examples of school intervention programmes from the WHO Eastern Mediterranean Region (Appendix 4); Screening tools that can be used in schools (Appendix 5); and other Resources (Appendix 6).

Objectives of this manual

The main objectives are:




- helping educators understand the importance of mental health in a school setting;
- enhancing educators' understanding about child development;
- incorporating mental health into healthy schools initiatives;

- providing age-appropriate behavioural management strategies including disciplining and management of disruptive behaviours;
- understanding how mental health can be promoted in school settings;
- identifying the warning signs of mental illness in schoolchildren and distinguishing them from emotional distress;
- providing appropriate interventions for a variety of psychiatric disorders;
- providing further resources that can be accessed by educators.

Guide to using this manual

This manual is intended to be a guide for educators to better support the mental health needs of their students and to take practical steps implementable in school settings. We emphasize interventions and supports that can be implemented at relatively low cost. The manual is divided into modules that can each be used separately. It is intended to be a concise and practical guide.

The manual uses visual aids to assist the reader. While reading the manual:

	Indicates "actionable items" including practical tips or interventions to be implemented
	Indicates more applicable to younger children, < 8 years
	Indicates more applicable to adolescents, > 13 years

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Module 1. Social-emotional childhood development

Children change constantly, beginning on the day they are born. They develop in multiple domains (Fig. 1), but not always evenly; for example, their language skills may develop more quickly than their physical abilities (motor development) or social skills. Teaching and classroom management techniques attuned to the unique students of each year are important for optimizing school success. Understanding child development is also very helpful in differentiating typical from atypical development and hence understanding typical versus atypical behaviour.

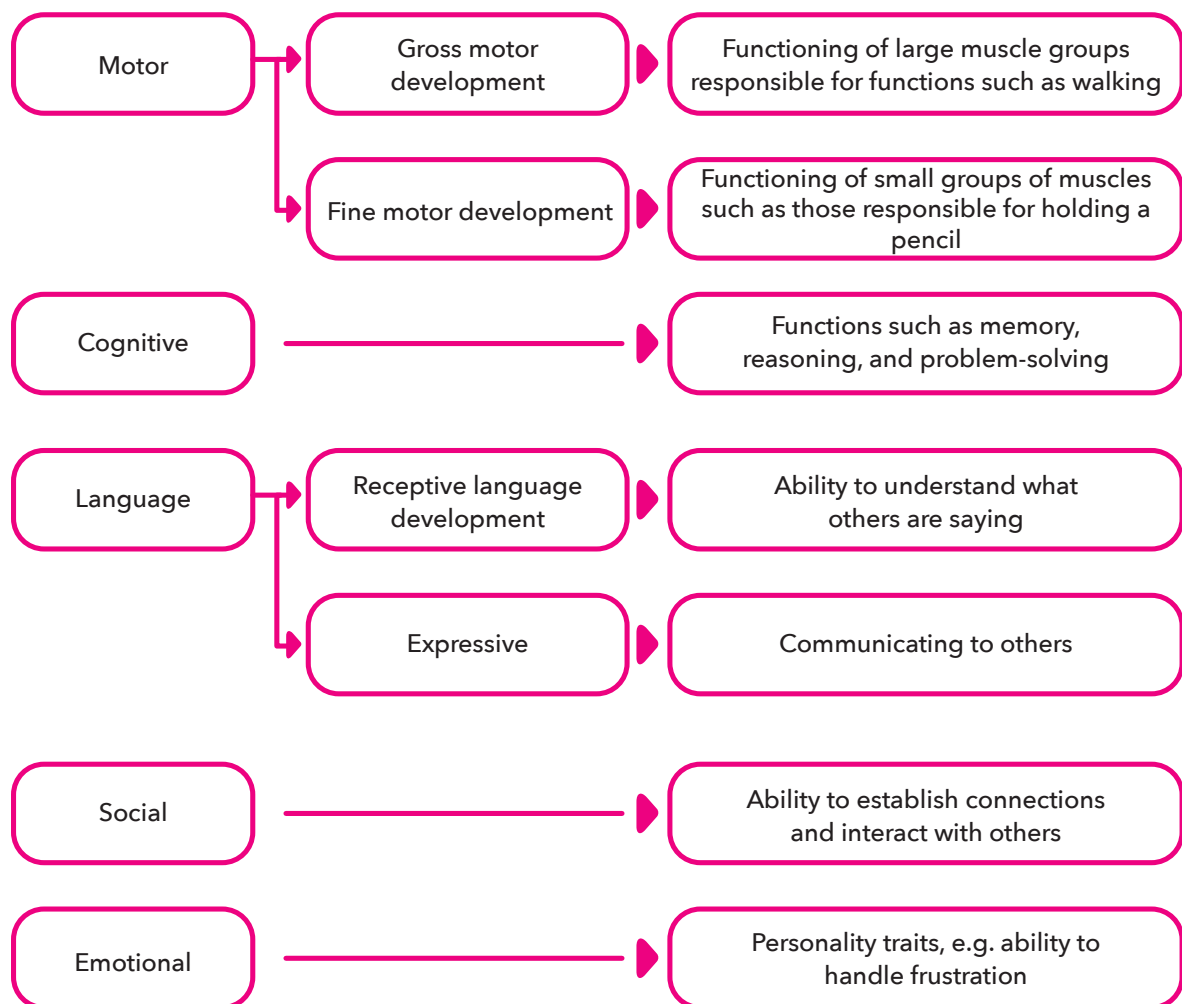


Fig. 1. Domains of child development

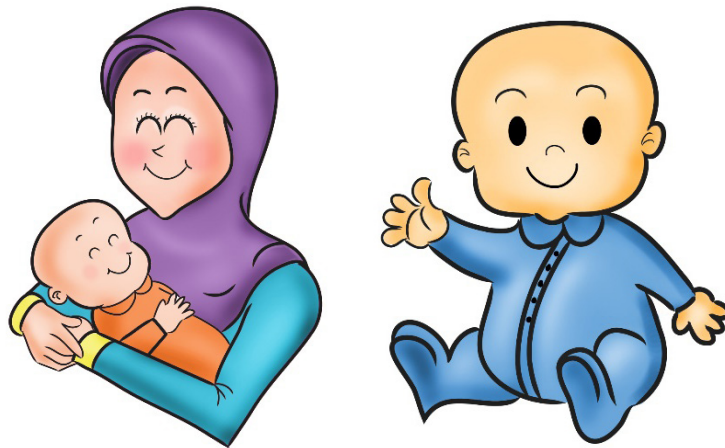
Development is characterized by processes by which individuals uniquely adapt to their environment. While child development is generally divided into stages, individual development is not so concrete; children may regress and seem to lose

skills, particularly when under stress. Development is dynamic and students, even of the same chronological age, are still on a continuum.

While the focus of this manual is school-aged children, the early development of preschoolers can reveal areas needing immediate intervention. Moreover, parenting practices during these early years can better prepare children to be ready to benefit from early school experiences.

This manual will emphasize the social and emotional development of preschoolers, children and adolescents and what educators can do to support such development.

Stages of development



Prenatal development

- A healthy pregnancy gets the child off to the best start. Minimizing exposure to stress, illness and/or toxins, including alcohol, tobacco or non-vital medications during the pregnancy is optimal.
- Complications during delivery may impact subsequent development. Intensive care treatment may warrant continuous monitoring of the child's progress and attainment of developmental milestones at age-appropriate intervals.
- The context or circumstances in which the child was born may be important, e.g. did the pregnancy occur at a time of high stress for the family? Was the pregnancy planned? Was the family hoping for a child of a certain sex? Did other stressors occur during the pregnancy (health issues with other family members, relocation or separation of parents, etc.)? Is the child an only child or do they have siblings?

Developmental tasks of preschoolers

Table 1. Milestones for preschool children

Age (years)	Social and emotional milestones	Strategies to promote healthy development
1	<ul style="list-style-type: none"> • Shy with strangers • May cry when caregiver leaves • Has preferences, like favourite items or people • Hands you a book when wanting to hear a story • Repeats sounds or actions to get attention • Puts out arm or leg to help with dressing • Plays games such as "peek-a-boo" and "pat-a-cake" 	<ul style="list-style-type: none"> • Play games (e.g. peek-a-boo) • Read and sing with children • Join in their play • Encourage children to play near other children, even if they do not play together • Play basic games that involve turn taking • Invite the child to do what he/she can do for themselves (e.g. taking off shoes or putting a book away)
2	<ul style="list-style-type: none"> • Imitates others, especially adults and older children • Gets excited when with other children • Increasingly independent • Plays mainly beside other children, may start to play with others • Tantrums are a typical way children may express their frustration 	<ul style="list-style-type: none"> • Provide consistent and predictable routines so that children learn what to expect • Give children warnings before the end of an activity • Encourage children's growing independence by letting them try things on their own • Respond to desired behaviours more than you attend to undesired behaviours; always show and tell your child what he/she should do • Provide choices (e.g. "Do you want the blue or red paper?") • Help children learn about their feelings by labelling them
3-5	<ul style="list-style-type: none"> • Interested in new experiences • Cooperates with other children • Increasingly inventive in fantasy play • Increasingly more independent • Often cannot distinguish between fantasy and reality • More likely to agree to rules at times • Sometimes demanding while sometimes eagerly cooperative • Wants to be like his/her friends 	<ul style="list-style-type: none"> • Encourage group play, be prepared for disagreements and challenging behaviour • Expect child to have simple responsibilities and follow basic rules • Establish limits and adhere to them • Help the child be responsible and discover the consequences of behaviour • Provide outlets for emotional expression • Provide opportunities for talking about self and family • Strengthen positive self-esteem • Promote independence as appropriate • Provide plenty of play space and provide for rest • Read to/with the child



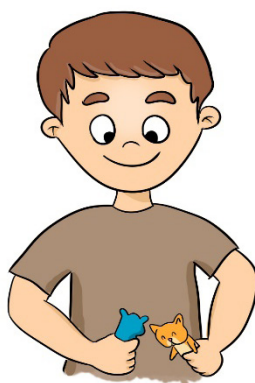
Developmental tasks of primary school-age children (6-12 years)

As children enter regular school at approximately age 6 years, they are usually expected to be ready to:

- play next to and with peers and to respect the space and boundaries between them;
- play games and sports with peers, sometimes winning and sometimes losing;
- develop their masculine and feminine roles and dress in a style comfortable for them;
- develop reading, arithmetic and writing skills (know letters/sounds, numbers and how to form letters/symbols);
- exhibit normal everyday skills, including eating meals, going to the bathroom alone and waiting their turn among others;
- develop a sense of right and wrong, to distinguish truth from falsehood, to ask for help from adults when distressed;
- develop increasing autonomy to follow through and complete tasks;
- work productively with peers and with staff.

Table 2. Milestones for primary school children

Age (years)	Social and emotional milestones	Strategies to promote healthy development
6-8	<ul style="list-style-type: none"> • Growing independence • Common fears - problems in the family, failure, rejection • Friends often from same neighbourhood and same sex as child • Showing more nurturance to others • Commanding to younger children but follow after older children • Start seeing the point of view of others more clearly • Defining themselves in terms of appearance, activities, possessions • Fewer angry outbursts and more frustration tolerance • Learning how to resolve conflict with peers • More self-conscious • Tattling is a common action to get adult attention • Inner control is being formed and practised every time a decision is made • May still be afraid of the dark or monsters 	<ul style="list-style-type: none"> • Encourage noncompetitive games and help set individual goals • Give lots of positive attention • Let children help define the rules • Talk about self-control and making good decisions • Talk about why it is important to be patient, share and respect others' rights
9-12	<ul style="list-style-type: none"> • To win, lead or be first is valued (e.g. to be the "boss," unhappy if they lose a game) • Often attached to an adult other than their parent (teacher, club leader, coach) • Quote their new "hero," try to please the person and strive for attention from them • Influenced by both peers and family • Feelings get hurt easily and mood swings are normal • Sensitive to negative feedback • Difficulty dealing with failure 	<ul style="list-style-type: none"> • Teach them to learn from feedback. Ask: "How could you do that differently next time?" • Always be alert to the feelings associated with what is said • Give positive feedback for successes • Offer activities that help children feel proud of who they are and what they can do • Balance activities between high energy and quiet activities



Several difficulties may emerge during this stage, some of which are common and some which may warrant more careful investigation through staff discussion with parents and clinicians (Table 3). Educators are in a position to help students navigate these typical challenges of development by continuing to educate students about what is and is not appropriate or acceptable behaviour. Teachers are in a position to be powerful role models and teach children the necessary skills to manage problems that are part of typical development.

It is important for educators to note that while some of the behaviours listed as areas of concern are also a part of typical development, the key distinction is the frequency, duration and level of behaviour. For example, it is normal for children aged 6-12 years to have some trouble concentrating for long periods of time or on tasks that are not interesting to them, but a child who has trouble focusing on an activity for a very short period of time is at risk of a more serious problem. Similarly, 6-8 year-olds are still developing emotional control and thus it is part of their typical development to be sensitive or become upset. Educators should be concerned about frequent, excessive and extended emotional reactions.

Table 3. Difícult behaviours of primary school-age children

Typical difícult behaviours of primary school-age children	Atypical difícult behaviours of primary school-age children (warranting further investigation)
<ul style="list-style-type: none"> • Arguments/fights with siblings and/or peers • Curiosity about body parts of males and females • Testing limits • Limited attention span • Worry about being accepted • Lying • Not taking responsibility for behaviour 	<ul style="list-style-type: none"> • Excessive aggressiveness • Serious injury to self or others • Excessive fears • School refusal/phobia • Frequent excessive or extended emotional reactions • Inability to focus on activity even for 5 minutes • Patterns of delinquent behaviours • Fire fixation/setting

Developmental tasks of secondary school-age children (12-18 years)

Adolescence is a time of significant change (Table 4), beginning with puberty, which now occurs at earlier ages, usually between 10 and 12 years. Adolescents go through a complex stage where they separate from parents to find their place among their peers. During this stage, adolescents often “try on” several different identities as they determine where they best fit among others and are more comfortable with themselves. Several tasks are associated with adolescence:

- achieving more mature relations with peers;
- achieving a masculine or feminine social role;
- accepting one’s physical strength and using the body effectively;
- achieving emotional independence from parents and other adults;
- beginning preparation for marriage and family life;
- beginning preparation for making a living and selecting a career;
- acquiring a set of values, ethics or an ideology as a guide to behaviour;
- developing socially responsible behaviour.



Table 4. Milestones for the secondary school-age child

Social and emotional milestones	Strategies to promote healthy development
<ul style="list-style-type: none"> • Heightened level of self-consciousness • Believe that no one else has ever experienced similar feelings and emotions • Exhibit the “it can’t happen to me” syndrome (invincibility) • Become very cause-oriented • Exhibit a “justice” orientation • Establishing an identity • Establishing autonomy • Establishing intimacy • Becoming comfortable with one’s sexuality 	<ul style="list-style-type: none"> • Create an atmosphere of respect, trust and honesty • Be considerate of students’ privacy • Empathize with the students’ perspective; put yourself in the students’ shoes! • Pick your battles - is this battle really worth fighting? • Maintain your level of expectations. Don’t write off negative behaviour as typical teenage behaviour • Know the warning signs when behaviour becomes dangerous • Notice changes in students’ behaviour

Several adolescent behaviours, although challenging, are part of typical development, e.g. mood swings, self-involvement, testing limits and peer conflicts. Educators are in an important position to identify atypical and problematic behaviours including those that may be indicative of a mental health problem. If educators identify any of these warning signs, they should not hesitate to contact the student’s parents and request a consultation with a mental health professional. Educators are in an extremely important position to notice changes in adolescents’ behaviour since teenagers often spend less time with parents. Educators may pick up changes in behaviour before parents are aware of a problem.

Moral development

Moral development involves children developing the ability to tell the difference between right and wrong and to utilize this knowledge to make decisions when faced with difficult choices (Table 5). Morality, similar to social-emotional development, happens in phases and is influenced by multiple factors in the child’s environment. Several theorists, e.g. Jean Piaget (1943) and Lawrence Kohlberg (1963), have described phases of moral development.

Table 5. Moral development in the school-age child

Age (years)	Typical moral development	Strategies to promote healthy moral development
< 10	<ul style="list-style-type: none"> • Children see the world through the lens of an other-directed morality such as authority figures (parents, teachers) • Rules are seen as absolute and unbreakable • Children’s understanding of why these rules should be followed is generally based on their appreciation of consequences associated with breaking the rules such as being punished 	<ul style="list-style-type: none"> • Set a good example through your own behaviour • Explain to children the reasons behind a rule • Demonstrate to them how one behaviour is better than another • Use storytelling to demonstrate moral situations • Praise the child for following a rule and bring their attention to how it made others around them feel (“Did you notice how Sarah felt when you shared your toys with her?”) • Encourage children to show empathy towards others, such as writing them a card if they are sick
10+	<ul style="list-style-type: none"> • Children’s morality changes as they develop the ability to view situations from other people’s perspectives • Their appreciation of morality becomes more self-directed and less “black and white” and absolutist in nature • Children will have generally begun to view moral rules as socially agreed-upon guidelines designed to benefit the group • Children still feel that it is important to follow rules, however these rules are viewed as guidelines that are meant to benefit society rather than inflexible orders they need to just follow • Children realize that choices should not be just based on the fear of negative consequences 	<ul style="list-style-type: none"> • Encourage volunteering • Encourage debate about complex moral situations. You may consider splitting the class into two groups each representing a different point of view and arguing the merits of each perspective • Use social studies and historical examples to raise complex moral and societal issues

Brain development and schooling

Certain key aspects of brain development are important for educators to be aware of in order to better understand child and adolescent behaviour. We review how difficulties with specific areas of the brain can impact behaviour and the importance of considering typical brain development when deciding on expectations in the classroom as well as how to address challenges in the classroom.

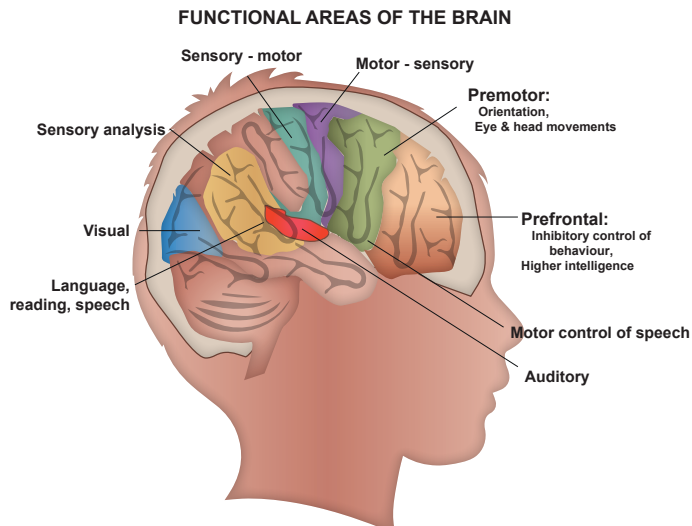


Fig. 2. Functional areas of the brain

Different areas of the brain serve different functions such as controlling speech, vision, hearing and language/reading. Many areas of the brain can impact behaviour seen in the classroom (Fig. 2). For example, the prefrontal cortex is used in decision-making and the ability to control behaviour. Skills controlled by this area are frequently referred to as executive functioning. The functioning of this part of the brain will impact students' abilities to solve problems and control impulsive behaviour in the classroom.

Differences in brain functioning and behaviour

Some children are born with genetic problems or medical conditions that may impact specific parts of the brain and affect how they function academically. For example, a child might have deficits in the area of the brain related to language, speech and sensory analysis. This could impact the child's ability to share learned information through speech or how the child might perceive things in their environment. Therefore, such children may need more assistance with speech or the teacher may need to find other ways for the child to share what they have learned. Due to stuttering, a children may not be able to show his/her actual reading proficiency. For these children, a silent reading task may be more useful. The child may also have a sensory processing problem where the environment is perceived differently than other students. A child with a processing problem may understand a concept but may not be able to explain it in a response to a verbal question. For one type of sensory processing problem, a child may be especially sensitive to their physical environment, such as having difficulty tolerating normal lighting, being more sensitive to noises, disliking being touched and not wanting to look directly

into other people's eyes. Because of this condition, the child might appear nervous or fearful and withdrawn in the classroom; however, they could be accommodated by being moved to a darker part of the classroom, getting to stand at the back of the line or having their desk away from others. In addition, the teacher needs to understand that the child is not being disrespectful when he/she does not make eye contact.

It is also possible for children and adolescents to develop difficulties over time with how their brains function, such as being in an accident, having a traumatic brain injury, or being exposed to trauma. Although these changes are not always permanent, it is important for an educator to consider how a child's behaviour may change in these circumstances. For instance, when a child is in an accident or experiences a physical trauma to their bodies, areas of their brain may also be affected and therefore impact their behaviour. If the area that is impacted is the prefrontal cortex, the child might have difficulty controlling their behaviour. Although early trauma may differ from an accident where there is physical injury to the brain, it can still impact how the brain functions and how the child behaves. For example, a child who experiences ongoing abuse may have actual physical changes to their brain that impact sleep, mood and attention and cause them to remain in a state of fear.

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Module 2.

Mental health promoting schools (promotion and prevention)

Social and emotional well-being

Schools will increasingly focus on the promotion of the emotional well-being of the students as an important variable influencing academic success. School programmes that focus on social, emotional and academic learning from kindergarten through high school improve school attitudes, behaviour and academic performance (Zins et al., 2004). School support also buffers against the effect of child victimization and vulnerability to substance abuse and quitting school (Dryfoos, 1993; Stadler, et al., 2010).

Schools are powerfully positioned to play a major role in such promotion. Students spend approximately 15 000 hours in school from elementary through high school. Teachers educate students while they serve as role models from whom students can learn important life skills such as emotional regulation, dealing with conflict and frustration, and modelling moral and ethical characteristics.



The Mental Health Foundation (1999) has identified important characteristics of schools that promote the mental well-being of their students includes:

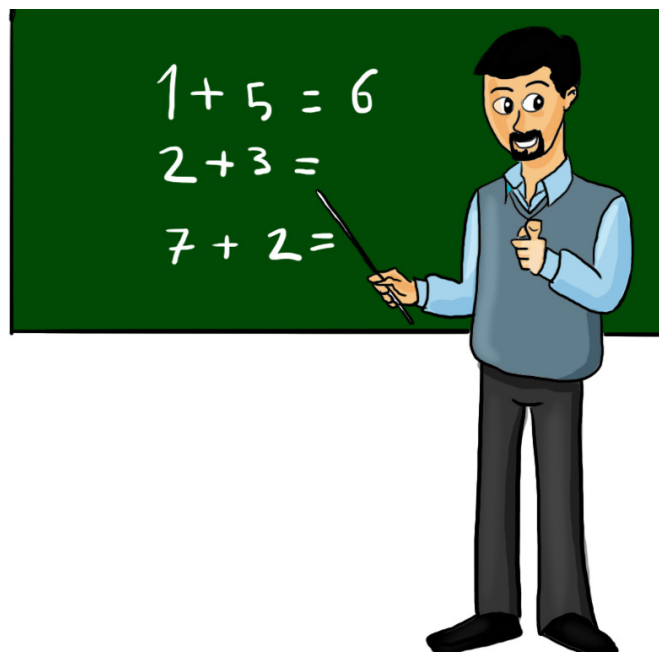
- having a committed senior leadership team that focuses on creating a culture based on trust, integrity, democracy and equal opportunity in which each child is valued and respected regardless of their abilities;
- creating a culture that values teachers, non-teaching staff and all those involved in the care and supervision of pupils;
- school-wide policies on important issues such as behaviour and bullying that are clearly set out, accepted and implemented throughout the school.

It is important that school curricula take a holistic approach to, and keep a balance between, academic content and personal, social and moral development.

Characteristics of a good teacher (Minhas et al., 2008)

A good teacher:

- understands different developmental stages of children, sets age-appropriate tasks according to the developmental stages and uses age-appropriate disciplining;
- is empathetic (recognizes feelings and reflects these back to students) and can see things from a child's perspective;
- is attuned to both the verbal and non-verbal communications of students and responds to these signals appropriately and in a timely manner;
- communicates effectively and clearly;
- makes student behavioural expectations clear and establishes limits that benefit and provide useful structure for the student;
- arranges the physical and interpersonal environment of the classroom in such a way to optimize teaching and minimize disruptive behaviour.



Characteristics of a good school (Minhas, et al., 2008; Zins, et al., 2004)

Characteristics of a good school include:

- diverse students with differing academic abilities;
- strong and consistent leadership by the principal and teachers;
- caring relationships between students and teachers;
- staff are involved in decision-making and consensus, and implementation is a joint responsibility;
- partnership between schools and families to facilitate learning;
- physical and interpersonal environments which are safe and orderly;
- cooperative learning and proactive classroom management;
- rules and limits clearly defined and firmly and fairly enforced;
- a positive, rather than negative or punitive, disciplinary style modelled by staff;
- students are involved and given responsibility for some aspects of the school depending on individual level of intellectual and social maturity;
- frequent assessment of students' progress, with the emphasis on acquiring fundamental skills and students recognizing and investing in the attainment of goals;
- a focus not only on academic work but also emotional well-being and social development;
- high academic expectations.

There is a very strong case for schools to be invested in mental health promotion at schools. Even in low- and middle-income countries, school interventions of a longer duration and which are more structured are most effective (Fazel et al., 2014).

Core values of a mental health-promoting school

Caring for all

It is important to foster a culture of understanding in which students who have difficulties are viewed as being in need of help rather than as a burden.



Practical steps to promote a caring environment include:

- Communicating through actions that all students are valuable, for example by spending time highlighting different students' talents and achievements and how each of them is unique.
- Creating an environment that doesn't discriminate between students, where each student is treated equally and fairly independent of their disability status or any other factor.
- Creating a mechanism to deal with complaints that includes clearly designating who a student can go to if they have a concern and a chain of command.

Valuing diversity

Help students appreciate how diversity (ethnic, religious, disability status) contributes to the education, understanding and appreciation of all. Teachers need to communicate positive attitudes towards children with special needs so that other students recognize how best to respond to children who may seem different. For example, a student helping another child using a wheelchair to move around the school.



Practical steps to promote diversity include:

- Establishing a buddy system.
- Having students with special educational needs in mainstream classrooms, which can have a positive impact on other students, particularly in the area of developing social skills.
- Helping students develop pride regarding their backgrounds, heritage and culture as they bring them up during school activities.

Building self-esteem

Schools play a fundamental role in students' self-esteem, and staff have a substantial impact on how students see themselves and how they are shaped for the future. Being in situations where they consistently experience failure at school usually has a detrimental impact on self-esteem in students. Similarly, when students have success at school, when they correct their mistakes, when staff have them do tasks (even "chores") that show confidence in the student, it builds self-esteem.

When students know that staff understand how they felt about something or why an action seemed to make sense, they develop greater self-esteem (e.g. "Yes, I can see how it made sense at that moment to just scream back at that person, it was scary; how do you feel that worked out?")



Practical steps to build self-esteem (Johnson and Johnson, 1999):



For older students

Give children responsibility and leadership roles whenever possible (look for tasks that students can do). Have children complete chores in the classroom (these can be rotated) or display leadership in activities such as organizing field trips.

- Use praise rather than reprimand. Attempt 5 positive comments for every negative comment throughout the school day.
- Foster cooperation rather than competition between students. Recognize when students work well together and produce something stronger than just individual parts. Notice and respond to students who help others and who are good "team members".
- Older students can mentor or "big brother/big sister" younger students to help the younger students play with others, learn to read, etc.





For younger students

Create activities that allow them to cultivate and demonstrate competence (www.connectability.ca).

- The child can create an “I am special” or “Things I am good at” book to focus on what they like about themselves and their strengths. Children can then take turns reading it to the group.
- Create “My hand activities”. Each child traces her hand and writes something about herself on each finger. These could be put up in class upon completion.
- Use scripted role plays (perhaps with puppets) to develop self-esteem by brainstorming ideas about what to do when children feel sad, distressed, angry or worried.
- Use beads for the children to make bracelets from. Each bead should represent something they like about themselves. They can then each talk to the group about the significance of the beads.

Building relationships

- Good relationships between students and their teachers and among students are very important for students’ emotional development because they learn many skills and values including core social skills, such as the ability to trust and be responsible for their own actions.
- Greater cognitive and affective achievement has been linked to more cohesive relationships and less tension within the classroom. Schools with poor relationships tend to lead to depression and absenteeism not only in students but also among teachers (Weare, 2000).
- Finding each student’s value and how they contribute positively is vital for students to feel good about themselves at school.
- Teachers model relationships for their students through their interactions with other teachers and with students, so the more collaborative, constructive and beneficial those relationships appear, the more students will be attracted to those behaviours.
- Liaising with parents is of paramount importance. Parental involvement is

positively associated with student success, higher attendance, greater teacher satisfaction and overall improved school climate (Hornby, 2000). Staff contact with parents should always model respect for parents but still provide parents with additional helpful and effective options at home. Making school and home similar also increases student anchoring of useful skills. If what works at school does not work at home for a student, it is more difficult for them to invest in school-related skills; often, parent conversations yield the best of both, with tactics applied in both places whether developed at home or at school.



Practical steps for relationship-building:

- Group work and activities provide a good opportunity for alliance building. Opportunities should be provided for children to develop social skills through role-play and other activities. The saying “if it’s not good for both, it’s not good for long” has relevance. Tasks or activities that are mutually enjoyable or beneficial are more likely to create better, more stable relationships.
- Procedures should be in place for teachers to manage potential differences with colleagues and students in a constructive manner.



Ensuring safety

- It is essential for children to feel physically and emotionally safe in the school setting. This is even more important for students with disabilities (physical and emotional).
- Aggressive behaviour, even if not directed towards the more vulnerable students, may threaten students and cause them to withdraw (Skiba & Peterson, 2000).



Practical steps for ensuring safety at school:

- Establish a school-wide policy for bullying and disruptive behaviours. All bullying, directly or through social media, requires attention (see section on cyberbullying in this manual). Prepare students for how to respond to bullying, whether as a victim or a bystander, through discussion and by providing practical, developmentally-attuned tactics for students to employ. Elementary age students can “tell” an adult when they perceive bullying, while older students may fear that “snitching/tattling” on peers leads to social ostracism, so tactics for ignoring, leaving, changing topics, or how to access other adults for help are often needed for this age group.
- Any form of threatening behaviour needs to be dealt with rapidly and effectively. Sometimes the “system” allows this by allowing teachers to threaten/frighten students, or through sports/activity teams that attempt to intimidate others.
- Ensure that teachers and staff are approachable. Staff need clarity on how to respond to student comments and preferred staff responses (listen, get the facts, help the student manage the situation quickly or identify who else needs to be involved to fix it).

Encouraging participation

- The most effective schools are the ones that create a positive atmosphere based on a sense of community and shared values (Elton Report, 1989).
- Effective participation is facilitated when a head teacher leads a staff team that actively consults with students and their parents regarding school affairs (Weare, 2000).
- Students are more likely to cooperate with regulations they had a role in developing.



Practical steps for improving participation at school:

- Allow students a say in running the school, such as through student councils or student input on school policies (through student representatives or voting on appropriate policy matters).

- Ensure parental involvement. Parent communication about student activities and successes (rather than just problems) increases parental involvement.
- Display students' work throughout the school and call attention to their achievements, even in helping others or in improving the school (e.g. cleaning up, painting a mural, or creating groups to play chess or other activities).



Fostering independence

- An important role of schools is to empower students to become independent.
- Learning is more effective when students are encouraged to think for themselves (Weare, 2000).
- The most significant variable affecting academic achievement is the student's ability to monitor and assess their own work and determine how to further develop and apply a skill. Constructive teacher feedback is very helpful in developing student independence and responsibility for their own learning (Hattie, 2008).



Practical steps for fostering independence at schools:

- Give students age-appropriate responsibilities within the class and the school.
- Offer structured opportunities to provide feedback and share views.
- Provide programmes that develop leadership, encourage debate and improve negotiation and public speaking such as the Model United Nations Programme (www.un.org/en/mun).

Early identification and intervention to promote well-being and mental health

- Identify and address problems at an early stage. By intervening early it is likely that more serious mental illness can be averted (Rutter et al., 1998).
- It is important for educators to balance the risk of “labelling” a child at an early age and the importance of early identification. Educators should not aim to diagnose children but rather to identify the student’s difficulties, provide school support and when necessary (e.g. the student continues to deteriorate despite school efforts) refer to medical specialists.



Practical steps for early identification and interventions at schools:

- Schools should develop policies and standard procedures for identification of children, providing support and a protocol for referrals.
 - Clarifying who teachers should contact (principal, lead teacher, etc.), helps accelerate appropriate early identification.
 - Child study teams at the school who meet to discuss and plan for struggling students can enhance this process.
- It may be hard at times to determine to what extent a behaviour is problematic. For example, pre-schoolers could be very active, so how do you determine if the child falls in the normal range of activity or is hyperactive?
 - A helpful tip is to compare to their age cohort. In a class of pre-schoolers, how does the identified child compare to his/her classmates?
 - Make use of a screening questionnaires (see Appendix 5. Screening tools).
- When in doubt, or the student is not improving, refer for an evaluation.

Support and training for teachers and other staff

- Working with children who have mental health problems can be very challenging and stressful (Hanko, 1995).
- Workload and student behaviour have been found to be significant predictors for depression in teachers (Ferguson, Frost & Hall, 2012).
- A teacher who is overwhelmed has more difficulty supporting their students.



Practical steps for supporting and training teachers and avoiding burnout include:

- Identifying problems early and creating a culture that encourages teachers to discuss difficulties they may be having in the classroom setting.
- Establishing teacher support groups allowing peer-to-peer consultations or consultations with the school psychologist or social worker if available.
- Helping teachers identify and reconnect with the reasons that they decided to be educators and promote these aspects in their daily work.
- Creating a school environment that is positive and fosters the professional and personal development of teachers.
- Training in behaviour management techniques (this is particularly helpful, see the section below on discipline and management of disruptive behaviour).
- Helping teachers understand that difficult behaviour by children may be a cover-up for other difficulties that may be too painful or too embarrassing for a student to discuss (i.e. domestic violence, divorce).

The role of parents in the child's education

Parents have a pivotal role to play in the education for their children within the school setting and beyond. According to a research study by Harvard Professor Ronald Ferguson (2007), "Nearly half of a child's achievement in school can be accounted for by factors outside the school, including parent support". It is therefore very important for parents to be active partners with the school in the education of their children.

The parental role may be divided into several areas, including:

- supporting the child's education at school and at home; Klepfer (2001) identified the following areas where parents can support their children:
 - attendance: ensuring that their children are attending school to be able to learn;
 - attitude: parents' attitude towards school may influence that of their children;
 - priority: education must be given a top priority;

- support: parents need to offer support and help their children when in need;
- role model: the parent needs to be a positive role model in shaping their children's attitudes towards learning;
- involvement: research reveals that high self-esteem and student achievement are closely related to positive parental involvement in school;
- communication: parents need to maintain communication with their child's school.



- providing an environment that is conducive to learning at home:
 - maintaining a calm and quiet environment;
 - providing adequate nutrition and encouraging physical activity;
 - limiting the use of electronics;
 - maintaining structure and insuring adequate sleep;
 - encouraging reading and doing homework.
- communicating with school and ensuring their child's academic attainment, emotional well-being and social development:
 - maintaining active communication between schools and parents (essential);
 - regular parent-teacher conferences to discuss the child's progress and coordinate efforts at home and at school;
 - parent-teacher associations (organizations intended to facilitate parents' involvement in schools).



Behavioural management strategies for schools

Discipline and management of disruptive behaviour


Discipline is an important part of school life and different strategies and techniques are used to discipline children. Use of negative discipline techniques like physical or corporal punishment, criticizing or threatening should never be used in a school setting owing to their harmful effects on the child (for example increasing aggression or development of low self-esteem). It is much better to use positive discipline techniques to ensure compliance.



Practical steps to manage disruptive behaviours:

- The best way is to take a preventative approach with a school/classroom routine and structure that minimizes opportunities for misbehaviour.
- Set reasonable and fair limits (rather than arbitrary and constantly changing limits and expectations).
- Ignore inappropriate behaviour when appropriate. It is not appropriate to ignore behaviour when a child is causing damage or hurting themselves or others. Remember that ignoring takes time to affect a behaviour, initially the child may even increase the intensity/frequency of a behaviour to gain attention.
- Redirect or distract behaviours when possible; for example, if a student starts to become disruptive, call on that student to read a passage out loud, answer a question, or have another student speak (so the misbehaving student may stop to avoid antagonizing a peer).

- Employ natural and logical consequences, e.g. letting children experience the consequences of their own actions whenever it is “safe” to do so. If the student speaks meanly to another student who then will not play with that student, then examining what happened (instead of forcing them to play together) may help the student recognize impacts and then be motivated to attempt alternative behaviours identified with staff assistance.
- Help students develop decision-making skills by giving them simple decisions to make and by considering the likely consequences of those decisions, both on themselves and on others.
- Help students develop alternatives to disruptive behaviours such as doing a productive (rather than destructive) task, taking a break in the classroom to regroup, going to do something else with others in the building (e.g. turn in attendance sheets), if the student is too upset to regroup, etc.
- Reward successes during the school day with praise, stickers or tokens that allow the student to “earn” privileges or desired activities (take a special book home, eat with a peer, choose a game).
- With the student, develop a multi-step plan for waiting, such as “count to 10, then raise your hand and look the teacher in the eyes.”
- Teach and reinforce positive strategies like sharing, negotiation and cooperation.
- Do a countdown for the last several minutes of an activity to help make transitions from one activity to another easier. For instance, announce when there are 5 minutes left, 4 minutes, etc.
- Praise students often for specific things they have done during the day. Praise them for calming down after disruptive behaviours; give them “positive attention” for what they do right.
- When the student resists following direction, shift the conversation to student choices and consequences (“You can decide whether to complete this project right now. If you choose not to, that will mean either you will have more homework tonight or you will be staying in after school to complete it”).
- Set limits against aggression at the beginning of the school year when everyone is calm and communicate your expectations clearly (“We will respect the space of others, so please stand at least one floor tile apart when we are in line; we only talk one at a time, so allow your peers to finish; we keep our hands to ourselves, we speak nicely to others”, etc).

- 
- Be consistent, predictable and fair in your disciplining methods.
 - Teach children to control anger by giving them “information” about how anger is aroused, highlighting triggers which make a child angry, and teach them to use words to convey feelings (rather than violent actions).
 - If a student becomes oppositional or upset, first recognize the reaction (“It is upsetting when you follow the steps and then get the wrong answer”) and then invite the student to consider alternatives (“Hmmm ... would you like to try a different problem and we’ll try the same steps and see if it’ll work, or would you prefer that we do that problem again and we’ll both go through each step to see where it’s going wrong?”).
 - Use “time outs” by removing the student from the class or difficult situation (usually 1 minute for each year of age).
 - Send positive notes home if the child was able to maintain good behaviours.
 - If reprimands are used, do it with calm emotions (without appearing overtly hostile or angry).
 - Use nouns that indicate belonging to a group when giving instruction (“We need you to stay calm so we can finish the maths exercise”).

Remember	Do not overdo any of the techniques.
	Be consistent and systematic.
	Do not humiliate or embarrass the student, criticize their personality, family, or background, but rather talk about the misbehaviour itself. The student is not “bad” but rather an “action” may be bad as the student “behaved badly”.
	Your tone of voice and attitude should remain friendly. If the student raises or uses a loud voice, speak softer (rather than escalate with the student).
	Reinforce desirable behaviour at every opportunity and attempt to provide 5 positive comments for any negative comment throughout the school day.
	Model positive behaviour and show students how you can handle frustration, by breaking events down, thinking aloud about options, and how you plan to remedy a situation. Practice what you teach. What you do (how you act) is far more important than anything you say to students.

Counselling

Teachers are not expected to be trained counsellors and should refer students who need counselling for professional help. However, teachers can use basic counselling skills in working with children (Table 6).



Table 6. Basic counselling skills that can be used by teachers

Skill	Operationalization
Relationship-building	Establishing a relationship based on empathy, trust and respect
Active listening	Using skills such as maintaining eye contact, appropriate use of body language, nodding one’s head, modulating tone to indicate empathy

Interviewing skills	Asking open-ended questions, e.g. "Can you tell me more about ... ?" Ask questions in a neutral, non-judgmental way Using questions appropriate for the child's age Reflective listening that demonstrates that the teacher has accurately understood the child's experience, e.g. "So you are saying you felt sad after the incident?"
Observations skills	Observing the child's verbal and non-verbal behaviour
Providing information	Providing factual information and challenging misconceptions




Circle time

Circle time (sometimes referred to as "group thinking time") is an increasingly popular technique used to facilitate students' communication of their feelings and concerns at school (UK Department for Education and Employment, 1999; Mosely 1996).



How to implement it:

- A facilitator (teacher or school counsellor if available) encourages students to explore issues of importance to the group (for example respecting the rights of others, bullying, substance abuse).
- Students should preferably sit in a circle to give them a feeling that they are in a safe and equal environment. If not possible, students can remain at their desks.
- The group should ideally consist of no more than 25 students to allow all a chance to participate in the discussions.
- The rules of the group should be presented by the facilitator:
 - respecting the opinions of others;
 - allowing each student a chance to participate;
 - no one is forced to share their opinion but participation is encouraged;
 - respecting each other's confidentiality.
- The agenda for each meeting should be defined clearly with students suggesting issues they would like to discuss.

- 
- Session structure:
 - beginning: reviewing the rules and presenting the topic of discussion;
 - middle: key issues are discussed;
 - closure: counsellor summarizes the discussions.
 - The facilitator's role is to actively listen, encourage participation by group members and allow them to come up with their own solutions.

For younger children, the facilitator may sit on a small chair or on the floor to be at the level of the students. Discussion topics could relate to identifying feelings, managing emotions and building self-esteem.

Life skills education

Life skills education should be an important part of mental health prevention and promotion efforts in emotionally healthy schools. According to a report of the UN interagency meeting (World Health Organization, 1999), life skills include:

- managing conflict;
- dealing with authority;
- problem-solving;
- making and keeping friends/relationships;
- cooperation;
- self-awareness;
- creative thinking;
- decision-making;
- critical thinking;
- managing stress;
- negotiation;
- resisting pressure;
- coping with disappointment;

- planning ahead;
- empathy;
- dealing with emotions;
- assertiveness;
- active listening;
- respect;
- tolerance;
- trust;
- sharing;
- sympathy;
- compassion;
- sociability;
- self-esteem.

According to the report, "Life skills education is designed to facilitate the practice and reinforcement of psychosocial skills in a culturally and developmentally appropriate way; it contributes to the promotion of personal and social development, the prevention of health and social problems and the protection of human rights."

The life skills training technique covers:

- hearing an explanation of the skill in question;
- observation of the skill (modelling);
- practice of the skill in selected situations in a supportive learning environment;
- feedback about individual performance of the skill;
- practice facilitated by role-playing in typical scenarios, with a focus on the application of skills and the effect they have on the outcome of a hypothetical situation;
- using skills learning "tools", e.g. by working through steps in the decision-making process;

- practice, starting with skills learning in non-threatening, low-risk, everyday situations and progressively transitioning to their application in threatening, high-risk situations;
- other important methods to facilitate life skills learning including group discussion debate, story-telling and peer-supported learning.

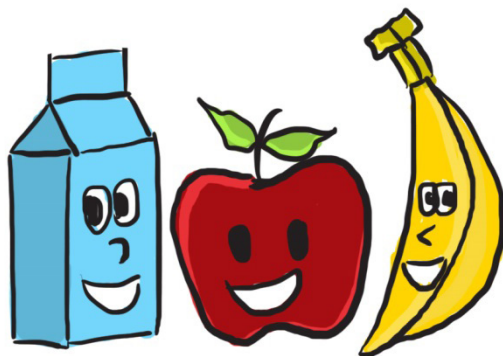
Teacher training is required for skills training. This can be provided as in-service training, but efforts should also be made to introduce it in teacher training colleges.

Other health-promoting efforts that impact mental health

In this section we will discuss other factors essential for healthy schools and relevant to mental health.

Nutrition

Proper nutrition is essential not only for a healthy body but also for a healthy mind. Nutritional deficiencies have a well-documented impact on cognitive and emotional development in children.



The WHO Regional Office for the Eastern Mediterranean notes that malnutrition remains the single biggest contributor to child mortality in the Eastern Mediterranean Region. Nearly one third of children in the Region are either underweight or stunted and more than 30% of the population suffer from micronutrient deficiencies. Due to the vital importance of this topic, the Regional Office held a meeting in Amman, Jordan in 2010 on nutrition, disability and mental health (World Health Organization, 2010).

There is a bidirectional relationship between mental health and nutrition. Several nutritional factors can influence mental health, including overall energy intake, intake

of the energy-containing nutrients (proteins, carbohydrates and fats) and intake of vitamins and minerals. Malnourished children have a greater degree of behavioural problems and deficient social skills and are also prone to decreased attention, deficient learning and lower educational achievement. In addition, children whose growth is stunted are also more prone to develop self-esteem issues and mental illness. Children who are on the other side of the spectrum, i.e. those who are obese, are also prone to developing self-esteem issues and emotional difficulties.

On the other hand, several mental illnesses can affect nutritional status. Depression for example is frequently accompanied by lack of appetite. The hallmark of eating disorders, including anorexia nervosa, bulimia and binge eating disorder, is an unhealthy relationship to food.

In addition, cognition, and subsequently the ability to learn and retain information, is linked to deficiencies in vitamin (vitamins B, C, D and E) and minerals (calcium, iodine, iron, magnesium, selenium and zinc). Poor nutrition has general effects on cognitive development resulting in lower IQ (lower by 15 points or more in the severely malnourished).



It is imperative that schools pay attention to the nutrition of their students and work with families towards ensuring children receive healthy diets. Many countries have established school nutrition programmes particularly for children who struggle with poverty and malnutrition.

The WHO Nutrition Friendly Schools Initiative is a school-based initiative to address the double-burden of nutrition problems throughout the life course (under-nutrition and obesity). Core components of the Nutrition Friendly Schools Initiative include:

- having a written nutrition-friendly schools policy;
- enhancing awareness and capacity-building of the school community;
- developing a nutrition- and health-promoting school curriculum;
- creating a supportive school environment;
- providing supportive school nutrition and health services.

Eating disorders

These cover a group of disorders where those affected (most commonly females) develop an unhealthy relationship with eating. They are among the most serious of all mental disorders. There are several types of eating disorder, including anorexia nervosa, where the person affected may suffer from a disturbed body image (thinking

they are obese while they may be very thin and undernourished) and abnormally low body weight. Affected individuals typically take extreme measures like restricting their food intake, over-exercising and inducing vomiting or taking weight loss pills among other behaviours. Another type of eating disorder is bulimia nervosa, where those affected may typically binge (eating large amounts of food) and regularly self-induce vomiting or misuse laxatives, diuretics or enemas after bingeing (purging type) or use other methods to prevent weight gain, such as fasting, strict dieting or excessive exercise (non-purging type).

Eating disorders may be life threatening and require professional care.

Vision/hearing/speech

Students who present with unidentified problems in their vision, hearing or speech may be thought to have mental illness. A non-verbal child may be thought to have autism or selective mutism at school while in reality may suffer from an expressive language difficulty. A student may be disruptive in class secondary to poor hearing (not being able to hear commands) or poor vision (not being able to follow teaching content).

Also, students who have impairments in vision, hearing or speech may find themselves struggling at school and subsequently be prone to low self-esteem and school avoidance.



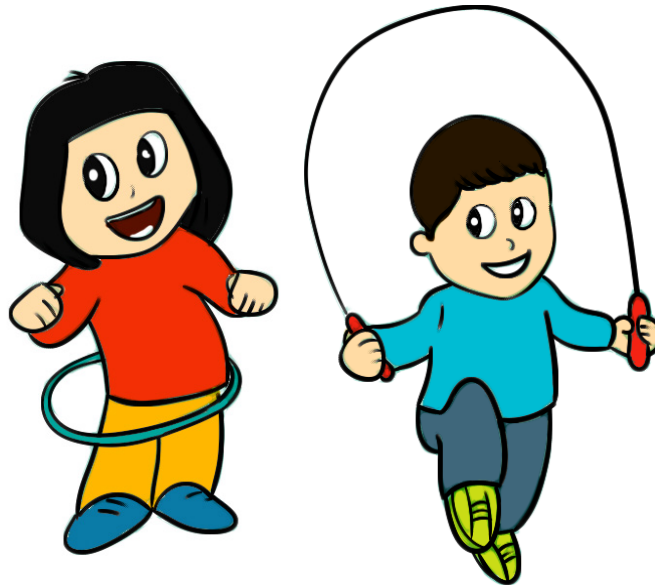
It is therefore important that educators be aware of the potential that students presenting with certain symptoms resembling mental illness should be referred for vision and hearing screening and speech evaluations.

Physical exercise

Regular physical activity in schools has significant health benefits in both the physical and the mental domains. Exercise improves strength and endurance, helps build healthy bones and muscles, can improve blood circulation and helps in weight control. It also has beneficial mental health effects including reducing anxiety and stress, maintaining a healthy body image and increasing self-esteem. It also helps keep children occupied with healthy activities. There is also evidence that links school-based physical activity to cognitive skills and improving academic achievement.

According to the United States Centers for Disease Control and Prevention (CDC), a comprehensive school physical activity programme is a multi-component approach by which school districts and schools use all opportunities for students

to be physically active, meet the nationally-recommended 60 minutes of daily physical activity, and develop the knowledge, skills and confidence to be physically active for a lifetime. The CDC together with SHAPE America has produced a guide for schools to develop, implement and evaluate comprehensive school physical activity programmes. This can be accessed at https://www.cdc.gov/healthyschools/physicalactivity/pdf/13_242620-A_CSPAP_SchoolPhysActivityPrograms_Final_508_12192013.pdf




Physical activity should be incorporated into the school curriculum and students encouraged to participate with the goal of achieving 60 minutes of physical activity per day. Any chance for physical activity at school should be utilized.

Media and mental health

Screen time

With the proliferation of different types of media (TV, computers, smart phones, etc.) children are increasingly spending time consuming media content. The American Academy of Pediatrics recommends parental monitoring of “media time”. Likewise, with increased access to electronics in schools and in after-school programmes, educators have a similar role to play.

 Action	<p>Action</p> <ul style="list-style-type: none"> • Limit the time children consume media content to 1-2 hours/day. • Provide alternative activities for entertainment such as playing outside, board games, etc. • Monitor the type of media content children are exposed to for language, violence and sexual content. • All entertainment media should be avoided for children under 2 years.
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Internet addiction

Internet addiction is becoming an increasingly common problem. It may manifest in a school setting in different ways both directly and indirectly. Directly, students may find themselves spending excessive time online whether on school computers or hand held devices. They may also give up leisure time or lunchtime to spend on the Internet. Internet addiction may also affect school activities indirectly. If the student is up all night browsing the Internet, they may be late to school, appear tired or unfocused or may not go to school at all.

There are no specific criteria to diagnose Internet addiction as it may vary from person to person, so there is no specific number of hours per day spent online that would indicate Internet addiction. However there are some warning signs that Internet use is becoming problematic (from helpguide.org), including:

- losing track of time spent online;
- having trouble completing tasks at school or at home;
- isolating from family and friends due to spending excessive time online;
- feeling guilty or defensive about your internet use;
- feeling a sense of euphoria while involved in internet activities.



Cyberbullying

Cyberbullying is bullying that takes place using technology. It can occur through different forms of electronic media including social media, texts and emails by sharing rumours, embarrassing pictures or stories and hate or racist speech as well as creating fake profiles, etc.

Prevention of cyberbullying requires close collaboration between parents and school staff and interventions including monitoring children's online presence and encouraging communication with school staff if a child or their friend is being cyberbullied. More information is available at stopbullying.gov.

Suicide prevention

According to WHO statistics:

- More than 800 000 people die annually from suicide, roughly one death every 40 seconds.
- Suicide is among the three leading causes of death in some countries among those aged 15-44 years and the second leading cause of death in the 10-24 years age group (these figures do not include suicide attempts).
- In 2004, suicide was estimated to represent 1.3% of the total global burden of disease.



The WHO recommends the following strategies for suicide prevention at a population level:

- restriction of access to means of suicide (such as toxic substances and firearms);
- identification and management of persons suffering from mental and substance use disorders;

- improved access to health and social services;
- responsible reporting of suicide by the media.

(Please consult Module 3 for classroom interventions related to suicide prevention.)

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Module 3.

Addressing student mental health problems in your classroom (and when to refer for additional help)

Mental health and school

Childhood and adolescence are periods characterized by rapid developments not only in the physical domain, but also emotionally and cognitively. Most people go through this period without significant mental health problems however, almost everyone experiences some emotional distress during their journey towards adulthood, which they learn to overcome and adapt to.

Prevention efforts in schools should be a priority and involve primary, secondary and tertiary prevention (Fig. 3).

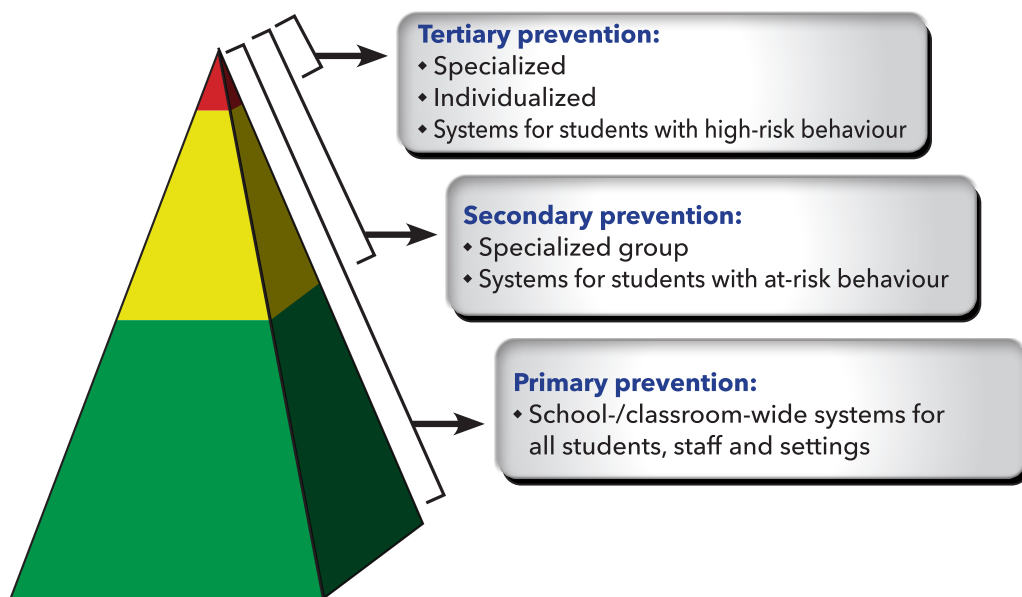


Fig. 3. Levels of prevention

Source. University of Maryland Technical Resource Center for School Mental Health.

It is not necessary for teachers to determine whether a child has a mental disorder, nor to diagnose a child with a mental disorder. Attempting to diagnose children risks inappropriately labelling a child, alienating children and their parents, and requires specialized training. Rather, it is important for teachers to understand how to support the mental health of all students in the classroom, including those with mental health problems and disorders, and to determine when mental health problems are severe enough to require additional help from family members and/or a mental health specialist.

When to refer to a specialist for evaluation and treatment

- When behaviours/symptoms are getting worse rather than better.
- When behaviours/symptoms are negatively impacting the child's functioning at home or at school.
- When symptoms are severe or distressing.
- When there is risk or danger towards self or others.
- When classroom interventions in the classroom alone are not enough.
- When in doubt, it's always better to get a consultation.

Some general behaviours and symptoms that may warrant a referral include:

- a sudden drop in scores or academic performance;
- sudden withdrawal or isolation from peers;
- being too emotional or quick to anger;
- frequently getting into fights or defiance;
- pervasive sadness and crying;
- exhibiting bizarre behaviours like responding to things that are not there;
- becoming mute or disengaged;
- truancy from school;
- appearing too tired or sleepy in class on a consistent basis;
- repetitive behaviours;
- self-injurious behaviours (e.g. cutting, head banging);
- significant changes in weight;
- frequently leaving the class due to pains and aches that do not appear on weekends or holidays.



Roles and responsibilities within the school in regard to mental health

Everyone in the school setting has a role to play in promoting mental health and providing a safe and emotionally healthy environment. School staff should work very closely with families; if a child is in need for a referral the family should be consulted first and provide consent for such an evaluation.

Some of the primary stakeholders in relation to a child's mental health in a school setting are delineated below:

Teachers are trained to educate students and their experience working with children with difficulties varies greatly. Teachers do not and should not diagnose children with mental illnesses, but do have a large role to play in maintaining a healthy classroom environment, early identification of children with difficulties and referring when needed.

Parents are active partners in promoting the mental health of their children in a school setting. Parents know their children more than anyone else, the home environment is important for learning and working collaboratively together with schools when their children are having difficulties is of paramount importance.


Social workers are concerned with helping individuals, families and communities to enhance their well-being. A social worker helps people develop their skills and their ability to use their own resources and those of the community to resolve problems. Some social workers with specialized training are able to provide therapy/counselling services. In many schools, if a social worker is available they would be first in line for consultation by teachers if a child is having a problem.

Child and adolescent psychiatrists are physicians who specialize in the diagnosis and treatment of emotional, behavioural and psychological challenges affecting children, adolescents and their families. They have a medical education and can prescribe medications.

Psychologists are trained professionals who evaluate and treat a range of emotional, behavioural and psychological challenges, conduct research and perform testing.

Occupational therapists are professionals who specialize in the assessment and treatment of conditions that affect an individual's ability to perform daily tasks.

Physical therapists are professionals who focus on improving or restoring mobility and reducing pain.



School nurses specialize in the advancement of the health, well-being and academic success of students. When available, the school nurse is typically in charge of administering psychotropic medications to students when these are prescribed during school hours.

Speech-language pathologists specialize in evaluating and treating disorders related to speech, language, communication, swallowing and fluency.

Community leaders such as politicians and religious leaders have an active role to play in improving mental health in school settings. Community leaders can help raise awareness about the importance of school mental health and also provide advocacy for providing school staffing and resources for mental health.

Privacy and confidentiality

It is important for any professional working with children with mental health challenges to appreciate issues of confidentiality. Parameters of privacy and confidentiality should be clearly delineated to the family to help them understand that the staff will protect the privacy of the student's information and the confidentiality of what he or she discloses in an evaluation. The child and the family also need to be informed that, if there are safety issues such as a child who wants to harm themselves and/or others, the staff will need to take appropriate actions to ensure everyone's safety.

Behavioural manifestations of common mental health problems and strategies to address them

In the following sections we present behavioural manifestations of common mental health problems, discuss case examples and present strategies that can be used to help students with these difficulties. Strategies are organized into three categories.

- Tier 1 strategies to address mild problems. Strategies are simple to implement, require minimal resources and will likely benefit all students in the classroom.
- Tier 2 strategies to address moderate problems, or if Tier 1 interventions are not sufficient to address problems. Strategies require specific activities tailored to the child with problems.
- Tier 3 strategies to address severe problems, or if Tier 2 interventions are not sufficient to address problems. Strategies require specific activities tailored to the child with problems and may necessitate the involvement of additional teaching staff.

General strategies that can be helpful for any child with emotional/behavioural difficulties include:

- empathic listening and taking a supportive stance;
- modelling positive mental health strategies such as relaxation, mindfulness and managing stress e.g. teach students to tighten and loosen their fingers or teach students to breathe in slowly and deeply through their nose, hold as they count to 5 and slowly exhale;
- helping students challenge negative thoughts and problem solve;
- providing academic support/accommodations to help them during times of stress.

The behavioural manifestations of common mental health problems that may be encountered in a school setting are described below.

Anxiety problems

Students with anxiety problems may:

- feel afraid, anxious, angry, irritable and/or frustrated;
- cry excessively, have tantrums;
- “freeze” or be unable to participate in activities;
- demonstrate clinginess with caregivers and teachers;
- be afraid to talk, avoid talking or not say what they want because they are afraid they will stutter;
- fidget;
- be easily frustrated;
- worry so much about getting everything right that they take much longer to finish their work;
- refuse to begin out of fear that they won’t be able to do anything right;
- avoid school out of fear of becoming embarrassed, humiliated or failing;
- get behind in their work due to numerous absences;

- experience symptoms such as chest tightness, stomach aches, headaches, shortness of breath and sweating.

Case study 1 (anxiety)

Mariam is a 12-year-old girl. She always appears worried and frequently bites her nails. She frequently leaves class with complaints of a headache that only occurs during school days. She is always worried about her family and if something bad would happen to them while she is at school, worried about her health and what will happen if she gets ill and worried about what others think of her. Sometimes when she gets anxious she feels her heart pounding and her body trembling, she becomes short of breath and starts to feel sweaty. She realizes that her worries are excessive but feels helpless confronting them.



Questions to consider

- What strategies could be implemented by the teacher to support Mariam?
- What strategies could be implemented by the parent to support Mariam?
- What strategies could be implemented by peers to support Mariam?
- Who else could support Mariam and how?
- When would you refer Mariam to a specialist?

A referral may be appropriate when the symptoms of anxiety become so overwhelming as to impact the child's educational attainment or social functioning and when classroom interventions are not sufficient to mitigate the problem. Refer if a child gets panic attacks. Also refer if there are concerns regarding self-injurious behaviours or suicidal thoughts or behaviours.

School-based interventions for anxiety (Table 7)

Table 7. Decreasing anxiety and stress

Troubling behaviours you might see in the classroom: escalating anxiety			
Intervention	Teacher	Parent	Friends
Speak slowly and calmly, encourage breathing slowly	T	P	
Break tasks down (right now we just need to walk to the building to see the birds)	T	P	
Help the students consider the probability of events ("I'm afraid to get on the bus because it will crash." "Hmmm...What are the chances it will crash? How many buses do you see driving out there that are not hitting other cars.")	T	P	
Help students evaluate all the evidence for their conclusions ("I'm no good at maths." "Hmmm....what have your maths grades been for the past week? All good except today? Wonder why you had one hard day and the others all went well?")	T	P	
Model and practice positive self-talk ("I can do this." "Even though I missed the last problem, I can get the next one correct.")	T	P	F
Have students use a fear thermometer to identify what most frightens them and what to do when they are at different levels	T	P	
Encourage student to utilize relaxation techniques (e.g. deep breathing, guided imagery, muscle relaxation).	T	P	
Use successive approximations: if the child is afraid to speak in class, allow them to speak alone in front of a mirror ... record and play self ... speak in front of a few classmates ... speak in front of the class	T	P	

Tier 1 strategies 

Tier 2 strategies 

Tier 3 strategies 

Role play 1

Student: I am afraid to take the bus home ... I know it will crash ... I saw a school bus crashing on TV.

Teacher: I see that you are worried, but what are the chances that the bus will crash?

Student: I don't know, I just feel that something bad will happen.

Teacher: How many buses do you see out there that are crashing into other cars?

Student: I don't know, I guess not many.

Teacher: Yes not many! So how have you been coming to school?

Student: I take the bus every day!

Teacher: And how many times has it crashed?

Student: It has never crashed, I just feel it might but what you are saying makes sense, maybe I shouldn't be too worried.

Teacher: You know we all sometimes experience thoughts when we are nervous that may be unhelpful. What question can you ask yourself when you have a first thought that is unhelpful?

Student: Hmm ... I don't know.

Teacher: What about something like: What is the evidence for that? How do I know this is true?

Student: Thanks, I'll try to remember to ask myself those questions.

Case study 2 (separation anxiety/school refusal)

Hatem is a 7-year-old boy. For the last two months almost every morning he has complained of a stomach ache when it is time for school and refuses to go. He was examined by his doctor, who was unable to find a cause for the pain. On weekends he is in good health and has no abdominal pain. His mother, Fatima, believes that her neighbour, with whom she had a conflict, has used black magic on Hatem that has made him unable to go to school. His mother gets angry with him every day and tries to drag him to school. He says he would rather stay home with his mother and that he worries something bad will happen to her while he is away. A few months back, while Hatem was at school his mother had a seizure and was hospitalized for a few weeks.



Please note that school refusal may also be for reasons other than separation anxiety.

Questions to consider

- What strategies could be implemented by the teacher to support Hatem?
- What strategies could be implemented by the parent to support Hatem?
- What strategies could be implemented by his peers to support Hatem?
- Who else could support Hatem and how?
- When would you refer Hatem to a specialist?

A referral may be appropriate when the symptoms of depression become so overwhelming as to impact the child’s educational attainment or social functioning and when classroom interventions are not sufficient to mitigate the problem. Also refer if there are concerns regarding self-injurious behaviours or suicidal thoughts or behaviours. If the child is presenting with physical symptoms they should be referred to their paediatrician to rule out any medical causes.

School-based interventions for separation anxiety (Table 8)

Table 8. Separation anxiety

Troubling behaviours you might see in the classroom: refusal to separate from parents to attend school			
Intervention	Teacher	Parent	Friends
Make school more magnetic (something to look forward to on arriving, such as playing with peers, etc.) and home less magnetic (no sleeping in, watching television or playing video games, etc.)	T	P	
Allow parents to send notes in the student’s lunch (rather than phone the student while at school)	T	P	
Have the student use “strength” cards (e.g. superheroes, etc.) to recall strengths and powers to manage stress	T	P	
Allow the child to spend time at first in the library or with other staff to ease them into the building (and reward efforts to get to the classroom)	T	P	
Introduce the student to next year’s teacher and have parents visit next year’s classroom during a vacation interval	T	P	
Identify a hierarchy of staff to meet the child on arrival at school and other staff to whom the child can go if distressed during class time	T		

Tier 1 strategies



Tier 2 strategies



Tier 3 strategies



Post-trauma problems

Students with post-trauma problems may:

- feel anxious or irritable;
- have drastic mood changes or appear unusually sad;
- act younger than their age;
- be clingy and/or whiny;
- be impulsive and/or aggressive;
- be unable to perform previously acquired skills, even basic functions like speech;
- have difficulty concentrating;
- be preoccupied and become easily confused;
- lose interest in activities;
- become quiet and/or sad and avoid interaction with other children;
- not show feelings or appear “numb”;
- avoid activities or places related to trauma;
- exhibit repetitive play with themes related to trauma;
- have nightmares/flashbacks;
- display an exaggerated startle response;
- have difficulty sleeping.

Case study 3 (post-trauma)

Amr is a 16-year-old boy who lives in a country that has recently experienced political unrest and he personally witnessed a shooting. His teacher Mr Mohamed noted a big change in his attitude and classroom behaviour a few months after the school year started. He used to be a very bright and engaged student, pleasant and well-liked by everyone. He was always attentive in class and eager to answer complicated maths problems on the blackboard. Recently, Amr became very withdrawn, appears distracted and his mood changed to be sad and irritable. He was also noted to be “jumpy” and would jump off his chair hearing any sudden noise. When a discussion

of the revolution started in class, Amr appeared very distressed and started to sweat profusely. Amr has also become mistrustful and always seems to be “watching over his shoulders”. Amr admits to getting daily memories, flashbacks and nightmares related to a shooting he witnessed.



Questions to consider

- What strategies could be implemented by the teacher to support Amr?
- What strategies could be implemented by the parent to support Amr?
- What strategies could be implemented by peers to support Amr?
- Who else could support Amr and how?
- When would you refer Amr to a specialist?

A referral may be appropriate when symptoms such as flashbacks and nightmares overwhelm the child to an extent that they are not able to concentrate in class, when the child becomes disruptive or aggressive and when classroom interventions are not sufficient to mitigate the problem.

School-based interventions for trauma, disasters and very stressful situations (Tables 9,10)

Table 9. Trauma, disasters and very stressful situations: distress, crying and irritability

Troubling behaviours you might see in the classroom: distress, crying, irritability			
Intervention	Teacher	Parent	Friends
Make the school a safe, predictable place with normal routines (however, academic demands may need to be decreased for days to weeks depending on the severity of the trauma)	T	P	
Allow the students to deal with traumatic reminders at their own pace	T	P	F
Consider school events to minimize trauma (avoid unnecessary fire drills or discussion of historical events that force the students to recall the trauma)	T	P	F
Teach relaxation techniques to diminish escalating distress; teach students to tighten and loosen their fingers, toes, etc.; teach students to breathe in slowly and deeply through their nose and hold as they count to 5, and slowly exhale	T	P	F
If a student shows distress, help them identify what triggered their distress (do this outside of class and consider alternatives e.g. reading different material, doing something to distract themselves while in class)	T	P	F
Identify with the student "signals" such as raising a finger to allow the student to be excused if distressed	T	P	F
Identify coping skills such as alternative activities that the student can do such as independent projects or activities for outside class	T	P	F
Help students recognize and think through their options and the likely consequences when something distresses or reminds them	T	P	F
Allow the student to write reactions in a journal that can be put away or reviewed with the teacher or other staff later	T	P	F
Allow the student to go see other staff to regroup and then return to class	T	P	

Tier 1 strategies



Tier 2 strategies



Tier 3 strategies



Table 10. Trauma, disasters and very stressful situations: intrusive thoughts or pashbacks

Troubling behaviours you might see in the classroom: intrusive thoughts or pashbacks			
Intervention	Teacher	Parent	Friends
Help the child recognize that their current situation is safe so they are grounded and not afraid in the classroom	T	P	F
Provide "a minute" for the student to think of other things or do something else (get a drink of water, do a different task, etc.)	T	P	
Encourage the student to identify friends who help support them and protect them in that moment	T	P	F
Allow the child to write down an intrusive thought or flashback to discuss with other staff	T	P	

Tier 1 strategies



Tier 2 strategies



Tier 3 strategies



Depression or sadness problems

Students with depression or sadness problems may:


- cry easily, look sad, feel alone or isolated;
- appear anxious or afraid;
- act angry or irritable;
- demonstrate marked changes in school behaviours;
- find it harder to stay on task, lose concentration;
- have frequent absences from school;
- experience change in academic performance;
- lose motivation;
- abandon favourite hobbies or sports, show decreased interest in being with peers, become withdrawn;
- change eating and sleeping habits;
- have changes in feeling, thinking and perceiving;
- express inappropriate guilt;
- express feelings of not being good enough, worthlessness, failure;
- express hopelessness: nothing to look forward to;
- speak in a monotonous or monosyllabic manner;
- be irritable, e.g. snapping at people for no apparent reason;
- be restless or slowed down;
- misuse drugs;
- eat/sleep too much or too little.


Students with depression are at increased risk for self-injury and suicidal thoughts and attempts. Educators should be wary of any comments about or signs of self-injury or suicide and every comment should be taken seriously and brought to the immediate attention of the child's parent, mental health specialist and/or school nurse

Students with mood stability problems may:

- show fluctuations in mood, energy and motivation (these fluctuations may occur hourly, daily, in specific cycles, or seasonally);

- alternate between fearfulness and recklessness;
- appear angry, irritable and/or frustrated;
- have episodes of overwhelming emotion such as sadness, embarrassment, elation or rage;
- have difficulty concentrating and remembering assignments, understanding assignments with complex directions, or reading and comprehending long, written passages of text;
- demonstrate poor social skills and have difficulty getting along with peers.

	<p>Younger children:</p> <ul style="list-style-type: none"> • frequently exhibit fast mood swings, many times within a day. • are more likely to be irritable and prone to destructive tantrums than to be overly happy and elated.
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	<p>Older adolescents:</p> <ul style="list-style-type: none"> • show similar patterns of mood instability as adults with changes from high to lows, involving high intensity of mood.
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Case study 4 (depression)

Yasmine is a 10-year-old girl who teachers notice has been appearing sad over the last 3 months. She frequently cries in class and appears excessively emotional. She also appears distracted and is unable to focus even on simple tasks. She no longer feels motivated to complete her work or engage in classroom discussions. She appears like she has lost a lot of weight. At home, her parents have noticed that she has been irritable and is quickly “triggered” by her sister. She complains of being very tired, being unable to focus and lacking the motivation to do almost anything.



Questions to consider

- What strategies could be implemented by the teacher to support Yasmine?
- What strategies could be implemented by the parent to support Yasmine?
- What strategies could be implemented by peers to support Yasmine?
- Who else could support Yasmine and how?
- When would you refer Yasmine to a specialist?

A referral may be appropriate when the symptoms of depression become so overwhelming as to impact the child’s educational attainment or social functioning and when classroom interventions are not sufficient to mitigate the problem. Also refer if there are concerns regarding self-injurious behaviours or suicidal thoughts or behaviours.

School-based interventions for improving mood and mood regulation (Table 11)

Table 11. Improving mood and mood regulation

Troubling behaviours you might see in the classroom: negative mood			
Intervention	Teacher	Parent	Friends
Check in with the student to quantify his/her mood (on a 10-point scale, with 10 being happy) and identify pleasurable activities to engage in (take a walk, listen to music, exercise, seek out a positive peer)	T	P	F
Identify activities or class projects where the student can work with supportive peers	T	P	
Help the student evaluate “all the evidence” surrounding negative thoughts	T	P	
Help students evaluate all the evidence for their conclusions (“I’m no good at maths.” “Hmmm ... what have your maths grades been for the past week? All good except today? Wonder why you had one hard day and the others all went well?”)	T	P	
Model and practice positive self-talk (“I can do this.” “Even though I missed the last problem, I can get the next one correct.”)	T	P	F
Allow the student to do alternative tasks or to be in other parts of the room if weepy or sad	T	P	
Have the student start with familiar, previously successful tasks to get going and then move to new and/or more challenging tasks	T	P	
Identify study partners who can support and assist with assignments	T	P	F

Troubling behaviours you might see in the classroom: negative mood			
Intervention	Teacher	Parent	Friends
Have the student write in a journal about moods and write songs or poems	T	P	
Outside of class, help the student identify things that contribute to distressing mood states	T	P	
Identify a staff response to self-injurious behaviours so that students are assessed without being stigmatized	T	P	

Tier 1 strategies  Tier 2 strategies  Tier 3 strategies 

Role play 2

Student: I don't want to take the test, I am a failure and will fail this test too.

Teacher: Hmm ... how have your grades been for the past year?

Student: They were not bad but I know I'll fail this test.

Teacher: You have always done well and you will do well this time too.

Student: I am not sure.

Teacher: How many times in your life have you passed a test?

Student: Many times, I can't remember the number.

Teacher: You have to remind yourself, if I have done it before, I can do it again.

Student: I guess you are right!

Teacher: You know we all sometimes experience thoughts when we are sad that may be unhelpful. What question can you ask yourself when you have a first thought that is unhelpful?

Student: Hmm ... I don't know.

Teacher: What about something like: What is the evidence for that? How do I know this is true?

Student: Thanks, I'll try to remember to ask myself those questions.

Case study 5 (suicide)

Mona is a 17-year-old girl. She has been having a hard time at home as she had met an older male whom she wanted to marry. Her parents found out about this and told her that she was too young to get married and requested she terminate the relationship immediately. Apart from going to school she was no longer allowed to leave the house without a family member. At school her teachers noticed that she had become distressed and appeared distracted and sad. It came to the attention of her teacher that she told her best friend at school that she has been thinking of ending her life. A few days later, Mona swallowed 20 pills from her mother's medication.



Questions to consider

- What strategies could be implemented by the teacher to support Mona?
- What strategies could be implemented by the parent to support Mona?
- What strategies could be implemented by peers to support Mona?
- Who else could support Mona and how?
- When would you refer Mona to a specialist?

Any concerns regarding suicide or self-injurious behaviours warrant immediate attention and a referral to a specialist.

School-based interventions for addressing suicidal behaviour (Table 12)

Table 12. Addressing suicidal thoughts and behaviours in the classroom

Troubling behaviours you might see in the classroom: suicidal thoughts or behaviours			
Intervention	Teacher	Parent	Friends
Strengthen protective factors against suicide, including good relationships with classmates and teachers and access to supports inside and outside the classroom	T	P	F
Identify students who may be at risk for suicide (sudden or dramatic changes in behaviour or performance, giving away material possessions)	T	P	
Establish dialogue with a distressed and/or suicidal young person; it is important to understand that the teacher is not alone in this communication process	T	P	
Respond to students who may be at risk for suicide (talking or writing about dying, feeling hopeless or having no reason to live or killing them self, looking for ways to kill them self) by taking necessary action	T	P	
Supervise the student identified to be at imminent risk constantly (or make sure they are supervised by an adult) until they can be seen by a professional	T	P	
Escort the student to see a professional and provide additional information to help in the assessment; a professional should notify the parents	T	P	

Tier 1 strategies



Tier 2 strategies



Tier 3 strategies



Hyperactivity, impulsivity and inattention problems

Students with hyperactivity and impulsivity problems may:

- have difficulty paying attention or staying on task;
- not complete tasks and make careless errors;
- make choices without thinking them through;
- blurt out answers before the teacher finishes a question;
- interrupt teacher and other students;
- talk too loudly;
- fidget/have difficulty remaining still and staying in seat.

Other children may easily get frustrated with them and they may become frustrated with peers and themselves.

Students with inattention problems may:

- not listen when spoken to;
- have difficulty paying attention or staying on task;
- not complete tasks and make careless errors;
- forget tasks and materials (jackets, books, pencils, homework);
- daydream or appear "spacey";
- have a very messy/disorganized desk area;
- lose objects;
- avoid activities that require sustained mental effort.


Case study 6 (ADHD/disruptive behaviours)

Hassan is a 7-year-old boy in second grade. His teacher notices that he is not able to sit still in class. He is always disrupting class and disturbing other students. When his teacher calls on him to stop he says he can't help it as "my body is always on the go". Other children complain that he is always in their space. He frequently finds himself distracted by other students and everything that happens in the class seems to capture his attention. His teacher feels that he is behind on his learning despite being a very smart student. His attention is poor even when she talks to him directly. Speaking to his mother, she notes that at home he also seems very hyperactive and makes decisions without really thinking about their consequences. He is always jumping around and breaking things. He is not organized and always seems to lose his work.



Questions to consider

- What strategies could be implemented by the teacher to support Hassan?

- 
- What strategies could be implemented by the parent to support Hassan?
 - What strategies could be implemented by peers to support Hassan?
 - Who else could support Hassan and how?
 - When would you refer Hassan to a specialist?

A referral may be appropriate when the symptoms are disruptive to the classroom, impact the child's educational attainment or that of others, put the child or others at a risk of injury and when classroom interventions are not sufficient to mitigate the problem.

School-based interventions for responding to problems with attention, organization, hyperactivity and impulsivity in the classroom (Table 13)

Table 13. Improving attention, organization, hyperactivity, impulsivity

Intervention	Teacher	Parent	Friends
Troubling behaviours you might see in the classroom: inattention			
Preferential seating; seat the student at front of class	T	P	F
Post rules, the daily routine and a school calendar in a regular place (e.g. front of classroom, refrigerator at home) and go over them daily	T	P	
Break steps down and have child repeat them back to you	T	P	
Allow extra time to complete tasks (not at recess as the student often needs to discharge energy)	T	P	
Provide the student a copy of notes or audio record	T		
Underline, circle, or highlight key terms on reading material for the student	T	P	
Have a staff member help the student write responses	T	P	
Troubling behaviours you might see in the classroom: disorganization			
Have students check in after doing the first 1-2 problems to ensure they are following the correct steps	T	P	
Praise/reinforce the child for doing the "right thing" when they follow steps, organize their desk and other goals prioritized for them	T	P	
Keep extra materials (pencils, books when possible) at school and at home	T	P	
Help the child organize desk and work space, e.g. papers in coloured folders	T	P	
Allow the child to start by completing sentences already started, or paragraphs structured for them ("I am in favour of _____. The first reason supporting this is _____")	T	P	
Have the child use a daily assignment book and check it before they leave for home	T	P	
Identify a "coach" staff person for the student to meet with at the end of each day to prepare materials before going home	T	P	F
Troubling behaviours you might see in the classroom: hyperactivity			
Provide breaks for the student to move about	T	P	
Break tasks down into 10-20 minute segments so that the students can move within the classroom	T	P	
Provide alternative outlets for physical activity; have the child raise a hand, count to five, then raise the other hand; have the student wiggle fingers/toes to relax (not be disruptive)	T	P	F
Provide goal-directed tasks such as distributing papers	T	P	F
Troubling behaviours you might see in the classroom: impulsivity			
Clarify rules of personal space (stand one floor tile/three arm lengths apart, use your inside voice after other person has stopped speaking, etc.)	T	P	F
Allow the child to have a designated place in lines with children (between two pro-social peers)	T	P	F
Allow the student to leave early with another staff member or peer to the next place/class	T	P	F

Tier 1 strategies



Tier 2 strategies



Tier 3 strategies



Autism

Students with developmental problems (like autism) may:

- have impaired social behaviour (eye contact, reading facial expressions, etc.);
- demonstrate communication and language difficulties;
- have a narrow range of interests and activities;
- have repetitive behaviours;
- usually, but not always, have some degree of intellectual disability.

Case study 7 (autism)

Joseph is a 6-year-old boy. He has no friends at school and doesn't seem interested in interacting with others. He spends a lot of time in class trying to line objects up and when excited he has a flapping hand movement. He is mostly non-verbal except for a few words he learnt recently and he doesn't look his teacher in her face. At times he gets upset and punches his face or bangs his head against the walls. In speaking to his mother, the teacher learns that he has had these problems since his first year and has received special educational services since.

Questions to consider

- What strategies could be implemented by the teacher to support Joseph?
- What strategies could be implemented by the parent to support Joseph?
- What strategies could be implemented by peers to support Joseph?
- Who else could support Joseph and how?
- When would you refer Joseph to a specialist?

A referral may be appropriate when the child becomes disruptive or aggressive, when there are self-injurious behaviours like head banging or biting and when classroom interventions are not sufficient. The child should also be referred for speech therapy for assisted communication in the case of speech delays and to occupational/physical therapy for sensory integration issues and motor impairments.

School-based interventions for dealing with social communication problems in the classroom (Table 14)

Table 14. Improving social communication and engagement with others

Troubling behaviours you might see in the classroom: observing social rules			
Intervention	Teacher	Parent	Friends
Describe rules in positive language for students (walk in a line, speak after the other person finishes, keep your hands to yourself, etc.)	T	P	F
Point out in stories, movies, television shows, etc. how people stand, look at each other and start, cue and stop conversations appropriately	T	P	F
Practice having students listen to another student and to ask 1–2 questions rather than change the topic or talk about themselves; this is sometimes easier when students identify particular interests and can be matched up	T	P	F
Use clear simple language (concrete instead of sarcasm, metaphors, idioms)	T	P	F
Explain nonverbal communications (facial expressions for happiness, anger, disgust, surprise, etc.) to help students accurately recognize emotions of others	T	P	F
Identify peers the student can work, play and eat snacks/meals with	T	P	
Provide signals and time for students to transition	T	P	
Substitute acceptable behaviours for unacceptable ones (touching a piece of fabric instead of pants, squeezing a soft ball instead of flapping or waving a pen, etc.)	T	P	
Provide students with examples of acceptable social behaviours (e.g. squeezing a soft ball instead of flapping)	T	P	
Provide a “social story” of events to the student to help them prepare for different social situations (https://carolgraysocialstories.com/)	T	P	
Position the student in a social skills group at lunch or other times to practice asking questions and speaking conversationally	T	P	F
When available, have another staff member familiar with sensory devices (e.g. occupational therapy) help the student identify alternative sensory experiences to calm down (deep joint compression, weighted blankets/clothes, headphones to block out noise, etc.), and identify school tasks (lifting, being in quiet places) that enhance learning	T	P	

Tier 1 strategies 


Tier 2 strategies 

Tier 3 strategies 

Psychosis

Students with psychosis problems may:

- have perceptions (visual, auditory, tactile) in the absence of external stimuli;
- have thoughts or beliefs that are unusual and not shared in the individual’s culture;
- speak in a way that is difficult to follow;
- behave unpredictably (e.g. childish silliness, agitation, complete lack of motor or verbal activity);

- 
- respond or interact with things that are not there;
 - feel like others want to hurt him/her or are plotting against them;
 - withdraw from peers in the classroom;
 - seem unmotivated to participate in class and to complete homework.

Case study 8 (psychosis)

Fahad is a 17-year-old boy. His teachers noticed in the last month that he has become very different and is “no longer his usual self”. He appears very withdrawn and refuses to eat any food in the classroom noting that his classmates are trying to poison him because “they are jealous”. He has also been mumbling to himself and interacting with someone who is not there. He thinks that a friend wants to hurt him and has planted cameras everywhere in the classroom, which makes him uncomfortable at school. His parents have taken him to an imam to perform ruqya (exorcism) but with no improvement in his symptoms.

Questions to consider

- What strategies could be implemented by the teacher to support Fahad?
- What strategies could be implemented by the parent to support Fahad?
- What strategies could be implemented by peers to support Fahad?
- Who else could support Fahad and how?
- When would you refer Fahad to a specialist?

A child presenting with psychotic symptoms should be referred for an evaluation as soon as possible. This evaluation should also include a complete medical examination to rule out medical conditions that may present with psychosis.



School-based interventions for dealing with unusual or distorted thoughts in the classroom setting (Table 15)

Table 15. Addressing unusual or distorted thoughts

Troubling behaviours you might see in the classroom: unusual or distorted thoughts			
Intervention	Teacher	Parent	Friends
Instead of arguing about unusual or distorted thoughts, shift to academic work ("OK, I heard your comments, and now we'll move forward with maths.")	T	P	
Provide grounding comments to help the students share the reality of others ("Well, despite your fears about others, you are in your 5th grade class with all your usual classmates.")	T	P	
Emphasize a simple structure and routine that remains familiar	T	P	
Rely on concrete, observable activities (e.g. maths instead of reading a complex character novel) when the student reports more unusual thoughts	T	P	
Employ a series of steps to deescalate students when unusual thoughts increase: 1) change topic, 2) change activity, 3) change setting (room or place) 4) change staff (have the student engage with different staff)	T	P	
Model and practice positive self-talk ("I will get through this—I made it through yesterday and will get through this today, too." "Even though I hear someone's voice, it is OK and will not hurt me.")	T	P	
Gather information from parents to understand potentially difficult topics as well as activities that can help distract the student (e.g. music, sports).	T	P	
Identify places and staff students can access when distressed	T	P	

Tier 1 strategies

Tier 2 strategies

Tier 3 strategies

Oppositional problems - conduct problems

Students with oppositional problems may:

- challenge class rules;
- refuse to do assignments;
- lose their temper;
- argue or fight with other students;
- argue with the teacher;
- deliberately try to provoke people;
- disobey rules and directions;
- intentionally create conflict with peers;
- blame others for their actions and behaviours;
- interpret motives and behaviours of others negatively;
- seek revenge for perceived wrongs.

Students with conduct problems may:

- engage in power struggles;
- react badly to direct demands or statements such as: "you need to ..." or "you must ...";
- consistently challenge class rules;
- refuse to do assignments;
- argue or fight with other students;
- create disruptions in the class;
- blame others and not take responsibility for their behaviour;
- steal from others;
- destroy property in the classroom;
- disrespect adults and other students;
- endanger the safety and well-being of others.

Case study 9 (conduct disorders)

Hamad is a 17-year old boy who is described by his teachers as "very difficult". He refuses to follow instructions and appears to enjoy defying authority, whether that of his teachers or his parents. He has not been regular in attending school and on many days doesn't attend. His parents report that he hangs out with "a bad group of

kids” and have caught him smoking marijuana. They suspect that he may be using other drugs and he has admitted to his school counsellor that along with a group of friends he had stolen money from a local store. When he is at school he frequently gets into physical fights with other students and was suspended a few times for bringing a knife with him to school.

Questions to consider

- What strategies could be implemented by the teacher to support Hamad?
- What strategies could be implemented by the parent to support Hamad?
- What strategies could be implemented by peers to support Hamad?
- Who else could support Hamad and how?
- When would you refer Hamad to a specialist?

A referral may be appropriate when the symptoms are disruptive to the classroom, impact the child’s educational attainment or that of others, put the child or others at a risk of injury and when classroom interventions are not sufficient to mitigate the problem. Also refer when there are substance abuse issues that require specialized interventions.

School-based interventions for dealing with problems associated with poor behaviour and lack of cooperation in the classroom (Table 16)

Table 16. Improving behaviour, cooperation and collaboration

Troubling behaviours you might see in the classroom: refusal			
Intervention	Teacher	Parent	Friends
Provide the student with a few appropriate choices (“You can do this work during lunch, or I’ll help you do the first problem now”)	T	P	
Use “I need you to” rather than “you need to” statements	T	P	
Use consistent cues, words and signals to identify inappropriate behaviours; state what you want instead of what you do not want; model politeness (“Please walk down the hall on the right side seeing if you can be the quietest you’ve ever been”)	T	P	F
Slowly think through the student’s alternatives and the likely consequences when refusal occurs; allow the student to consider and choose options	T	P	
Acknowledge the student’s frustration or disappointment when something doesn’t go as they want and then invite the student to figure out another solution for now	T	P	
Identify the student’s good efforts even if the results are not successful	T	P	
Focus on fixing problems rather than who is to blame; reward collaborative efforts between the student and others	T	P	F
Have students describe how they think others feel when a conflict occurs	T	P	F

Troubling behaviours you might see in the classroom: refusal			
Intervention	Teacher	Parent	Friends
Have students role play how to resolve conflicts	T	P	F
Confront lies/distortions outside of class	T	P	
Allow the student to correct mistakes or misdeeds	T	P	
Identify a "time-out" space in the classroom where the student can go to calm down	T	P	
Minimize escalations by speaking softly and sparsely and demonstrating patience to allow the student to do the right thing	T	P	
Identify a staff member to walk or talk with the angry student to process the event outside of class	T	P	
With parents, identify prosocial events/activities or other helpful peers and students for the student to spend more time with	T	P	F

Tier 1 strategies ■ Tier 2 strategies ■ Tier 3 strategies ■

Case study 10 (bullying)

Mahmoud is a 16-year-old boy who has a history of bullying other students. Recently he has been targeting some younger students, including Hassan, an 11-year-old, soft-spoken boy. Mahmoud has been chasing Hassan in the playground and has taken away his sandwich. He calls him names and has engaged in a few fights with him. He has threatened that if Hassan tells the teachers that he will "get him outside of school".



Questions to consider

- What strategies could be implemented by the teacher to support Mahmoud?
- What strategies could be implemented by the parent to support Mahmoud?
- What strategies could be implemented by peers to support Mahmoud?
- Who else could support Mahmoud and how?
- When would you refer Mahmoud to a specialist?

A referral may be appropriate when the behaviours are impacting the child’s educational attainment or social functioning and that of others and when classroom interventions are not sufficient to mitigate the problem. Referrals should also be employed when there are other accompanying psychiatric symptoms that warrant further treatment. Also refer if there are concerns regarding self-injurious behaviours or suicidal thoughts or behaviours.

School-based interventions for improving behaviour, cooperation and empathy (Table 17)

Table 17. Improving behaviour, cooperation and empathy

Troubling behaviours you might see in the classroom: bullying			
Intervention	Teacher	Parent	Friends
Intervene immediately, separate the children involved and make sure everyone is safe; it is OK to get another adult to help	T	P	
Stay calm, listen without blaming and model respectful behaviour	T		
Support children who are bullied and makes sure they are safe; rearranging classroom or bus seating plans may be needed	T	P	F
Conduct classroom activities to educate about bullying (lead a class discussion about how to be a good friend, write a story about the effects of bullying or benefits of teamwork, role-play a scenario, read a book about the topic)	T		F
Involve students in sports and clubs to enable them to take leadership roles and make friends without feeling the need to bully	T	P	F
Maintain open communication between schools and parents	T	P	

Tier 1 strategies



Tier 2 strategies



Tier 3 strategies



Substance use problems

Students with substance use problems may:

- be moody and irritable, including sudden mood or personality changes;
- have low self-esteem and depression;
- behave irresponsibly;
- withdraw socially;
- pull away from family, teachers, other trusted adults;
- be argumentative and disruptive;
- break rules;
- decline in academic performance;
- have memory and learning problems;
- demonstrate poor judgment in situations;
- be late and absent from school;
- have problems with family and peer relationships and a lack of empathy for others;
- engage in other risky activities;
- change former activities or friends;
- demonstrate general lack of interest.

Case study 11 (substance use)

Hazim is a 17-year-old boy. His teacher noticed that his behaviours have significantly changed in the last 2 months. Before, he used to be a well-liked student who excelled academically. More recently, his grades have dropped significantly, he rarely attends class and when he comes he appears angry and moody, which has led to several fights. In a meeting with the school social worker, Hazim admits that he has been snorting cocaine and injecting heroin.



Questions to consider

- What strategies could be implemented by the teacher to support Hazim?
- What strategies could be implemented by the parent to support Hazim?
- What strategies could be implemented by peers to support Hazim?
- Who else could support Hazim and how?
- When would you refer Hazim to a specialist?

A referral may be appropriate for any child who is using drugs.

School-based interventions for dealing with substance use (Table 18)

Table 18. Addressing substance use

Troubling behaviours you might see in the classroom: using substances			
Intervention	Teacher	Parent	Friends
Improve school connectedness, which helps students with substance use problems	T	P	
Develop positive relationships with teachers, administrators and peers at school	T	P	
Define and enforce policies that establish school as a drug-free environment	T	P	F
Provide information and resources on substance abuse	T	P	
Clarify if certain activities (sports, drama, etc.) can help occupy the student's time in a meaningful way	T	P	F
Consider a recovery school for severe cases if available	T	P	
Encourage student to engage with substance-free peers and settings	T	P	

Tier 1 strategies



Tier 2 strategies



Tier 3 strategies



For interventions related to substance abuse in a primary care setting see Henry-Edwards S et al., 2003.

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Appendix 1. Teacher wellness

Importance of teacher wellness

Teacher wellness and mental health are critical to the success of students and schools. Teachers who focus on their own wellness are more likely to stay in the teaching profession and less likely to “burn out” (becoming very physically and emotionally tired after doing a difficult job for a long time). In addition, teachers who are mentally healthy are more likely to have positive interactions with their students. Also, research demonstrates that by focusing on teacher wellness, schools save money and there are many benefits to both the adults and students in the school.

Teacher stress and burnout

One reason that it is important to focus on teacher wellness is that teachers report high rates of stress in their profession. In many countries, there are also high rates of teacher turnover (teachers leaving the profession).

Teachers report several common sources of stress (Fisher, 2011; Kokkinos, 2007; Travers & Cooper, 1996):

- large class size;
- behavioural challenges in students;
- inadequate resources and poor physical space;
- bureaucracy;
- workload and paperwork;
- high responsibility for others;
- perceived inadequate recognition or advancement;
- gap between pre-service training expectations and actual work experience.

In addition to stress, teachers are likely to experience vicarious trauma and secondary stress from their students. According to the National Child Traumatic Stress Network (2008), “any educator who works directly with traumatized children and adolescents is vulnerable to the effects of trauma”.

Vicarious trauma is “the emotional residue or strain of exposure to working with those experiencing the consequences of traumatic events”. Vicarious trauma can occur from working with just one student with trauma, or can result from a “cumulative” number of interactions with traumatized students.

Many teachers report burnout, the condition where a person has become very physically and emotionally tired after doing a difficult job for a long time. Burnout is a multi-faceted phenomenon having three features (Maslach & Jackson, 1981):

- emotional exhaustion leading to increased feelings of strain, tension, anxiety and frustration and may include physical fatigue and insomnia;
- depersonalization involving a feeling of being removed and disconnected from oneself and others;
- reduced personal accomplishment, a feeling that you are not achieving your goals as you have in the past and that you are not making, and cannot make, a difference.

Signs of burnout include:

- emotional numbing, feeling “shut down”
- loss of enjoyment
- no time or energy for yourself
- sense of cynicism or pessimism
- increased illness or fatigue, aches and pains
- increased absenteeism, “sick days”
- greater problems with boundaries
- difficulty making decisions, or making poor decisions.

Teachers who report feeling burned out report significantly more negativity in their interactions with students, including sarcasm, aggression and responding negatively to mistakes.

Teacher wellness programmes

The following elements should be included in a comprehensive wellness programme for teachers (Directors of Health Promotion and Education, 2018):

- health education and health-promoting activities that focus on skills development and lifestyle behaviours that change along with awareness-building, information dissemination and access to facilities, and are preferably tailored to employees' needs and interests;
- safe, supportive social and physical environments, including organizational expectations about healthy behaviours and implementation of policies that promote health and safety and reduce the risk of disease;
- integration of the worksite programme into the school or district structure;
- linkage to related programmes such as employee assistance programmes, emergency care and programmes that help employees balance work and family life;
- worksite screening programmes, which ideally are linked to medical care to ensure follow-up and appropriate treatment as necessary;
- individual follow-up interventions to support behaviour change;
- education and resources to help employees make decisions about health care;
- an evaluation and improvement process to help enhance the programme's effectiveness and efficiency.

Teacher wellness programmes result in:

- greater job satisfaction among employees;
- increased teacher morale and well-being;
- improved employee performance;
- fewer absences;
- increased teacher ability to combat stress and build healthy coping strategies;
- improved retention of teachers.

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Appendix 2. Risk and protective factors for mental illness

Risk factors	Protective factors
Individual	
Genetic factors	Good physical health and development
HIV infection	
Other illnesses	
Malnutrition	Adequate nutrition
Substance abuse	No abuse of substances
Poor problem solving abilities	High level of problem solving ability
Learning disorders	Strong learning abilities
Poor school performance	Good school performance
Strong relationships	Poor relationships
Maladaptive personality traits/difficult temperament	Well-adjusted personality
Sexual, physical and emotional abuse/neglect	No history of abuse
Poor ability to learn from experiences	Ability to learn from experiences
Intellectual disability	Good intellectual functioning
Poor self-esteem	Good self-esteem
Poor social skills	Strong social skills
Irresponsible attitude towards sexual activity	Responsible attitude towards sexual activity
Family	
Poor maternal health during pregnancy and delivery	Good maternal health
Inconsistent care giving	Consistent care giving
Family conflict	Supportive family relationships
Poor family discipline	Good family discipline
Poor family management	High level of maternal education
Death of a family member	No losses in the family
Family detachment	Family attachment
Lack of opportunities for positive involvement in the family	Opportunities for positive involvement in family

Poor parental role modelling	Good parental role modelling
No incentive for involvement in family	Rewards for involvement in family
School	
Failure of school to provide appropriate environment to support well-being, attendance and learning	Caring, supportive, protective and stimulating school environment, promoting initiative and creativity
Academic failure/school drop out	Opportunities for involvement in school life
Inadequate or inappropriate provision of education	Positive reinforcement from academic achievements
Bullying	Positive relationship with peers
Failure of school to recognize psychosocial needs of children facing difficulties	Good identification and early intervention for students facing difficulties
Poor teacher-student relationships	Positive, nurturing relationship with teacher
Disengagement with school	Identity with school or need for educational attainment
Community	
Transitions (e.g. urbanization, migration)	Connectedness to community and community organizations
Community disorganization	Organized, supportive communities
Poverty	Adequate financial resources
Discrimination and marginalization	Inclusiveness and embracement of diversity
Exposure to violence	Safe neighbourhoods
Absence of role models	Positive role models
Lack of recreational opportunities	Opportunities for leisure

Appendix 3. Bullying prevention and intervention in schools

(Adapted from: stopbullying.gov, US Department of Health and Human Services)

Manage classrooms to prevent bullying

Teachers can consider the following techniques to promote the respect, positive relations and order that helps prevent bullying in the classroom.

- Create ground rules. Develop rules with students so they set their own climate of respect and responsibility.
- Use positive terms like what to do rather than what not to do.
- Support and reinforce school-wide rules.
- Be a role model and follow the rules yourself. Show students respect and encourage them to be successful.
- Make expectations clear; keep your requests simple, direct, and specific.
- Reward good behaviour; try to affirm good behaviour four to five times for every one criticism of bad behaviour.
- Use one-on-one feedback and do not publicly reprimand.
- Help students correct their behaviours. Help them understand violating the rules results in consequences: "I know you can stop (negative action) and go back to (positive action). If you choose to continue, then (consequence)."

Classroom meetings

Classroom meetings provide a forum for students to talk about school-related issues beyond academics. These meetings can help teachers stay informed about what is going on at school and help students feel safe and supported. These meetings work best in classrooms where a culture of respect is already established. Classroom meetings are typically short and held on a regular schedule. They can be held in a student's main classroom, home room, or advisory period.

Establish ground rules. Children should feel free to discuss issues without fear. Classroom meetings are not a time to discuss individual conflicts or gossip about others. Reinforce existing classroom rules. Start the conversation. Focus on specific

topics, such as bullying or respectful behaviours. Meetings can identify and address problems affecting the group as a whole. Stories should be broad and lead to solutions that build trust and respect between students. Use open-ended questions or prompts such as:

- Share an example of a student who helped someone at school this week.
- Without using names, share an example of someone who made another student feel bad.
- What did students nearby do? What did you do? Did you want to do something different - why or why not?
- If you could describe the perfect response to the situation what would it be? How hard or easy would it be to do? Why?
- How can adults help?

End the meeting with a reminder that it is everyone's job to make school a positive place to learn. Encourage children to talk to teachers or other trusted adults if they see bullying or are worried about how someone is being treated. Follow up when necessary. Monitor student body language and reactions. If a topic seems to be affecting a student, follow up with him or her. Know what resources are available to support students affected by bullying.

Stop bullying on the spot

When adults respond quickly and consistently to bullying behaviour they send the message that it is not acceptable. Research shows this can stop bullying behaviour over time. There are simple steps adults can take to stop bullying on the spot and keep children safe.

Do:

- Intervene immediately. It is OK to get another adult to help.
- Separate the children involved.
- Make sure everyone is safe.
- Meet any immediate medical or mental health needs.
- Stay calm. Reassure the children involved, including bystanders.
- Model respectful behaviour when you intervene.



Avoid these common mistakes:

- Don't ignore it. Don't think children can work it out without adult help.
- Don't immediately try to sort out the facts.
- Don't force other children to say publicly what they saw.
- Don't question the children involved in front of other children.
- Don't talk to the children involved together, only separately.
- Don't make the children involved apologize or patch up relations on the spot.

Support students involved. All children involved in bullying - whether they are bullied, bully others, or see bullying - can be affected. It is important to support all children involved to make sure the bullying doesn't continue and effects can be minimized.

- Support children who are bullied. Listen and focus on the child. Learn what's been going on and show you want to help. Assure the child that bullying is not their fault.
- Know that children who are bullied may struggle with talking about it. Consider referring them to a school counsellor, psychologist, or other mental health service.
- Give advice about what to do. This may involve role-playing and thinking through how the child might react if the bullying occurs again.
- Work together to resolve the situation and protect the bullied child. The child, parents and school or organization may all have valuable input. It may help to ask the child being bullied what can be done to make him or her feel safe. Remember that changes to routine should be minimized. He or she is not at fault and should not be singled out. For example, consider rearranging classroom or bus seating plans for everyone. If bigger moves are necessary, such as switching classrooms or bus routes, the child who is bullied should not be forced to change.
- Develop a game plan. Maintain open communication between schools, organizations and parents. Discuss the steps that are taken and the limitations around what can be done based on policies and laws.
- Be persistent. Bullying may not end overnight. Commit to making it stop and consistently support the bullied child.

Avoid these mistakes:


- Never tell the child to ignore the bullying.
- Do not blame the child for being bullied. Even if he or she provoked the bullying, no one deserves to be bullied.
- Do not tell the child to physically fight back against the child who is bullying. It could get the child hurt, suspended, or expelled.
- Parents should resist the urge to contact the other parents involved. It may make matters worse. School or other officials can act as mediators between parents.
- Follow up. Show a commitment to making bullying stop. Because bullying is behaviour that repeats or has the potential to be repeated, it takes consistent effort to ensure that it stops.

Address bullying behaviour. Parents, school staff and organizations all have a role to play. Make sure the child knows what the problem behaviour is. Young people who bully must learn their behaviour is wrong and harms others. Show children that bullying is taken seriously. Calmly tell the child that bullying will not be tolerated. Model respectful behaviour when addressing the problem.

Work with the child to understand some of the reasons he or she bullied. For example, sometimes children bully to fit in. These children can benefit from participating in positive activities. Involvement in sports and clubs can enable them to take leadership roles and make friends without feeling the need to bully. Other times children act out because something else - issues at home, abuse, stress - is going on in their lives. They may also have been bullied. These children may be in need of additional support, such as mental health services.

Use consequences to teach. Consequences that involve learning or building empathy can help prevent future bullying. School staff should remember to follow the guidelines in their student code of conduct and other policies in developing consequences and assigning discipline. For example, the child who bullied can:

- lead a class discussion about how to be a good friend;
- write a story about the effects of bullying or benefits of teamwork;
- role-play a scenario or make a presentation about the importance of respecting others, the negative effects of gossip, or how to cooperate;

- 
- do a project about civil rights and bullying;
 - read a book about bullying;
 - make posters for the school about cyberbullying and being smart online.

Involve the child who bullied in making amends or repairing the situation. The goal is to help them see how their actions affect others. For example, the child can:

- write a letter apologizing to the student who was bullied;
- do a good deed for the person who was bullied or for others in your community;
- clean up, repair or pay for any property they damaged.

Avoid strategies that don't work or have negative consequences. Zero tolerance or "three strikes, you're out" strategies don't work. Suspending or expelling students who bully does not reduce bullying behaviour. Students and teachers may be less likely to report and address bullying if suspension or expulsion is the consequence.

Conflict resolution and peer mediation don't work for bullying. Bullying is not a conflict between people of equal power who share equal blame. Facing those who have bullied may further upset children who have been bullied.

Group treatment for students who bully doesn't work. Group members tend to reinforce bullying behaviour in each other.

Follow up. After the bullying issue is resolved, continue finding ways to help the child who bullied to understand how what they do affects other people. For example, praise acts of kindness or talk about what it means to be a good friend.

Appendix 4. Examples of school intervention programmes from the WHO Eastern Mediterranean Region

Very few school interventions from the WHO Eastern Mediterranean Region have been reported in the literature; however, readers are referred to the 2014 review by Fazel et al. on school interventions from other low- and middle-income countries. Those reported from the Region were mostly in war-related trauma settings so the generalizability of the results is questionable. Listed below are some studies conducted in the Region:

1. Qouta SR, Palosaari E, Diab M, Punam^aki RL. Intervention effectiveness among war-affected children: a cluster randomized controlled trial on improving mental health. *J Trauma Stress*. 2012;25(3):288-98.

Location: Gaza, occupied Palestinian territory


Intervention: Children in school classes were randomized into intervention (n = 242) and waitlist control (n = 240). The intervention group participated in 16 sessions of teaching recovery techniques (TRT) and the controls received normal school-provided support. Data on post-traumatic stress symptoms (PTSS), depressive symptoms and psychological distress were collected at baseline (T1), post-intervention (T2) and 6-month follow-up (T3).

Main findings: At T2, the intervention significantly reduced the proportion of clinical PTSS among boys. In girls it reduced the symptom level and proportion of PTSS in girls who had a low level of peri-traumatic dissociation.

2. Peltonen K, Qouta S, El Sarraj E, Punam^aki RL. Effectiveness of schoolbased intervention in enhancing mental health and social functioning among war-affected children. *Traumatology*. 2012;18(4):37-46.

Location: Gaza, occupied Palestinian territory

Intervention: 225 Palestinian children participated and were divided into an intervention group (n = 141) and a control group (n = 84). A school mediation intervention aimed at improving social functioning through methods of problem solving, conflict resolution and dialogue skills and at enhancing mental health through caring for peers and preventing disruptive and aggressive behaviour was conducted. Participants reported symptoms of post-traumatic stress disorder (PTSD), depression (CDI), psychological distress (SDQ), quality of friendship, pro-social behaviour and aggressiveness at baseline at the beginning of the school year (T1) and at post-intervention eight months later (T2).



Main findings: Participating in the mediation intervention did not decrease symptoms or increase friendship quality or pro-social and nonaggressive behaviour. The mediation intervention was effective only in limiting the deterioration of friendships and post-traumatic behaviour across the intervention period. Authors noted that the findings may be partly explained by severe military violence during the academic year under inspection.

3. Thabet AA, Vostanis P, Karim K (2005). Group crisis intervention for children during ongoing war conflict. Eur Child Adolesc Psychiatry. 2005 Aug;14(5):262-9.

Location: Gaza, occupied Palestinian territory

Intervention: Children with moderate to severe posttraumatic stress reactions were allocated to group intervention (n = 47) encouraging expression of experiences and emotions through storytelling, drawing, free play and role-play; education about symptoms (n = 22); or no intervention (n = 42). Children completed the CPTSD-RI and the CDI pre- and post-intervention.

Main findings: No significant impact of the group intervention was established on children's post-traumatic or depressive symptoms. The authors suggested that continuing exposure to trauma and the non-active nature of the intervention were behind these findings.

4. Karam EG, Fayyad J, Karam AN, Tabet CC, Melhem N, Mneimneh Z, et al. Effectiveness and specificity of a classroom-based group intervention in children and adolescents exposed to war in Lebanon. World Psychiatry. 2008;7(2):103-9.

Location: South Lebanon

Interventions: All students (n = 2500) from six villages, most heavily exposed to war, received a classroom-based intervention delivered by teachers, consisting of cognitive-behavioural and stress inoculation training strategies. A random sample of treated students (n = 101) and a matched control group (n = 93) were assessed 1 month post-war and 1 year later. Mental disorders and psychosocial stressors were assessed using the Diagnostic Interview for Children and Adolescents (Revised) with children and parents. War exposure was measured using the War Events Questionnaire. The prevalence of major depressive disorder (MDD), separation anxiety disorder (SAD) and post-traumatic stress disorder (PTSD) were examined pre-war, 1 month post-war (pre-intervention) and 1 year post-war.

Main findings: The rates of disorders peaked 1 month post-war and decreased over the year. There was no significant effect of the intervention on the rates of MDD, SAD or PTSD. Post-war MDD, SAD and PTSD were associated with pre-war SAD and PTSD, family violence parameters, financial problems and witnessing war events.

Appendix 5. Screening tools that can be used at schools

(From Massachusetts General Hospital School Psychiatry Program: www.schoolpsychiatry.org, accessed 15 October 2013)

Table A5.1. Checklists for preliminary mental health screening

Checklist	Target age (years)	Who completes checklist? (No. of items)	Time to complete (minutes)	View free online
Child Behaviour Checklist	1.5-18	Parent, teacher: (118) Student: (112) Clinician: (96-99)	15-20	
Behavioral assessment system for children, 2nd ed.	2-21 8-21	Parent (134-160) Teacher: (100-139) Student: (139-185)	Parent, teacher: 10-20 Student: 30	
Child/adolescent psychiatry screen	3-21	Parent: (85)	15-20	Yes
Conners, 3rd ed.	3-17	Parent: (49) Teacher: (28)	30	
Home Situations Questionnaire	4-11	Parent: (16)	5	Yes
School Situations Questionnaire	4-11	Teacher: (12)	5	Yes
Pediatric Symptoms Checklist	6-16	Parent: (35)	5-10	Yes
SNAP-IV-C rating scale, revised	6-18	Parent, teacher: (90)	10	Yes
Beck youth inventories of emotional and social impairment	7-14	Student: (5 self-reports, 20 items each)	5-10 per inventory	

Note: The Child Behaviour Checklist and Conners are available in Arabic.

Appendix 6. Resources

Please note, WHO does not endorse any of these resources; they are made available here for the reader's reference.

Regional

- Resources in Arabic on child mental health and child development: www.mawared.org
- Handuleh D, Whitwell S, Fekadu D. Report: school mental health project in Somalia. *Arab J Psychiatry*. 2013;24(1):46-51. doi:10.12816/0000098.
- Minhas FA, Nizami AT, Minhas A, Javaid KB, Omer S. Training manual on mental health for school teachers. Rawalpindi, Pakistan: Institute of Psychiatry, WHO Collaborating Centre for Mental Health Research & Training, Rawalpindi Medical College; 2008.
- Teacher's manual. Beirut, Lebanon: Institute for Development, Research, Advocacy and Applied Care; 2012.

International

- Resources for educators and parents on learning disorders and child mental health: Child Mind Institute (<https://childmind.org/audience/for-educators/>).
- Embry DD, Biglan A. Evidence-based kernels: fundamental units of behavioral influence. *Clin Child Fam Psychol Rev*. 2008;11(3):75-113. doi:10.1007/s10567-008-0036-x.
- Clemson University website for the Olweus Bullying Prevention Program (OBPP) (http://www.clemson.edu/olweus/Training%20Materials/Section%2004--School-Wide%20Elements/Fundamental%20Units%20of%20Behavioral%20Influence_Embry_Biglan%20Tab%204%20Doc%207.pdf, accessed 21 December 2018).
- US government Stop Bullying website (<https://www.stopbullying.gov/>).

Websites with resources, announcements or events related to school mental health

- Massachusetts General Hospital School Psychiatry Program (www.schoolpsychiatry.org).
- UCLA School Mental Health website (<http://smhp.psych.ucla.edu>).
- University of Maryland School of Medicine National Center for School Mental Health (<http://www.schoolmentalhealth.org/Resources/>).

Training manual

- Weare K, Gray G. Promoting mental and emotional health in the European network of health promoting schools. A training manual for teachers and others working with young people. Copenhagen: WHO Regional Office for Europe; 1995.

Books

- Atkinson M, Hornby G. Mental health handbook for schools. London: Routledge; 2002.
- Patel V, Aronson L, Divan G. A school counsellor casebook. New Delhi: Byword Books Ltd; 2013.
- Weist D, Lever NA, Bradshaw CP, Owens JS, eds. Handbook of school mental health: research, training, practice and policy, 2nd ed. New York: Springer Science+Business Media; 2014.

Videos

- Comprehensive school mental health. A partnership among families, schools, and communities. Presented by Stephan SH, Lever N. University of Maryland School of Medicine's Division of Child and Adolescent Psychiatry (<https://www.youtube.com/watch?v=P8QaLGj0mWo>, accessed 18 December 2018).

Schools provide a great opportunity to promote mental health and emotional well-being, prevent mental health problems and identify and support children who are experiencing emotional difficulties. This manual provides a concise and practical guide for educators to better support the mental health needs of their students and to take practical steps that are implementable in school settings. It is intended for those involved in the educational process, including teachers, school administrators, nurses, social workers and school counsellors, in addition to educational policy-makers and nongovernmental organizations. It accompanies a training package that includes lecture outlines, slide presentations and handouts.



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