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Children and Adolescents Mental Health: A Review of Mental Health in Schools and Communities

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Abstract

There is growing evidence and awareness regarding the magnitude of mental health issues across the globe, starting half of those before the age of 14 and have lifelong effects on individuals and society. Despite the multidimensional nature of this global challenge, which necessarily requires comprehensive approaches, many interventions persist in seeking solutions that only tackle the individual level. The aim of this paper is to provide a systematic review of evidence for positive effects in children and adolescents' mental health resulting from interventions conducted in schools and communities in which interaction among different agents is an integral component.

Keywords: School-based; Community-based; Dialogue; Mental health; Well-being; Emotional development; Interventions; Program; Interaction

Introduction

Childhood and adolescence are critical periods to promote mental health as more than half of mental health problems start at these stages, and many of these persist throughout adult life. Currently, this has become a priority as worldwide data shows an increase in the prevalence of mental health issues in childhood and adolescence and the percentage of those afflicted reaching nearly 20% the situation is further exacerbated by the fact that many of these children and adolescents are not receiving the specialized care they require

Consequently, important efforts to bring together the best evidence about mental health have been done and raised the challenge of agreeing about fundamental issues in the field such as the definition of mental health and other related concepts According to WHO, mental health is understood not as a mere absence of illness, but rather, in a broader sense, as a state of well-being in which individuals develop their abilities, face the stress of daily life, perform productive and fruitful work, and contribute to the betterment of their community). This definition served as the basis for WHO Mental Health Action Plan, 2013–2020, which incorporates the concepts of mental health promotion, mental illness prevention and treatment, and rehabilitation. Particularly, developmental aspects of children and young people, including, for instance, the ability to manage thoughts, emotions, as well as to build social relationships, and the aptitude to learn, are emphasized in the plan as critical facets to be tackled in mental health interventions [1,2].

Mental health interventions conducted in schools and in the communities start from the premise that the problems experienced by adolescents are determined by the interaction of individual, environmental and family factors Accordingly, schools and communities offer an optimal context to intervene as children and adolescents grow and develop through social interaction. Schools and communities can make the most of its environment to foster child and youth development and to promote good mental health. Many of the mental health programs implemented in schools promote the development of social skills, socio-emotional competences, and learning outcomes while at the same time reducing disruptive behavior the school environment and climate can therefore play a critical role in encouraging the promotion of protective factors for mental health, such as social-emotional competences and skills.

Hence, social and cognitive development is enacted through social interactions in a particular cultural and social context drawing on the contributions of Vygotsky's theory of cognitive development; human interaction that takes place in the social and cultural context enhances learning and is fundamental for psychological function. These cultural processes in which people learn and developed occur through interactions with others, including symmetrical (peer) as well as expert–novice (e.g., teacher–student) relations importantly, specific instruments have been produced to capture productive forms of dialogue across educational contexts [3].

Most of the research have been devoted to understanding the central role played by the quality of dialogue and interaction between students, in small group classrooms, or in whole class setting teacher-student interaction Furthermore, research conducted in community-based schools has also reported the benefit of involving families and community members in learning interactions with elementary students, especially for those belonging to vulnerable populations Accordingly, community plays a central role as human develop through their interactions in the sociocultural activities of their communities. Similar improvements have been reported among students with disabilities as a result of engaging in caring and supportive interactions among peers and with other adults when solving academic tasks in interactive groups The relevance of productive forms of dialogue and supportive interactions among peers, teachers and other community members, have also reported positive effects in 4th grade students prosocial behavior These studies evidence the potential of educational interventions that draw on the potential of fostering interactions among different agents and promote productive dialogues as a tools for academic and social improvement [4].

However, when searching for mental health improvement through

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dialogic interactions, the research is scarce. The pioneering study carried out by showed the psychological and social benefits of the therapy based on open and anticipation dialogues with adults and adolescents that also involved the family along with the professionals. Rather than focusing in the individual, facilitating supportive interactions among peers, professionals and family members might be an asset underpinning mental health interventions with children and adolescents. This study showed the critical role of collective interactions, which were very different from a dialogue between two individuals They identified multi-system treatments (MST) characterized by engaging in close interaction professionals with adolescents, family, and other networks. Replication of these US studies in Norway found evidence of effectiveness, particularly, in the adolescents' social skills "what ultimately caused the observed outcome was not revealed. After all, methods do not help or cure anyone as such. Psychological methods -and other interaction-based means- exist as they user activity."

Whereas, determining the effect of the interaction itself in the outcomes obtained might be problematic, the authors of these paper aim to examine interaction-based mental health interventions, defined as those in which collective interactions, that involve professionals, family and community members with children and adolescents, are an integral component of the intervention. This systematic review focuses on those interventions conducted in schools and communities and its outcomes on children and adolescents' mental health. According to the WHO definition of mental health provided above, primary studies selected for this review will include positive outcomes in a broader sense, comprising not only the reduction of symptoms of mental disorder but also the promotion of emotional well-being.

Methods

The study carries out a systematic review, a methodology developed by the EPPI Centre of the UCL Institute of Education. We have also taken into account the recommendations by PRISMA and checklist by Joanna Briggs Institute (JBI), in order to offer transparency, validity, replicable, and updateable in this study.

Search Strategy

This systematic review has been focused and defined by the question: Do interaction-based mental health interventions in schools and communities have positive effects among children and adolescents? This question has been defined in terms of PICOS: In children and adolescents (Population) are interaction-based interventions (Intervention) effective in decreasing disruptive behaviors and affective symptoms such as depression and anxiety (in children and adolescents with mental health problems), and in increasing social skills, and improving well-being and academic engagement (in children and adolescents in general)? (Outcomes) [5].

For the review, empirical articles published in international scientific journals in the areas of psychology, education, and mental health and focused on interventions among children and youth between 2007 and 2017 were searched and screened. To that effect, the following databases were analyzed

The articles were searched using the following the exploration was completed with searches that employed synonyms or derivatives of the keywords. The keywords were also combined to refine the search. The publications containing the search criteria in the title, in the keywords and in the abstract were include [6].

Inclusion and Exclusion Criteria

In order to identify and select the studies most relevant to our research, inclusion and exclusion criteria were established.

The inclusion criteria were the following:

- Special population group: children and adolescents.

- Target age: 6 to 18 years of age, inclusive.

- Mental health interventions in which collective interactions, including professionals, families, and community members with children and adolescents, are an integral component.

- Studies reporting outcomes of the intervention in decreasing symptoms and/or promoting well-being.

The exclusion criteria were the following:

Interventions focus on early childhood, youth, or adults.

Target age is not specified, or the target population is below 5 or above 18 years.

Mental health interventions focusing on one-to-one interactions (i.e., professional-child/professional-adolescent).

The intervention is not described or assessed, as in trials, theoretical research or literature reviews.

Selection Process

The first part of the search yielded a total of 384 articles from indexed journals: 183 in published in the WOS database, 12 in Scopus, 33 in ERIC and 156 in PsycINFO. All these articles were entered into the Mendeley software for its screening and review. Basic information such as the title, year, authoring, and abstracts was obtained and introduced in a spreadsheet for a first screening [7].

The Evolution of School Mental Health

Current efforts to deliver mental health supports and services in schools were born out of significant changes within both the education and mental health systems in recent decades. The education sector formally recognized its responsibility to address students with disabilities, including serious emotional disturbance (SED), with the passage of the Education for all Handicapped Children Act in 1975, now known now known as the Individuals with Disabilities Education Act (IDEA). Similarly, Section 504 of the Rehabilitation Act of 1973 mandates that children with disabilities are entitled to a free and appropriate education and that children with adocumented "physical or mental impairment that substantially limits one or more major life activities" must receive supports Both policies facilitated movement toward schools delivering mental health support and necessary educational accommodations for students with emotional and behavioral disabilities . Simultaneously, the mental health sector saw an increase in federally funded community mental health demonstration projects that included children's (not just adult) services, eventually leading to a mandate for children's services to be part of community mental health programming. However, insufficient federal and state funding left these mandates largely unmet. It was not until the 1980s, amidst growing recognition of the inadequacy of children's mental health care quality and access, and overreliance on residential treatment , that mental health systems began to reflect child- and family-centered care in the "least restrictive environments." Investment by the National Institute of Mental Health in the Child and Adolescent Services System Program (CASSP), now managed by the Substance Abuse and Mental

Health Services Administration (SAMHSA), in the Systems of Care effort led the way for child-serving systems, including schools, to become committed partners in addressing the mental health of our nation's youth. In contrast to the fragmentation too often characteristic of the child mental health system, Systems of Care emphasized a shared responsibility of agencies (mental health, education, juvenile justice, child welfare) to coordinate a full array of community-based services for children and their families This was a key advance in the integration of schools and mental health; schools were no longer left to manage mental health problems alone during school hours, yet they were also no longer able to deem mental illness the burden of the mental health sector [8].

Creating Comprehensive School Mental Health Systems

The evidence shows that schools enhance both access and quality of mental health supports and services for students while our current community mental health system is inherently limited to supporting those young people most in need of care. The impacts of student (and staff) wellbeing on student performance have become increasingly vivid and motivating for those committed to school achievement, uncovered through the efforts of researchers examining factors related to academic achievement across all countries. Hence, the education sector is primed to accept mental health into their sphere, both as a part of their overall mission to produce healthy and productive citizens, and in their effort to optimize student academic performance.

Those core features of comprehensive school mental health systems include:

- A full complement of school and district professionals, including specialized instructional support personnel, who are well-trained to support the mental health needs of students in the school setting;
- Collaboration and teaming among students, families, schools, community partners, policymakers, funders, and providers to address the academic, social, emotional. and behavioral needs of all students and the predictable problems of practice in crossing systems and roles;
- A thorough and continuous needs assessment of school and student needs and strengths, coupled with resource mapping of school and community assets, to inform decision-making about needed supports and services;
- A full array of tiered, evidence-based processes, policies. and practices that promotes mental health and reduces the prevalence and severity of mental illness;
- Use of screening and referral as a strategy for early identification and treatment;
- Use of evidence-based and emerging best practices to ensure quality in the services and supports provided to students;
- Use of data to monitor student needs and progress, assess quality of implementation, and evaluate the effectiveness of supports and services; and
- Diverse and leveraged funding and continuous monitoring of new funding opportunities from national/federal, state, and local sources to support a sustainable comprehensive school mental health system.

Install multi-tiered systems of mental health supports in all schools

CSMHSs rely on a public health framework, striving to prevent problems before they become worse, often referred to in the education sector as a multi-tiered system of supports (MTSS). Aligned with tiered academic support models, MTSS for mental health most often employ a three-tiered model, as illustrated in Figure 1. Schools already operate from tiered systems of academic supports, designed to catch academic problems early (or ideally before they occur through screening), and so are well-positioned to implement a tiered framework for mental health. Tier 1: Universal Mental Health Promotion and Prevention for All Students Universal services and supports (Tier 1) are mental health-related activities, including promotion of positive social, emotional, and behavioral skills and wellness, designed to meet the needs of all students regardless of whether they are at risk for mental health problems. These activities can be implemented school-wide at the grade level and/or at the classroom level. One of the most well-researched and recognized universal mental health examples is the Good Behavior Game. Over 60 studies have reviewed the Good Behavior Game (a 20-minute daily classroom activity to encourage working well as teams, sustaining focus, etc.). Not only does this universal intervention benefit student behavior and achievement during the school year , but the positive outcomes persist into adulthood, with lasting effects on young adult behaviors, including lower rates of substance use disorders, delinquency/incarceration, and suicide ideation . Multiple universal mental health promotion and prevention programs involve the promotion of social and emotional competence in all students, teaching of core positive behaviors and relationship skills, and mental health literacy. A solid evidence base exists for the impact of school-based primary prevention. Students engaged in social-emotional learning (SEL) programming demonstrate a significant increase in standardized academic test scores compared to their peers not engaged in SEL training. In addition to positive student outcomes, educators trained to implement SEL curricula report lower depression and job-related anxiety, higher quality interactions with students and greater perceived job control than those not trained in SEL. The importance of these traits for school and life beyond the school years has resulted in 25 states now having learning goals that articulate what students should know and be able to do socially and emotionally, up from only 4 states doing so in 2015. Meta-analyses indicate that students participating in school social-emotional learning programs show significantly greater social-emotional skills, positive self-image, and prosocial behaviors, and significantly fewer [9].

Conclusion

Young people spend approximately 15,000 hours in schools by age 18, so schools are, de facto, a significant partner, invested daily in cultivating each child's social-emotional health and skills for coping with stress and adversity. Schools are a vital component of the mental health system for ensuring our entire nation's youth have access to a comprehensive array of mental health supports and remedying many of the limitations of existing mental health systems that are not truly accessible for too many students. Federal, state and local investments in school mental health acknowledge this potential, with MTSS now a regular part of the dialogue among educators [10,11].

There is evidence of a positive effect on the mental health of children and adolescents, both in decreasing internalizing and externalizing symptoms, and in promoting personal well-being. Factors that foster mental health as social support or engagement also increase with interventions programs that include interaction as a main feature.

However, more research is needed into the specific impact of interaction on the mental health of children and adolescents, as well as analyzing the type of interactions that have the most beneficial effect.

Conflicts of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

References

1. Levin s Harvey, Gary E Howard, Eisenberg M Howard (1990) Neurobehavioral outcome one year after severe head injury. Experience of the Traumatic Coma Data Bank. J Neurosurg 73:699–709.
2. McCunny J Robert, Russo K Pearl (1984) Brain injuries in boxers. Phys Sportsme12:53–67.
3. Brooks N, Campsie L, Symington C, Beattie A, Mckinley W (1986) The five year outcome of severe blunt head injury: A relatives view. J Neurol Neurosurg Psychiat 49:764–770.
4. Davis DL, Boster L (1988) Multifaceted therapeutic inervention with the violent psychiatric patient. Hospital and Community Psychiatry 39:867–869.
5. Rapoport MJ, McCullagh S, Streiner D, Feinstein A (2003) The clinical significance of major depression following mild traumatic brain injury. Psychosomatics 44:31–37.
6. Hovenkamp-Hermelink JHM, Jeronimus FB, Myroniuk S, Riese H, Schoevers AR, et al. (2021) Predictors of persistence of anxiety disorders across the lifespan: a systematic review. Lancet Psychiat 8: 428-443.
7. Stein BM, Sareen J (2015) Clinical Practice: Generalized Anxiety Disorder. N Engl J Med 373: 20590-68.
8. Taylor G, McNeill A , Girling A, Farley A, Lindson-Hawley N, et al. (2014) Change in mental health after smoking cessation: systematic review and meta-analysis. BMJ 348: g1151.
9. Olthuis JV, Watt MC, Bailey K, Hayden JA, Stewart SH (2016) Therapist-supported Internet cognitive behavioural therapy for anxiety disorders in adults. Cochrane Database Syst Rev 3: CD011565.
10. Baldwin DS, Anderson IM, Nutt DJ, Allgulander C, Bandelow B, et al. (2014) Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder: A revision of the 2005 guidelines from the British Association for Psychopharmacology. J Psychopharmacol 28: 403-439.
11. Witte S, Loew D, Gaus W (2005) Meta-analysis of the efficacy of the acetonic kava-kava extract WS1490 in patients with non-psychotic anxiety disorders. Phytother Res 19: 183-188.